VAN NATTA'S WORKERS' COMPENSATION REPORTER

VOLUME 43

(Pages 1-814)

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

43 Van Natta ____ (1990)

In the Matter of the Compensation of
DUANE C. LEAFDAHL, Claimant
WCB Case No. 89-15307
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Acker, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Holtan's order that upheld the self-insured employer's denial of his medical services claim for his current left knee condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact, with the following supplementation: The work claimant performed for Sause Brothers took place on ocean-going tug boats operating along the west coast of the Continental United States and between the coast and Hawaii. The injurious incident claimant experienced on August 7, 1988 took place on a Sause Brothers tug boat docked at Richmond, California.

CONCLUSIONS OF LAW AND OPINION

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

The Referee concluded that claimant's subsequent work as a crew member on a tugboat (Sause Brothers Ocean Towing) independently contributed to a worsening of his compensable left knee condition. The Referee reasoned that claimant was required to file a federal claim under the Jones Act, and his failure to do so defeated his claim for medical services under Oregon Workers' Compensation Law. We agree, for the same reasons stated by the Referee.

In a situation in which subsequent out-of-state employment independently contributes to a condition for which workers' compensation benefits are sought in Oregon, the original Oregon employer will remain responsible if the initial Oregon employment continues to materially contribute to that condition. Miville v. SAIF, 76 Or App 603 (1985). This rule applies, however, only if: (1) the claimant has filed a claim in the foreign jurisdiction where the second injury or exposure occurred; (2) that claim has been rejected; and (3) the earlier Oregon injury continues to be a material contributing cause of the present disability. See Olson v. EBI Companies, 78 Or App 261 (1986).

The court has construed Miville, supra, to stand for the proposition that where the medical evidence shows that the subsequent out-of-state employment contributed independently to the condition, even though the Oregon employment continues to materially contribute to the same disability, the original Oregon employer is not responsible if no claim was filed in the foreign jurisdiction. Progress Quarries and Western Employers Insurance v. Vaandering, et al, 80 Or App 160 (1986).

In the present case, the employer (International Paper) argues that, because claimant's work for Sause Brothers independently contributed to the condition for which compensation is now sought, Sause Brothers would be liable for his condition. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986). International Paper also argues that because claimant was employed as a crew member of a vessel, his injuries would fall under the provisions of the Jones Act, 46 USCA Sec. 688, et seq.

Finally, International Paper contends that, because the Board is without jurisdiction over Sause Brothers in this matter, the Runft case does not operate to preclude it from shifting responsibility to a later employment where the later employer is not joined as a party to the proceeding. Runft v. SAIF Corporation, 303 Or 493 (1987).

We agree with International Paper's argument that, under the circumstances, the Miville, Olson and Progress Quarries cases are applicable. We conclude that, because we are without jurisdiction over Sause Brothers, the Runft case does not preclude International Paper from shifting responsibility to the subsequent employer even though that employer (Sause) was not joined as a party. The employer has proven that claimant's subsequent employment with Sause independently contributed to his current left knee condition and, therefore, International Paper is no longer responsible for claimant's medical services for his left knee.

ORDER

The Referee's order dated February 16, 1990 is affirmed.

In the Matter of the Compensation of
JUANITA L. STINNITT, Claimant
WCB Case No. 89-19573
ORDER ON REVIEW
Robert J. Jackson (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

The SAIF Corporation requests review of Referee Schultz' order which found that SAIF had "unilaterally terminated" temporary partial disability benefits. On review, the issue is temporary disability. We reverse.

FINDINGS OF FACT

Claimant worked as a volunteer driver, driving one day a week for eight hours, for the Adult and Family Services Division of the State of Oregon. She was injured in a single car motor vehicle accident on November 18, 1987.

Claimant was paid temporary total disability at the rate of $50 per week until she was released for modified work, working two days a week for four hours per day. When claimant returned to modified work, SAIF modified the temporary disability payments to temporary partial disability, in the amount of $0 (Exs. 16, 17, 18A, 19, & 20)..

As of the date of hearing, claimant was not medically stationary, nor had her claim been submitted for closure.

CONCLUSIONS OF LAW AND OPINION

To begin, we cannot tell from the record what, if any, temporary total disability claimant was entitled to. ORS 656.210(1) provides in part:

> "When the total disability is only temporary, the worker shall receive during the period of that total disability compensation equal to 66-2/3 percent of wages, but not more than 100 percent of the average weekly wage nor less than the amount of 90 percent of wages a week or the amount of $50 a week, whichever amount is lesser. . . ."

The lesser of $50 and 90 percent of claimant's wages (zero) would be zero. However, ORS 656.210(2)(C) provides that, for workers with no remuneration, such as claimant, the Director may prescribe, by rule, a method of determining a weekly wage. Former OAR 436-60-20(7)(k) provides that volunteer workers' weekly wage shall be computed on the same assumed wage as the premium is based. We cannot determine from this record what that assumed wage was.

Assuming claimant's "wage" for premium purposes was $55.56 or less, claimant was entitled to $50 per week for temporary total disability. See former OAR 436-60-020(6).

Because temporary total disability is a wage replacement (see Cutright v. Weyerhaeuser Co., 299 Or 290 (1985)), an insurer is permitted to reduce temporary total disability to temporary partial disability when a worker returns to work. OAR 436-60-030(1) provides the method for computing temporary partial disability . Temporary partial disability is computed by subtracting post-injury wage earnings (here such wages would be the wage upon which premiums were based pursuant to OAR 436-60-020(7)(k)) from wages on the date of injury (also the wage used for premium purposes) and dividing the difference by the latter figure.

Here, claimant's assumed wage after her return to work was presumably the same as her wage on the date of injury, i.e., the wage upon which premiums were based. (Claimant has not proven otherwise.) Where post-injury earnings equal or exceed wages on the date of injury, the amount of temporary partial disability owing is zero. OAR 436-60-030(2); Safeway Stores v. Owsley, 91 Or App 475 (1988); Fink v. Metropolitan Public Defender, 67 Or App 79 (1984). Claimant was, therefore, entitled to temporary partial disability in the amount of zero upon her return to work.

Claimant argues that the insurer was not permitted to reduce temporary total disability to temporary partial disability because claimant did not return to "wage earning employment." In other words, claimant asks that, although her actual earnings on the date of injury were zero, an assumed wage be utilized for computing temporary total disability. But claimant then argues that we not use the assumed wage for purposes of temporary partial disability, but use her actual wage instead. We reject that argument. The relevant inquiry is, when she returned work, whether claimant's actual earnings had been diminished. Safeway Stores v. Owsley, supra at 479.

Whether we use claimant's actual earnings pre- and post-injury or use her assumed wage, pursuant to OAR 436-60-020(7)(k), it is clear that after returning to work, claimant's wage was the same and her earnings had not been diminished. She suffered no wage loss. Accordingly, we conclude that SAIF properly reduced claimant temporary total disability to temporary partial disability (zero) upon her return to modified work.

ORDER

The Referee's order dated February 7, 1990, as reconsidered February 27, 1990, is reversed.

In the Matter of the Compensation of
FRANK L. STODDARD, Claimant
WCB Case No. 84-10872
ORDER ON REMAND
Emmons, et al., Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

This matter is before the Board on remand from the Court of Appeals. Stoddard v. Credit-Thrift Corp., 103 Or App 283 (1990). The court has reversed that portion of our prior order, Frank L. Stoddard, 41 Van Natta 2115 (1989), which held that the removal of architectural barriers was not a reasonable and necessary medical service. Consequently, the court has remanded with instructions to determine the issue of whether the modifications of his home and the removal of architectural barriers is reasonable and necessary under ORS 656.245(1).

FINDINGS OF FACT

Claimant, who is 6 feet 1 inch tall and weighs 200 pounds, is a C-5 quadriplegic as a result of a compensable injury in August 1971 for which he was awarded permanent total disability benefits. He was an inpatient at the Rehabilitation Institute of Oregon Division of Good Samaritan Hospital (RIO) until April 1972. He had reached maximum motor improvement by January 1972. Upon his release, reports were submitted to the insurer regarding claimant's progress, his current status and his future medical needs by Dr. Cross, M.D., Medical Director of RIO, and by Ms. Nelson, Rehabilitation Counselor, of the Vocational Rehabilitation Division, Department of Human Resources.

Claimant functions as a C-5 quadriplegic. The only functioning muscle groups are in the shoulder area and biceps. He is able to operate an electric wheelchair by using the shoulder muscles to manipulate the lever. He depends on an assistant for bathing, dressing, personal hygiene, transferring in and out of bed and getting on and off the toilet.

Over the years, claimant has been hospitalized multiple times for surgeries as as result of urinary tract infections and skin ulcers.

Claimant used his own funds to have a home built with architectural modifications designed to accommodate his wheelchair, including wider halls, a wider bedroom door, and a master bedroom the size of two regular bedrooms, which was built to contain a bathroom with an accordion door 10 to 15 feet long. After making these changes, claimant was able to bathe in the bathtub by using a Hoyer lift attached to the tub. This home had back door and front door wheelchair access and a door/fire escape from the bedroom to the outside.

After a divorce, claimant's home was sold and claimant purchased another home in Salem. Although the halls are wide enough for claimant's wheelchair to pass along, this home is not designed to accommodate a wheelchair. Claimant is currently unable to enter two of the three bedrooms or either of the two baths because the doorways are too narrow. He is able to use the master bedroom because he had the doorway widened himself. The bath is too small to manipulate a wheelchair in it. Claimant's bathing is therefore limited to spongebaths given in bed. He hangs his head off the side of the bed for hairwashes. His bowel care is performed while lying down. Claimant has no door/fire escape from the bedroom directly to the outside. This home has front door wheelchair access only. In order to enter the front door, claimant installed a narrow two-piece wooden ramp which he is unable to use unassisted. The ramp has no railings and

it gets slippery when wet or icy. Some of claimant's assistants have fallen on it, and his electric wheelchair has slipped and lost traction on it. The front entrance has no overhang to protect it from the weather.

In order to retain some body strength, claimant has exercise weights located in the garage. To use the weights or to enter his van, he must go out the front door of the house and around the outside of the house to the garage because the kitchen door is not wide enough to enter with a wheelchair, and the washer, dryer and water heater are located just inside the door, blocking access to the house.

The employer denied claimant's request for funds to modify this home, including widening of the doors to his bedrooms and one bathroom so that he can enter those rooms in his wheelchair; remodelling one bathroom so that he can use the shower and the toilet; replacing his bedroom window with a patio door and installing a deck and ramp as an emergency exit; replacing the wooden ramp to his front door with a concrete ramp with railings; and covering the open space from his house to the garage, so that he would be protected from the elements while he travels by wheelchair to use his van or to use his weights. Claimant requested a hearing based on those denials.

FINDINGS OF ULTIMATE FACT

Modification of claimant's home and removal of architectural barriers in order to accommodate his wheelchair are reasonable and necessary medical services.

CONCLUSIONS OF LAW AND OPINION

The Referee upheld the insurer's denial of the architectural modifications of claimant's present home. We affirmed. In so doing, we reasoned that, although the use of shower facilities would provide some degree of independence for claimant, claimant would not be able to perform this or other tasks without the assistance of caregivers. Thus, we found no need to decide whether the modifications were covered under ORS 656.245(1), since even if they were covered, the services would not be reasonable and necessary. The court rejected the view that the services are not reasonable and necessary because a caregiver's assistance is required. The court, reasoned that 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, and if claimant shows that the requested changes would make claimant more independent, then claimant has provided some evidence that the changes are necessary because of the nature of claimant's injury and the process of recovery. In light of the court's decision, we reverse the Referee, based on the following reasoning.

The carrier must provide, for the life of the worker, reasonable and necessary medical services required by the nature of the compensable injury. Former ORS 656.245(1). Therefore, in order to be compensated for the requested services, claimant has the burden of proving that they are reasonable and necessary because of the nature of the injury. Id.; McGarry v. SAIF, 24 Or App 883, 888 (1976). Claimant, a quadriplegic who is permanently totally disabled, is, because of the nature of his injury, confined to a wheelchair. To prove reasonableness and necessity for the requested architectural modifications, claimant must establish that the modifications would likely 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 persuaded that the reports and testimony provided in support of claimant's request establish that the requested architectural modifications are reasonable and necessary medical services.

Dr. Cross, M.D., medical director of the Rehabilitation Institute of Oregon, reported the following to the carrier in 1972, as part of his estimate of the funds the carrier would need to carry in its reserve, given claimant's life expectancy of 65 to 71 years:

> "A home normally does not have adequate architectural allowance for wheelchairs, especially electric. The floorplan should be on one level, if it is to be accessible. Door widths must be 30 or more inches to clear the wheels of the chair. A bathroom must be large enough for getting into, in addition to a hoist or lift to get [claimant] in and out of the bathtub. . . A ramp into the house is necessary with a grade not exceeding a 1:12 ratio (one foot height must have 12 feet of ramp or fraction thereof)." (Ex. 14-3)

Dr. Cross also noted that skin complications from pressure sores can be prevented with adequate skin care, turning regularly, and cleanliness. The cost of a major sore, he stated, can approach $8,000 to $10,000 for a hospital stay, surgery, and antibiotics. (Ex. 14-2). Cross further stated that pulmonary complications of pneumonia often occur with minor respiratory infections because claimant in unable to cough or breathe deeply. Only claimant's diaphragm sustains his respiration, since all his other muscles that normally assist in breathing and coughing are non-functional. (Ex. 14-2).

Ms. Nelson, rehabilitation counselor for the Vocational Rehabilitation Division, reported that items considered extremely important for the future in terms of maintaining an optimum psychological outlook and prevention of physical deterioration would be to provide claimant with assistive devices or equipment that would increase his independence. She explained that the costs of physical and psychological deterioration and nursing home care are greater than rehabilitation. She further explained that it is an accepted medical fact that if a disabled individual is capable of activating himself and re-integrating his life into the community, his medical situation is more likely to stabilize and reduce his medical needs. (Ex. 15).

Ms. Brooks, an equipment specialist who has been working with the medical needs of those with physical disabilities for seven years, testified that doctors recommend that paraplegics and quadriplegics be as independent and self-sufficient as possible. Both she and Mr. Vladyka, who has been dealing with permanently totally disabled quadriplegics and paraplegics for the SAIF Corporation since 1976, stated that the architectural alterations requested by claimant, namely ramps, wider doorways, and remodelling of bathroom facilities to accommodate a wheelchair are modifications commonly made to houses occupied by wheelchair-bound persons to enable them to become as mobile and independent as possible within the confines of the home. Brooks also testified that quadriplegics and paraplegics become more self-sufficient if they learn to sit up and perform as much of their own toileting and bathing as possible. In addition, a widened door and exit ramp from claimant's bedroom directly outside are necessary for his safety and the safety of his caregivers in the event of fire or other emergency. (Tr. 134, 137).

Claimant testified that the narrow wooden ramp he has provided for himself becomes icy and slippery in cold and wet weather, and that he cannot negotiate the ramp in his wheelchair without the aid of assistants. He also testified that his caregivers have slipped and fallen on the ramp. He also testified that a wider, cement ramp with railing would be less slippery and would enable him to negotiate it alone. (Tr. 135). He also testified that remodelling the bathroom would allow him to use the commode and shower that the Referee ordered to be

provided for the purpose of upright bowel care and bathing. (Tr. 133). Claimant uses weight lifting equipment as part of a weight lifting and conditioning program. The equipment, as well as his van, is located in his garage. Therefore, more direct, covered access would enable him to go directly from the house to the garage rather than outdoors on a ramp that is slippery in wet weather. (Tr. 136, 137).

One of the objectives of the Workers' Compensation Law is to restore the injured worker physically and economically to a self-sufficient status to the greatest extent practicable. ORS 656.012 (emphasis supplied). We note that the requested services will not completely restore claimant's self-sufficiency. Although he will be as self-sufficient as possible within the home, he will still require assistance in many areas of his life. However, the appropriate test for whether a medical service is reasonable and necessary is not whether claimant will continue to need the assistance of a caregiver. Stoddard v. Credit Thrift Corporation, 103 Or App 283 (1990). Rather, the test is whether the requested services are reasonable and necessary as required by the nature of the compensable injury. ORS 656.245. Here, the medical and lay evidence persuasively establishes that the aforementioned services enable claimant to become more independent and self-sufficient, and, as such are reasonable and necessary.

We also find, in light of the evidence provided by Dr. Cross concerning the need for cleanliness to minimize hospitalization and surgery from skin ulcerations and urinary tract infections, and the extensive record of claimant's hospital admissions, that access to bathroom and shower facilities is an appropriate preventative service. Furthermore, in accord with the information provided by Dr. Cross that claimant is especially susceptible to life-threatening respiratory difficulties, we find that the protection from the elements that would be gained by covering the area from claimant's house to his garage is not only restorative, but preventative as well. In addition, provision of an emergency exit and wheelchair ramp from claimant's bedroom also qualifies as a preventative service.

Accordingly, we hold that the proposed modifications to claimant's home and the removal of architectural barriers are reasonable and necessary treatment under ORS 656.245(1). Therefore, we reverse that portion of the Referee's order that upheld the insurer's denial of architectural barrier modifications. Inasmuch as claimant has finally prevailed after remand from the Court of Appeals, his counsel is entitled to an attorney fee for services rendered before every prior forum. ORS 656.388(1). However, we note that claimant's attorney has already been awarded $2,887.50 by the court regarding this issue. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee pursuant to ORS 656.388(1) for claimant's counsel's services concerning the architectural modification issue is $500, to be paid by the insurer. This fee is in addition to claimant's prior awards. 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, we note counsel's prior award at the court level for this issue, as well as his awards of $3,000 for services at hearing and $1,100 for services on review concerning the insurer's denial of other medical services.

IT IS SO ORDERED.

In the Matter of the Compensation of
SAM J. AGUIRRE, Claimant
WCB Case No. 87-04491
ORDER ON REVIEW (REMANDING)
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Cushing and Myers.

Claimant, pro se, requests review of Referee Nichols' order that: (1) affirmed a Determination Order award of no unscheduled permanent disability for a low back injury; (2) upheld the insurer's partial denial of continued and current chiropractic care as not reasonable or necessary; (3) declined to assess penalties and attorney fees for an allegedly unreasonable denial; and (4) granted the insurer authorization to offset an overpayment of temporary disability compensation against future awards of permanent disability. On review, the issues are extent of unscheduled permanent disability, medical services, penalties and related attorney fees, and offset. We remand.

Claimant, pro se, timely requested review of the Referee's order. Notice of this appeal was also timely provided to the insurer/employer through its counsel. Nollen v. SAIF, 23 Or App 420, 423 (1975); Denise M. Bowman, 40 Van Natta 363, 364 (1988). Claimant's request for review was mischaracterized as a request for a new hearing, rather than a request for Board review. Rosemary Goins, 41 Van Natta 1340 (1989). As a result, this case was not docketed for review by the Board. Instead, the request was acknowledged by the Hearings Division and a new case number was assigned, WCB Case No. 87-14986.

The pleadings, exhibits and the hearing transcript in WCB Case No. 87-04491 have apparently been lost and, therefore, are unavailable for our review. The unavailability of those documents prevents the Board from conducting its de novo review.

Pursuant to ORS 656.295(5), should we determine that a case has been improperly, incompletely or otherwise insufficiently developed, we may remand to the Referee for further evidence taking, correction or other necessary action. Considering these circumstances, we conclude that remand is an appropriate action.

Accordingly, this matter is remanded to the Presiding Referee with instructions to assign this case to another Referee to reconvene a hearing. At this new hearing, the parties shall be entitled to present evidence, either testimonial or documentary, concerning the issues that were addressed at the prior hearing. The parties and the Referee shall attempt to complete a record that accurately represents the proceedings and record which were present at the prior hearing on July 29, 1985. Thereafter, the designated Referee shall issue a final, appealable order addressing all issues raised at the prior hearing.

ORDER

The Referee's order dated September 1, 1987 is vacated. This case is remanded to the Presiding Referee for further action consistent with this order.

In the Matter of the Compensation of
MAURICIO V. CONTRERAS, Claimant
WCB Case No. 90-04825
ORDER DENYING RECONSIDERATION
Roger D. Wallingford, Claimant Attorney
C. Douglas Oliver (Saif), Defense Attorney

Claimant has requested reconsideration of our November 28, 1990 Order of Dismissal. We deny the request.

A Board order is final unless within 30 days after the date of mailing of copies of such order, one of the parties appeals to the Court of Appeals for judicial review. ORS 656.295(8). The time within which to appeal an order continues to run, unless the order had been "stayed," withdrawn or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986).

Here, our order issued November 28, 1990. Therefore, the thirtieth day from our order was December 28, 1990. Claimant mailed a motion for reconsideration to the Board on December 28, 1990. Inasmuch as the motion was mailed by certified mail, the request was "filed" on December 28, 1990. See OAR 438-05-046(1)(b).

Although claimant's motion was "filed" within the requisite 30-day period, the motion was not physically received by the Board until December 31, 1990. By that time, the Board's statutory authority to take any further action concerning its November 28, 1990 order had expired. ORS 656.295(8).

The Board attempts to respond to motions for reconsideration as expeditiously as it possibly can. Yet, despite these efforts, the ultimate responsibility for preserving a party's rights rests with that party. Here, although technically "filed" while the Board retained authority to reconsider, claimant's motion was not actually received by the Board until its authority had elapsed. Thus, the unfortuitous timing of claimant's motion effectively foreclosed the Board from substantively responding to claimant's motion.

In conclusion, because the Board's November 28, 1990 order has neither been appealed, abated, "stayed", nor republished, it has become final by operation of law. ORS 656.295(8). Accordingly, the Board lacks jurisdiction to consider claimant's motion.

IT IS SO ORDERED.

In the Matter of the Compensation of
DENNIS A. DIMMICK, Claimant
WCB Case No. 89-11677
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
David O. Horne, Defense Attorney

Reviewed by Board Members Myers and Cushing.

The insurer requests review of Referee Galton's order that granted claimant permanent total disability, whereas a Determination Order awarded claimant 50 percent (160 degrees) unscheduled permanent disability his low back. On review, the issue is permanent total disability, and, in the alternative, extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and "Findings of Ultimate Fact" as our own.

CONCLUSIONS OF LAW AND OPINION

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

In order to prove entitlement to permanent total disability compensation, claimant must show that he is not "employable or able to sell his services on a regular basis in a hypothetically normal labor market." Harris v. SAIF, 292 Or 683, 695 (1982). Claimant must also establish that he is willing to seek regular gainful employment and that he has made reasonable efforts to obtain such employment. ORS 656.206(3); SAIF v. Stephens, 303 Or 41 (1989); See Thomas A. Engkilterra, 42 Van Natta 2591 (1990).

Claimant's attending physician, Dr. Berselli, M.D., opined that claimant was not employable given his degree of pain and given his severe restrictions. We find no reason not to defer to the opinion of the treating physician. 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. Berselli noted that claimant's work experience is in computer programming and computer operations which requires constant sitting. However, the medical evidence establishes that claimant is not able to sit for more than one half hour at a time. His restrictions are not contested.

The record also establishes that claimant was willing to seek regular gainful employment. Specifically, vocational counselor, Lipnicki, continually indicated in his reports, dated as late as May 1988, that claimant cooperated fully with training programs and that he was highly motivated to return to work. There is no contrary evidence.

Finally, we find that claimant made reasonable efforts to obtain employment. The only instance of a possible lack of motivation on claimant's part was when claimant terminated an on-the-job training program after two weeks because of reported ongoing back pain associated with driving 40 miles to and from the work site. The insurer offered claimant the possibility of staying in a hotel temporarily during the training, but claimant declined the offer. There is no evidence that claimant's termination of the program was directly based on his lack of desire to stay in a hotel. Until the time claimant moved to Olympia, Washington, claimant cooperated fully with vocational counselor Lipnicki. No regular employment was secured throughout the duration of the vocational rehabilitation. Further, the vocational rehabilitation was terminated not because of claimant's failure to make reasonable efforts to find work, but because claimant moved to Washington, an area in which he had previously worked as a programmer.

We conclude that claimant has established that he is permanently and totally disabled.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the complexity of the issue, the time devoted to the case, and the value of the interest involved.

ORDER

The Referee's order dated February 27, 1990 is affirmed. For services on Board review, claimant's attorney is awarded a reasonable assessed fee of $750, payable by the insurer.

In the Matter of the Compensation of
MICHELE M. JIMENEZ, Claimant
WCB Case No. 89-10758
ORDER ON REVIEW
Ackerman, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Howell and Perry.

The insurer requests review of that portion of Referee Irving's order that set aside its denial of claimant's mental stress claim. Claimant cross-requests review of the portion of the Referee's order that ordered the insurer to accept a temporary worsening of claimant's preexisting condition. Claimant argues that the issue of the permanency of her condition was not properly before the Referee. On review, the issue is compensability and, if the claim is compensable, the Referee's authority to order acceptance of only a temporary worsening. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," but not the "Findings of Ultimate Fact," with the following supplementation.

All new employees at Litton participated in an eight-day training program to learn soldering. Then they "hit the line" and began assembling circuit boards for cruise missile guidance systems. The completion time allowed on the first six or eight boards decreased with each one, until the worker was expected to "come in with budget." Thereafter, failure to meet quality standards or time limitations resulted in QIRs (Quality Improvement Reports) and NRFIs (Not Ready For Inspection reports); verbal warnings in the supervisor's office and, less often, in the presence of coworkers; written warnings and eventual termination.

In February 1989, when claimant went on medical leave, she was on the verge of being fired for poor performance.

CONCLUSIONS OF LAW AND OPINION

Claimant alleges that she has been subjected to work-related stress resulting in a compensable mental condition under former ORS 656.802.

To carry her burden, 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." Former ORS 656.802(1)(b) and 656.802(a) & (c). Moreover, she must prove by clear and convincing evidence that her condition arose out of and in the course of her employment. Former 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. Ronald V. Dickson, 42 Van Natta 1102 (1990); Deborah Anderson, 42 Van Natta 514 (1990); Donna E. Aschbacher, 41 Van Natta 1242 (1989); Ellen L. Crawford, 41 Van Natta 1257 (1989).

Only two of the statutory requirements for upholding this claim are contested on review. The insurer contends that claimant has not proven, by clear and convincing evidence, that her worsened dysthemic disorder and interrelated anxiety arose from stress at her job. Assuming that claimant has established that her mental condition resulted from work exposure, the insurer argues that claimant has not proven, by a preponderance of the evidence, that her work stressors were conditions other than reasonable discipline, corrective actions, or job performance evaluations. ORS 656.802(2).

Assuming, for the moment, that claimant's psychological condition is work-related, we are not persuaded that claimant's stress resulted from supervisory methods other than reasonable discipline, corrective action, or job performance evaluations.

Claimant and three of her former coworkers testified that work on the electronic assembly lines for this weapons manufacturer was stressful. The workers agree that they were pressured to solder circuit boards within budgeted time limits, while conforming to strict quality standards. One worker explained that work at Litton was more exacting than at other electronic assembly plants, because Litton's product required unusual precision. (Tr. 162). However, claimant is the only worker who stated that her stress was due to the employer's supervisory methods, rather than the exacting nature of the work itself.

Claimant does not dispute the fact that her work did not meet required standards. She admits that her performance deteriorated. However, she contends that her lack of success at this job was due to the employer's supervisory methods, which she perceived as harassment. Claimant contends that this alleged harassment interfered with her work (Tr. 130-31), caused her stress, and resulted in a worsened psychological condition. The core of claimant's argument is her contention that the supervisory methods employed by her supervisor, Ben McCauley, were not reasonable discipline or corrective action. Consequently, she contends that perceived harassment by McCauley is a compensable stressor.

Claimant's former coworkers described McCauley's supervision as "harsh." However, they related McCauley's "harshness" to the fact that the consequences of poor performance could be harsh, in that one might lose one's job.

Claimant alone contends that McCauley's discipline amounted to harassment. When asked what she meant by harassment, claimant responded: "They would tell you that you were not properly doing your job. . . . They would threaten you with your job." (Tr. 46.) Based on these explanations, we find that the harassment claimant perceived was the same threat of job loss perceived as harshness by her coworkers. We are not persuaded that the threat of losing one's job due to undisputed poor performance constitutes either harassment or unreasonable disciplinary action.

Claimant also complains that she did not receive help to improve her work, suggesting that the employer's reprimands were not reasonable corrective action. We find this complaint unsupported. Claimant admits that Myers, another line worker, was allowed to help claimant for several weeks. Myers was moved next to claimant for the purpose of helping claimant improve her work. (Tr. 182). This was the only time claimant was able to meet the time limits. (Tr. 47). We are not persuaded that the employer neglected to help claimant learn how to do her work. In this regard, we also note that claimant participated in a training program at the beginning of her employment.

Claimant asserts that employees, including claimant, cried often at Litton. This assertion is supported by the record. Apparently claimant contends that employee crying is evidence of the employer's unreasonableness. We

are unwilling to infer that the employer's supervision of claimant was unreasonable on that basis. We cannot determine from this record why employees other than claimant may have cried. Because we cannot determine the cause, we cannot assume that other employees cried for the same reason as claimant. Thus, an inference that other employees cried due to the employer's supervision is unwarranted and may not be relied upon to support claimant's contention that supervision was unreasonable.

Claimant also complained that McCauley "yelled" at her daily (Tr. 45) and weekly (Tr. 52). Two former coworkers, who sat on either side of claimant, testified that they never heard McCauley raise his voice. Again, we are not persuaded by claimant's characterization of her discipline. Given her conceded poor work performance, and her coworkers' testimony, it may be that claimant used the vernacular of "yell" to describe being reprimanded, rather than the volume of McCauley's voice. In this regard, we note that claimant admits that she was treated the same as other workers. (Tr. 110). The mere fact that discipline or corrective action was taken, does not establish its character as unreasonable.

Conclusion

It is undisputed that claimant reacted to supervision as though it was unreasonable. However, we are unwilling to find the employer's disciplinary or corrective methods to be unreasonable, based on claimant's reaction to it or on an inference from other employees' crying on the job. Moreover, based on claimant's explanation of what she meant by harassment and on the observations of nearby coworkers, we are not persuaded that this characterization of McCauley's methods is accurate.

We conclude that claimant has not carried her burden of proving that her psychological condition arose out her work, nor that the employer's disciplinary or corrective actions were unreasonable. See ORS 656.266. Her claim is not compensable. Former ORS 656.802(2). Because of our conclusion as to ORS 656.802(2)(b), we need not address the insurer's other contention.

ORDER

The Referee's order dated November 9, 1989 is reversed. The insurer's denial is reinstated and upheld in its entirety. Claimant's $4,000 attorney fee award is reversed.

January 4, 1991 Cite as 43 Van Natta 13 (1991)

In the Matter of the Compensation of
KURT KRAAL, Claimant
WCB Case No. 89-09254
ORDER ON RECONSIDERATION
David Hollander, Claimant Attorney
Williams, et al., Defense Attorneys

Liberty Northwest requests reconsideration of our November 23, 1990 Order on Review that affirmed the Referee's award of an assessed penalty-related fee for an unreasonable denial. Specifically, Liberty contends that the Board did not have jurisdiction to consider the compensability of claimant's current condition. And secondly, that portions of the order were internally inconsistent. We abated our order to allow sufficient time to consider Liberty's motion. Having completed our further consideration of the matter, we now proceed to our review.

We agree with the insurer insofar as portions of the order were internally inconsistent. Therefore, in order to eliminate the inconsistency, we amend our Order on Review by deleting in the entirety the first paragraph found on the top of page three.

Accordingly, our November 23, 1990 order is withdrawn. On reconsideration, as amended herein, we republish our November 23, 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
MARY E. MESSNER, Claimant
WCB Case No. 89-11187
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Perry and Speer.

Claimant requests review of Referee Brown's order that: (1) declined to grant permanent total disability; and (2) increased her unscheduled permanent disability award for a back injury from 29 percent (92.8 degrees), as awarded by Determination Order, to 66 percent (211.2 degrees). On review, the issue is extent of unscheduled permanent disability, including permanent total disability. We reverse.

FINDINGS OF FACT

Claimant sustained multiple injuries during the course and scope of her employment when the vehicle she was riding in rolled a number of times down a 100 foot embankment. (Ex. 1). Her condition is diagnosed as a post lumbar transverse process fracture syndrome, with myofacial pain, and extensive trunk trauma. (Ex. 6).

Claimant has transverse process fractures at L2, L3, and L4 on the left and L3 on the right. The fracture on the right is united, as is the fracture at L2 on the left. The left fractures at L3 and L4 remain disunited. (Ex. 6). Claimant stands with a flattened lumbar lordosis, and mild lumbar list to the left. There is slight asymmetry of gluteal musculature, the left side being smaller. (Ex. 6).

Dr. Gilsdorf, orthopedist, and Dr. Strieby, surgeon, examined claimant in September 1988 and November 1988 respectively, and recorded claimant's physical capacities/limitations. (Exs. 6 & 7). The examinations indicate that claimant is in pain doing most maneuvers; that she has marked tenderness on palpation through the mid lumbar paravertebral and left posterior gluteal region areas. Recumbent rest relieves her discomfort. The physicians noted that claimant's symptoms are consistent with their medical findings. (Ex. 6 & 7).

Dr. Strieby opined that claimant will never be able to return to the type of work that she was previously doing at the time of her injury, but could work at light or sedentary employment "at a later time." (Ex. 14-43). He reported that only supportive, conservative treatment measures will possibly benefit claimant. (Ex 7-2).

Claimant can lift up to 20 pounds occasionally with pain; claimant can lift only 10 pounds comfortably. (Tr. 23). Claimant is restricted from climbing on ladders; claimant is limited in her ability to sit or stand to no more than 30 minutes, limited in her ability going up and down stairs, walking on uneven ground, and in her repetitive back and leg movement. (Ex. 14-29).

Claimant was found to be medically stationary on November 18, 1988 and her claim was closed on January 27, 1989. (Exs. 10, 11, 12).

Claimant is 47 years old. She lived in Bly, Oregon at the time of her injury and was living in Bly, Oregon at the time of the hearing. (Tr. 49). Claimant has not limited her employment opportunities by her own choice. Prior to moving to Bly, Oregon, claimant and her husband owned, lived in and managed a motel in Ukiah. (Tr. 27). Claimant has a high school education and her extensive vocational history is that of unskilled labor. She has worked as a teacher's aide and as an office receptionist doing a minimal amount of clerical work. Claimant tested poorly in clerical skills. (Ex. 14-16).

CONCLUSIONS OF LAW AND OPINION

The Referee, concluding that claimant has limited her employment opportunities by her own choice by purchasing a home subsequent to the injury and residing in Bly, Oregon, and that qualified jobs exist in claimant's geographic area -- Bly, Oregon -- found that claimant is not permanently 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). Under that doctrine, a claimant, with some residual physical capacity, may be permanently and totally disabled due to a combination of her 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 she is willing to re-enter the work force and that she has made reasonable efforts to do so. Even if claimant demonstrates that a work search would be futile, claimant must establish that 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 automobile accident. Claimant is 47 years old and has a high school education. Claimant, whose extensive work history consists solely of unskilled labor, cannot return to her regular work. Claimant is limited in her ability to sit or stand to no more than 30 minutes, must change positions frequently and she can only lift ten pounds occasionally with any degree of comfort. (Exs. 7, 15; Tr. 58). Therefore, although Dr. Strieby opined that claimant could work at light or sedentary employment "at a later time," we find that, as of the date of hearing, claimant is limited more to sedentary than light work.

Claimant has no transferable skills appropriate for sedentary work. Claimant tested poorly in clerical skills. (Ex. 14-76). Although at the time of the hearing claimant was taking part in vocational classes to improve her meager office skills -- taking basic English and grammar classes -- she does not currently possess the skills necessary for sedentary employment. See Gettman

v. SAIF, 289 Or 604 (1980) (Permanent total disability status cannot be determined in light of speculative future changes). Moreover, claimant's pain causes her difficulty in her classes. (Tr. 22; 90).

Claimant lives in a rural area where the labor market is limited. There is no evidentiary basis upon which to make a finding that there are qualified jobs in claimant's geographic area. Mr. Anderson, claimant's vocational counselor, who, at the time of the hearing had not found qualified employment for claimant, testified that although he had not done a recent labor market study, in his opinion there would be jobs available. He did not have a specific job in mind -- only that there is a company in the area known to be willing to hire injured workers. (Tr. 82-84; 96). The standard is whether claimant is currently employable or able to sell her services on a regular basis in a hypothetically normal labor market. Harris v. SAIF, 292 Or 683, 695 (1982). The speculative jobs Mr. Anderson testified to do not provide sufficient evidence of available jobs for a determination that claimant is currently employable.

Mr. Anderson testified that claimant is "highly motivated" to study and work within her rehabilitation program. (Tr. 90; 97-98). We are persuaded that claimant would be willing to seek regular gainful employment, but for the limitations imposed by her compensable injury.

Taking into consideration claimant's age, education, work experience, adaptability to nonphysical labor and transferable skills, we conclude that claimant is permanently and totally disabled as a result of her compensable 1987 injury.

ORDER

The Referee's order dated October 6, 1989 is reversed. In lieu of the Referee's increased award of unscheduled permanent disability, claimant is granted permanent total disability effective October 6, 1989, the date the hearing record closed. The SAIF Corporation is permitted to offset permanent partial 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 SAIF 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
MARTA J. NELSON, Claimant
WCB Case Nos. 89-10832 & 89-18052
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
VavRosky, et al., Defense Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Cushing and Myers.

The self-insured employer requests review of Referee Schultz's order that: (1) set aside its denial of claimant's aggravation claim for her respiratory condition; and (2) upheld Wausau's "de facto" denial of claimant's "new occupational disease" claim. On review, the issues are compensability and responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" as our own.

ULTIMATE FINDINGS OF FACT

Claimant's work exposure with Wausau's insured was not the major contributing cause of claimant's current respiratory condition.

The compensable May 1988 claim was not a material contributing cause of claimant's current respiratory condition.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's current respiratory condition was materially related to claimant's compensable May 1988 claim. Finding no worsening of the underlying condition due to the work exposure at Wausau's insured, he found the self-insured employer responsible. We disagree.

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); Andrew R. Comeau, 42 Van Natta 1630 (1990). We proceed to consider whether or not claimant's current condition is compensable.

Compensability

To establish a compensable claim against Wausau, claimant must prove that her work exposure was the major contributing cause of the onset or the pathological worsening of her respiratory condition. A symptomatic worsening of an underlying condition is insufficient to carry claimant's burden. Former ORS 656.802(1)(a); Weller v. Union Carbide Corp., 288 Or 27, 35 (1979); Dethlefs v. Hyster Co., 295 Or 298, 309-10 (1983).

To establish compensability against the self-insured employer, claimant must show by a preponderance of the evidence, that the compensable May 1988 claim was a material contributing cause of her current respiratory condition. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979).

The question of causal relation is of such medical complexity that we can not decide it without expert opinion. Therefore, the resolution of the issue turns primarily on an analysis of medical evidence. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Dr. Stibolt, a pulmonary specialist, performed an independent medical evaluation of claimant on June 6, 1988. This was after the work exposure with the self-insured employer, but prior to the work exposure at Wausau's insured. At the time, he found claimant to be asymptomatic. The pulmonary function tests were normal. Nonetheless, Dr. Stibolt diagnosed claimant's condition as "hypersensitivity pneumonitis," because claimant by history had demonstrated "classic" symptoms of that illness. Inasmuch as claimant was asymptomatic, he concluded that claimant's condition resulting from the work exposure at the self-insured employer had completely resolved.

In explanation of his working diagnosis, Dr. Stibolt indicated that he had no knowledge of the specific substance causing claimant's condition or whether or not the unknown substance was present in both employments. He also could not confirm that claimant had become "sensitized" to a specific substance while with the self-insured employer. Further, it was his opinion that claimant's respiratory condition was not permanently affected by the first work exposure, whether viewed in terms of impairment, pathological worsening or "sensitivity." Dr. Stibolt was unable to opine any causal relationship between claimant's current

respiratory condition and the respiratory condition resulting from the work exposure with the self-insured employer.

Accordingly, we are not persuaded that Dr. Stibolt's opinion establishes that claimant's work exposure at Wausau's insured was the major contributing cause of her respiratory condition, nor can we conclude that claimant's May 1988 claim with the self-insured employer was a material contributing cause of claimant's current respiratory condition.

Claimant was also examined by Dr. O'Hollaren, a pulmonary specialist, upon referral from claimant's treating physician, Dr. Casono. On the basis of his May 10, 1989 examination and additional pulmonary function tests, Dr. O'Hollaren could make no definitive diagnosis of claimant's condition. He noted that the tests were normal, and claimant was asymptomatic. Consequently, he opined no causal connection with either of claimant's work exposures. At most, he speculated that claimant's respiratory condition was related to nonoccupational "anxiety."

To conclude, we find the medical evidence does not sufficiently establish compensability of claimant's current condition, regardless of the theory of compensability.

Responsibility

Because claimant failed to establish that her work exposure at Wausau's insured was the major contributing cause of her respiratory condition, or that her current condition was materially related to the May 1988 claim with the self-insured employer, we conclude that the present claim is not compensable against either carrier. Accordingly, we do not reach the responsibility issue.

ORDER

The Referee's order dated January 8, 1990 is reversed in part and affirmed in part. The self-insured employer's denial of June 1, 1989 is reinstated and upheld. Claimant's attorney fee award of $2,250 is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
ALLEN G. RILEY, Claimant
WCB Case No. 89-12138
ORDER ON REVIEW
Ray English, Claimant Attorney
Lindsay, et al., Defense Attorneys
David Lillig (Saif), Defense Attorney

Reviewed by Board Members Howell and Perry.

Claimant requests review of Referee Leahy's order that set aside the SAIF Corporation's acceptance, on the noncomplying employer's behalf, of claimant's injury claim for his low back. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

In 1984, claimant compensably injured his back working for a Washington employer. He experienced temporary paralysis in both legs and could not work

for a month. He has had recurrent back problems ever since. In 1988, claimant reinjured his back in a nonwork-related accident. He sought treatment with Dr. Czarnecki, D.O., who diagnosed recurrent low back pain.

Claimant began working for the employer as a transmission mechanic in 1988. On January 30, 1989, claimant was informed that business was slow and that he might be laid off. Later that day, claimant told his shop foreman that "this would be a fine time to hurt my back." He reported no back injury that day and completed his shift.

After claimant arrived at work on January 31, 1989, he left with the employer's permission on a nonwork-related trip to Heppner, Oregon. When he returned around noon, he went home during his lunch break and did not return to work. He later called the employer and told him that the ride to Heppner had aggravated his back and that he needed to see a doctor. He also asked for, and received, confirmation that he was going to be laid off. Claimant never returned to work.

On February 1, 1989, claimant saw Dr. Czarnecki for low back symptoms. An acute lumbar sprain was later diagnosed. On February 15, 1989, claimant filed a workers' compensation claim, alleging that he had sustained an industrial injury to his back on January 30, 1989, while picking up and carrying a 160 pound transmission. (Ex. 4).

Dr. Mason, M.D., examined claimant on March 13, 1989. A CT scan revealed a minimal bulge and slight canal narrowing at the L4-5 level. Dr. Mason noted claimant's history of repeated episodes of loss of motor and sensory function and recommended neurological treatment. Later reports indicated that claimant's neurological examination was within normal limits.

Claimant filed a second 801 form on March 16, 1989. On April 3, 1989, the Compliance Section of the Workers' Compensation Division issued its "Proposed and Final Order; Notice" finding that claimant was a subject worker on January 30, 1989 and that his employer was a noncomplying employer from January 1, 1988 to March 16, 1989. (Ex. 10). SAIF received notice of the claim on April 6, 1989.

SAIF accepted a low back strain, on behalf of the employer, on May 25, 1989, and notified the employer of its acceptance. The employer filed a request for hearing on June 12, 1989, within 60 days of SAIF's letter notifying it of acceptance but more that 60 days after referral of the claim to SAIF. The employer issued a denial of the claim on July 24, 1989. Claimant subsequently requested a hearing on September 12, 1989, seeking compensation and attorney fees.

CONCLUSIONS OF LAW AND OPINION

Subsequent to the Referee's order, 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 activity capable of affecting acceptance. Kristi L. Chase, 42 Van Natta 1247 (1990).

Here, the employer requested a hearing on June 12, 1989, more than 60 days since April 3, 1989, the date SAIF received notice of the claim. Consequently, the employer is entitled to a hearing but, in order to defeat compensability, must prove fraud, misrepresentation or other illegal activity. Furthermore, because SAIF is the exclusive processor of claims filed with a noncomplying employer, the employer's July 24, 1989 denial of the claim is a nullity. Ronald D. Wytcherley, 42 Van Natta 1713 (1990).

The Referee made explicit findings that claimant's testimony regarding the alleged injury was not credible and he refused to believe him. After our de novo review of the record, we concur in the Referee's findings. We also find that the alleged injury did not in fact occur. There is no credible evidence that claimant sustained a work-related injury on January 30, 1989. Although the injury allegedly caused an immediate onset of pain and occurred within feet of claimant's shop foreman and another worker, it was unreported and unwitnessed. Claimant did not report the injury until he knew that he was going to be laid off and after he had stated that "this would be a fine time to hurt my back." We find that the record, as a whole, supports the employer's contention that claimant had filed a fraudulent claim.

It follows that claimant's statements on the claim form and to his doctors that he had sustained an on-the-job injury were misrepresentations of fact. Under such circumstances, we conclude that SAIF's acceptance could reasonably have been affected if the true facts had been known. See Newport Elks Club v. Hays, 92 Or App 604 (1988). Therefore, we conclude that the employer has established that the claim was accepted based on fraud, misrepresentation or other illegal activity.

We turn to the question whether the preponderance of the persuasive evidence establishes that claimant's low back disability and need for medical treatment is related to a January 30, 1989 lifting incident at work. Considering claimant's lack of credibility, it follows that the medical opinions based on his history of events likewise lack credibility. See Miller v. Granite Construction Co., 28 Or App 473 (1977). Accordingly, we hold that claimant's injury claim is not compensable.

ORDER

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

In the Matter of the Compensation of
CHARLES E. ROBINSON, Claimant
WCB Case No. 89-17655
ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Perry and Speer.

The self-insured employer requests review of Referee Schultz' order that set aside its denial of claimant's claim for medical services for his low back condition. On review, the sole issue is compensability of medical services. We reverse.

FINDINGS OF FACT

Claimant has a history of back problems, dating back at least to an industrial injury in 1970. That condition resolved prior to the 1979 back injury for which he now seeks medical services.

Following the 1979 injury, Dr. Bert performed a right hemilaminectomy at L4-5. In 1985, he performed an exploratory laminectomy at L4-5 with discectomy and fusion at the L4-S1 levels. In 1987 Bert repaired claimant's pseudarthrosis at the L4-S1 levels with an iliac crest bone graft. Later that year, Bert performed a C6-7 discectomy.

Claimant again sought treatment with Bert in December 1988, complaining of increasing low back and leg symptoms. Bert ordered two MRI's, which revealed some spinal stenosis at L3-4, above the solid fusion. (Exs. 104, 105, 110A).

Bert is currently willing to perform surgery at the L3-4 narrowing, based on claimant's insistence that he cannot handle the constant pain he suffers.

Drs. Woolpert and Rosenbaum examined claimant in August 1989. Dr. Bert's associate, Dr. Holbert, examined claimant in October 1989.

CONCLUSIONS OF LAW AND OPINION

An injured worker is entitled to all reasonable and necessary curative or palliative medical care required for a compensable injury. See former ORS 656.245; 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. The proposed surgery is not "reasonable and necessary" if it would not reasonably be expected to result in any material improvement in claimant's condition. Art Prouty, 40 Van Natta 1250, 1252 (1988).

Here, Dr. Bert, claimant's treating orthopedist, has performed four surgical operations on claimant's back. Although he recommends another operation, he predicts no more than a 50 percent chance of improvement in claimant's symptoms following the proposed surgery. (Ex. 114-7). Nevertheless, he is willing to perform the operation, based on claimant's desire to have it and on an "even" chance that it will relieve some of claimant's pain. Bert describes the proposed surgery as reasonable, because claimant has related that he cannot live with his pain. (Id.) Bert's opinion is the only medical evidence supporting claimant's request for medical services.

Claimant was also examined by Drs. Woolpert, Holbert and Rosenbaum, orthopedists. Following an August 18, 1989 examination, Dr. Woolpert reported "considerable evidence of non-organic pain behavior as noted with the stocking hypesthesia, give away of all muscle groups on the left side, positive Waddell testing, [and] marked response to very minimal palpation." (Ex. 108-5). In addition he noted that, although claimant has symptoms compatible with stenosis, he does not have objective indications of nerve compression. Woolpert acknowledged claimant's spinal canal narrowing at L3-4, but doubted benefit from the proposed surgery, due to claimant's considerable non-organic pain behavior. (Ex. 108-6). After reviewing both MRI's, Woolpert's opinion remained the same. He found little difference between the two studies and concluded that claimant's stenosis is not progressive. Based on claimant's non-organic pain behavior; his failure to respond to previous surgery; the likelihood that existing scar tissue would remain; as well as the absence of objective findings indicating nerve compression, Woolpert concluded that the proposed surgery is not indicated. (Ex. 113-2).

Bert's associate, Dr. Holbert, examined claimant on September 27, 1989. He concluded that claimant does not have "serious neurological deficit and what he has is probably related to the scarring of the nerve roots at his old discectomy level." He suspected that the L3-4 stenosis may be influencing claimant's left leg discomfort. Holbert opined that "alot" of claimant's pain is related to scar tissue, which is not amenable to surgical treatment. Consequently, he had "alot of doubt" whether further surgery would improve claimant's condition. (Ex. 111-3).

Dr. Rosenbaum examined claimant on August 4, 1989. He observed leg give away, which disappeared when claimant was distracted. (Ex. 107-3). Rosenbaum

conceded that a patient could suffer painful radiculopathy without objective abnormalities. However, in claimant's case, he felt that the history is not reliable enough to support a diagnosis of nerve compression in the absence of objective findings. (Ex. 107-4-5). Upon concluding that the probability of pain relief is relatively low, Rosenbaum recommended against repeat surgery. (Id.) After reviewing the MRI results and additional medical records, Rosenbaum stated that it is "very unlikely" that correction of the stenosis would have any effect on claimant's back pain. Moreover, he doubted that the surgery would lead to improvement in the leg pain. (Ex. 112-1). Rosenbaum agreed that claimant's non-organic pain behavior makes it less likely that he would benefit from surgical therapy. (Id.)

Assuming, without deciding, that claimant experiences the symptoms which he reports, we conclude that the proposed surgery is not reasonable and necessary. In reaching this conclusion, we are persuaded by the well-reasoned opinions of Drs. Woolpert and Rosenbaum. Because the operation which Dr. Bert recommends is not reasonably expected to improve claimant's condition, it is not a compensable medical service for which the employer is responsible. ORS 656.245.

ORDER

The Referee's order dated January 31, 1990, as amended February 13, 1990, is reversed. The self-insured employer's denial dated August 31, 1989 is reinstated and upheld. The Referee's assessed attorney fee award of $3,000 is reversed.

January 4, 1991 Cite as 43 Van Natta 22 (1991)

In the Matter of the Compensation of
KELLEY R. WHITE, Claimant
WCB Case No. 88-10598
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Perry and Speer.

Claimant requests review of that portion of Referee Peterson's order that: (1) declined to award temporary total disability benefits commencing September 30, 1987; (2) declined to award interim compensation benefits commencing January 23, 1989; and (3) declined to assess penalties and attorney fees for allegedly unreasonable (and untimely) claims processing. On review, the issues are temporary total disability compensation, interim compensation and penalties and attorney fees. We reinstate claimant's hearing request and affirm on the merits.

FINDINGS OF FACT

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

Claimant was not making reasonable efforts to find work when her condition worsened in September 1987.

CONCLUSIONS OF LAW AND OPINION

The Referee dismissed claimant's requests for hearing. No party requested that the hearing request be dismissed. No other authority supports a dismissal of the hearing requests. Therefore, we reinstate the hearing requests and proceed to the merits.

On the merits, we adopt the Referee's "Conclusions of Law and Opinion," with the following supplementation regarding the temporary disability issue.

Claimant is not entitled to temporary disability benefits if she was not in the work force at the time of her worsening. Cutright v. Weyerhauser, 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).

Claimant testified that she was feeling "pretty good," when she left Oregon and stopped treating with Dr. Squire, chiropractor, in the fall of 1987. (Tr. 19). Her symptoms worsened after her move and she sought treatment with Dr. Martinez, chiropractor, on September 30, 1987, in Arizona. (Ex. 6A-2).

To carry her burden regarding the temporary disability compensation which she seeks, claimant must prove that she was rendered unable to work by her worsened compensable condition. The only medical evidence regarding claimant's condition in September 1987, when the worsening occurred, is the opinion of Dr. Martinez. In an undated report, which SAIF received on January 23, 1989, Martinez opined that on September 30, 1987, claimant's "condition allowed only light duty work status, no lifting or repetitive bending." (Ex. 10A-1). However, in the same report, Martinez also stated that claimant would not have been able to perform secretarial duties in September 1987. (Id.) Inasmuch as Martinez' opinion contradicts itself regarding claimant's ability to work and is conclusory, we are not persuaded by it. Accordingly, we conclude that claimant has not met her burden of establishing that she was unable to work in September 1987.

Moreover, we are not persuaded that claimant was in the work force at the time of her worsening. See Delma R. Olsen, 42 Van Natta 1688 (1990). She worked for the Oregon National Guard until she moved to Arizona. She testified that she was "planning" to go to work in Arizona. (Tr. 20, 29). Upon her arrival in Arizona, claimant inquired about secretarial work at the Arizona National Guard, located less than one block from her home. (Tr. 26). She testified that she would have been hired there if she had been willing to accept lower wages than she had made in Oregon and a part-time starting position. (Tr. 27).

Claimant did not go to work for the Arizona National Guard. Although she testified that she made "a few" other employment applications during her first week in Arizona (Tr. 30), we are not persuaded that she made reasonable efforts to obtain employment. We reach this conclusion because she did not accept employment when it was available. In addition, we note that claimant testified that she did not more actively seek employment because of difficulties involving care of her three young children.

ORDER

Claimant's requests for hearing are reinstated. The Referee's order dated August 1, 1989 is otherwise affirmed.

In the Matter of the Compensation of
EUGENE P. GAUDIO, Claimant
WCB Case No. C0-00455
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Doblie & Associates, Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Myers and Cushing.

On December 12, 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 $50,000 by the SAIF Corporation, claimant fully releases his right to future workers' compensation benefits, except medical services, for his compensable injury. In addition, claimant stipulates to "de facto" denial of the varicose veins of the left leg and any related treatment or symptoms.

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).

Here, the proposed disposition purports to release claimant's rights and obligations not only under his accepted claim, but it also attempts to resolve a "de facto" denied claim for varicose veins of the left leg and any related treatment or symptoms. The latter portion of this release does not pertain to an accepted claim and, as such, is not a proper matter for disposition under ORS 656.236 and the aforementioned administrative rules. See Victor F. Lambert, 42 Van Natta 2707, 2708 (1990).

Inasmuch as the offensive portion of the parties' agreement cannot be excised without substantially altering the bargain underlying the exchange of consideration, we are without authority to approve any portion of the proposed disposition. Karen A. Vearrier, 42 Van Natta 2071 (1990). Consequently, the disposition is set aside. Following our standard procedure, we would be willing to consider a revised agreement which does not contain provisions exceeding our authority under ORS 656.236 and OAR 438-09-001 et seq. Finally, we parenthetically note that this agreement was not accompanied by a "Claim Summary Sheet" pursuant to OAR 436-60-145(7).

IT IS SO ORDERED.

In the Matter of the Compensation of
RICARDO AGUAS, Claimant
WCB Case No. 89-07959
ORDER ON RECONSIDERATION
W. Daniel Bates, Jr., Claimant Attorney
James L. Edmunson, Attorney
Terrall & Miller, Defense Attorneys

Claimant's former attorney requests reconsideration of that portion of our December 14, 1990 order that awarded claimant's attorney an approved fee equal to 25 percent of any increased compensation created by our order, not to exceed $3,800, payable directly to claimant's attorney. Noting that he rendered all

services at hearing and on Board review concerning this case, claimant's former counsel asks that the fee be awarded to him.

On March 7, 1990, claimant's current counsel had advised us that claimant's former counsel was "entitled to whatever fees are awarded on review in this case for services up to this time." At the time of this March 1990 notice, the briefing schedule had been completed and the case was pending review. Therefore, all services rendered in this case were performed by claimant's former attorney.

Under such circumstances, we modify our December 14, 1990 order as follows. The final sentence in the "Order" section on Page 2 is amended to provide that: "Claimant's former attorney is awarded 25 percent of any increased compensation created by this order, not to exceed $3,800, payable directly to claimant's former attorney."

Accordingly, our December 14, 1990 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our December 14, 1990 order. The parties' rights of appeal shall begin this date.

IT IS SO ORDERED.

In the Matter of the Compensation of
GINGER L. CHRISTMAS, Claimant
WCB Case Nos. 89-24888 & 89-12677
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Roy Miller (Saif), Defense Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Speer and Howell.

Safeway Stores, Inc., a self-insured employer, requests review of Referee Menashe's order that: (1) set aside its "new injury" denial of claimant's right shoulder and arm condition; and (2) upheld the SAIF Corporation's aggravation denial of the same condition. The issue on review is responsibility. We affirm.

FINDINGS OF FACT

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

Although claimant had a "hot spot" in the area of her right shoulder in December 1984, this condition was not present at the time of Dr. Grimm's July 1988 examination prior to her employment with Safeway.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Opinion and Conclusions."

Because compensability was litigated at hearing and addressed in the Referee's Opinion and Order, and because Safeway initiated review and claimant's compensation was not reduced or disallowed, claimant is entitled to an assessed fee under ORS 656.382(2). See Tanya L. Baker, 42 Van Natta 1870, on recon 42 Van Natta 2818 (1990) (Compensability, if an issue at hearing, remains at risk

on Board review by virtue of Board's de novo review authority). 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 serices on review concerning the compensability issue is $200, to be paid by Safeway. In reaching this conclusion, we have particularly considered the minimal time devoted to this issue (as represented by claimant's respondent's brief), and the risk to claimant.

ORDER

The Referee's order dated February 23, 1990 is affirmed. For services on Board review, claimant's counsel is awarded a reasonable assessed attorney fee of $200, to be paid by Safeway Stores, Inc.

In the Matter of the Compensation of
ALLAN A. FOWLER, Claimant
WCB Case No. 89-03018
ORDER ON REVIEW
Charles G. Duncan, Claimant Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Myzak's order which: (1) upheld the insurer's denial of medical services for claimant's current right knee condition; and (2) affirmed a Determination Order which awarded no scheduled permanent disability for claimant's right knee condition. On review, the issues are medical services and extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the Referee's "Findings of Fact" and "Findings of Ultimate Fact." In addition, we supplement with the following findings of fact.

Claimant received time loss and 30 percent scheduled permanent disability for a prior 1978 right knee injury. On March 7, 1989, the 1978 insurer denied claimant's request for right knee surgery. On August 28, 1989, claimant and the prior insurer entered into a Disputed Claim Settlement agreement for $15,000; claimant agreed to dismiss all issues raised or raisable as a consequence of the prior insurer's denial.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the January 1988 injury does not continue to materially contribute to claimant's current right knee condition. She further found that claimant has no additional impairment as a result of that injury. We agree and adopt the Referee's "Opinion and Conclusions of Law" with the following comment.

Medical Services

Claimant contends that, because the January 1988 injury slightly contributed to claimant's current condition, the Referee should have applied the last injurious exposure rule to hold the insurer at the time of that injury responsible. We find that the Referee applied the correct test. The question raised at hearing was compensability of medical services. Therefore, we address only whether claimant's January 1988 injury continues to materially contribute

to his current right knee condition. See Van Blokland v. Oregon Health Sciences University, 87 Or App 694 (1987).

Dr. Schachner, orthopedic surgeon, performed an independent medical examination in May 1988. We find his opinion to be tentative, at best. Assuming "material" worsening equates with 15 percent disability, the doctor ventured to opine that it was very unlikely that the January 1988 injury caused a material worsening of claimant's preexisting knee condition based on the nature of the minor injury and trauma sustained.

Dr. Filarski has been claimant's treating orthopedic surgeon since 1978 and has had the unique opportunity to observe claimant's condition both before and after this most recent injury. Therefore, we rely on his consistent and well-reasoned opinion that the residuals of claimant's January 1988 injury have ended. Dr. Filarski performed a closing examination in July 1988. He noted that claimant's symptoms had returned to pre-injury status, and that his continuing symptoms were secondary to his significant preexisting degenerative arthritic condition. In response to an inquiry from claimant's counsel, Dr. Filarski rated the contribution of the January 1988 injury to claimant's impairment at 1 percent; he explained that he utilized this low figure in order to relate the insignificance of this injury to claimant's other knee injuries. We interpret Dr. Filarski's statement regarding percentage to reenforce what he has stated throughout the course of claimant's treatment--the January 1988 injury did not materially contribute to claimant's current condition.

Accordingly, we find that claimant's 1988 injury does not continue to materially contribute to his current right knee condition.

Extent of Scheduled Permanent Partial Disability

No physician has stated that claimant has any impairment as a consequence of his January 1988 injury. As noted above, examining physician Schachner noted that it was very unlikely that the January 1988 injury caused a material worsening of claimant's preexisting knee condition. Treating physician Filarski has stated that claimant has returned to his preinjury status of continuing symptoms of degenerative arthritis and that he has no permanent impairment due to his January 1988 injury. Accordingly, we also affirm the Determination Order that awarded claimant no scheduled permanent disability as a result of this work injury.

ORDER

The Referee's order dated December 18, 1989 is affirmed.

January 8, 1991 Cite as 43 Van Natta 27 (1991)

In the Matter of the Compensation of
BRYAN G. OGDEN, Claimant
WCB Case Nos. 88-17878 & 88-14296
ORDER OF ABATEMENT
Max Rae, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of that portion of our December 11, 1990 order that declined to address the issue of responsibility for claimant's condition after April 7, 1988.

Before considering SAIF's request for reconsideration, we request a response from claimant within 10 days from the date of this order. Consequently,

our December 11, 1990 order is abated and withdrawn. At the conclusion of the aforementioned period, we shall take this matter under advisement.

IT IS SO ORDERED.

January 9, 1991 Cite as 43 Van Natta 28 (1991)

In the Matter of the Compensation of
NEIL C. DUCLOS, Deceased, Claimant
WCB Case No. TP-90058
THIRD PARTY DISTRIBUTION ORDER
William H. Skalak, Claimant Attorney
J. David Thurber (Saif), Defense Attorney

Claimant, the personal representative of the deceased worker's estate, has petitioned the Board for resolution of a dispute concerning the "just and proper" distribution of proceeds from a third party settlement. ORS 656.593(3). Specifically, the dispute involves objections from the SAIF Corporation, as paying agency, to a proposed equal distribution of a $155,100 settlement between the surviving spouse and the decedent's adult child. We conclude that the proposed distribution is just and proper.

FINDINGS OF FACT

In July 1985 the deceased worker died from lung cancer. At the time of his death, the decedent had been retired for several years. He was survived by his wife and his 35 year old married daughter, who was appointed personal representative of his estate.

The estate filed an occupational disease claim for asbestos-related lung cancer. SAIF's denial was eventually set aside by a Referee's order. Thereafter, SAIF began providing workers' compensation benefits.

The personal representative also initiated a wrongful death action against various asbestos companies. With SAIF's approval, the action was settled with the third parties for $155,100. In October 1990, settlement approval was further granted by a Multnomah County Probate Court Judge.

A "Petition and Order for Apportionment of Proceeds" was submitted to the probate court. The petition stated that the decedent's widow and child were each entitled "to receive the amount that would justly, fairly and reasonably compensate them for their pecuniary loss and for loss of society, companionship and services of decedent." After distribution of attorney fees and litigation costs, the petition proposed to distribute the remaining proceeds equally between the widow and the decedent's adult child. The Probate Court Judge granted the petition, but provided that any dispute concerning the effect of SAIF's lien against the settlement proceeds would be submitted to the Board.

The decedent spent virtually all of his leisure time with his immediate family, which included his wife, his daughter, her husband, and their two children (ages 7 and 10). After his daughter's marriage, the decedent maintained their close relationship by either telephone or nearly daily personal visits. The decedent also provided financial and emotional support to his daughter concerning such matters as the acquisition of her family's home, the beginning of their own business, the purchase of his grandchildren's school clothes, and the supplementation of their living expenses.

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, or if death results from the injury, the other beneficiaries, 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 or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593(1). "Beneficiary" means an injured worker, and the husband, wife, child or dependent of a worker, who is entitled to receive payments under Chapter 656. ORS 656.005(2).

Here, as an adult child, the decedent's daughter is not a "beneficiary" under the workers' compensation statutes. ORS 656.005(2). Thus, she will neither receive workers' compensation benefits as a result of the decedent's death nor will her share of the settlement proceeds be subject to SAIF's statutory lien. Scarino v. SAIF, 91 Or App 350, 355, rev den 306 Or 660 (1988).

SAIF has approved of the settlement of the wrongful death action for $155,100. However, contending that an equal allocation of settlement proceeds between the decedent's widow and adult child is unfair and unreasonable, SAIF objects to the proposed distribution. We disagree.

To begin, SAIF questions whether the decedent's daughter sustained pecuniary loss as a result of his death. Such a loss, in addition to the loss of society, companionship and services of the decedent, is necessary for recovery as a dependent under the wrongful death statutes. ORS 30.020(2)(d); 30.030(4); 30.040.

The statements presented in the decedent's daughter's petition to the probate court, in her capacity as personal representative of the estate, for approval of the settlement and the allocation of proceeds, as supported by the sworn attestations made in affidavits from herself and her mother, persuasively establish that the decedent's daughter suffered both financially and emotionally from the loss of her father. Consequently, the daughter would be entitled to a share of the recovery in accordance with her loss. ORS 30.040.

Alternatively, SAIF asserts that an equal apportionment of the settlement proceeds to the decedent's adult daughter is "excessive, unwarranted, not substantiated by the evidence, and not a fair and reasonable distribution under the workers' compensation statutes." Rather than an equal allocation, SAIF suggests that the daughter would be entitled to a "nominal" share of the proceeds commensurate with her position as a fully emancipated, adult child of the retired decedent. Furthermore, as examples of a "nominal" share, SAIF refers to several wrongful death settlements in the state of Washington and Multnomah County, Oregon, as well as the adult children's portion of the settlement in the Scarino case.

The particular settlements and specific distributions in the cases cited by SAIF are of little assistance in determining whether the apportionment of proceeds in this case is just and proper. Rather, each case must be judged on its own set of circumstances.

Here, as set forth in the decedent's daughter's sworn petition to the probate court, in her capacity as personal representative for her father's estate, and as persuasively supported by sworn affidavits from the decedent's widow and daughter, a distribution of settlement proceeds in equal portions represents just, fair, and reasonable compensation for their respective financial and emotional losses resulting from the decedent's death. Other than SAIF's unsubstantiated suggestion that this settlement disbursement is designed to avoid SAIF's

lien, there is no basis for believing that any "gamesmanship" has occurred in this proposed allocation. We further note that this proposed distribution has previously received contingent approval by the Probate Court. Under such circumstances, we find no grounds to disturb a proposed distribution of settlement proceeds conducted in accordance with the personal representative's statutory obligations. See ORS 30.030(4), 30.040; Scarino v. SAIF, supra, at page 355, n. 2.

Accordingly, we hold that SAIF's lien as a paying agency attaches only to the decedent's widow's share of the settlement proceeds. Therefore, the decedent's widow is directed to distribute to SAIF its statutory share of the proceeds from her portion of the settlement in accordance with ORS 656.593(1), which we find to be just and proper. See ORS 656.593(3).

IT IS SO ORDERED.

In the Matter of the Compensation of
ALBERTA M. LAKEY, Claimant
WCB Case No. 89-00188
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The self-insured employer requests review of that portion of Referee Seymour's order that awarded claimant 45 percent (144 degrees) unscheduled permanent disability for a neck and back injury, whereas a Determination Order 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.

Claimant was awarded 30 percent unscheduled permanent disability for a shoulder injury by an October 31, 1984 Determination Order. That Determination Order closed claimant's 1984 left shoulder injury claim. (Ex. 25). Claimant's left shoulder injury resulted in a permanent restriction from performing other than sedentary work.

Claimant suffered this neck and back injury in November 1987. She filed a claim in March 1988. The claim was initially denied, but later accepted pursuant to a September 12, 1988 stipulation.

Claimant subsequently experienced left shoulder symptoms, similar to those experienced from her 1984 compensable injury, and right shoulder symptoms. Claimant continued to receive treatment for her left shoulder from 1980 to the date of hearing. Although the record reflects that claimant has some right shoulder symptoms, no claim has been filed for that condition.

Claimant has been compensated for the loss of earning capacity resulting from her left shoulder condition. Claimant has not regained any of the loss of earning capacity compensated for by the October 31, 1984 Determination Order.

The November 14, 1988 Determination Order, which closed the neck and back claim, awarded no permanent disability.

CONCLUSIONS OF LAW AND OPINION

The Referee awarded claimant 45 percent unscheduled permanent disability. After our de novo review of the record, and taking into consideration claimant's prior award of permanent disability, we modify the Referee's award.

Claimant's current claim was closed by a November 14, 1988 Determination Order. 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).

Age and Education

The appropriate value for claimant's age of 54 years is 1. Former OAR 436-35-290(3).

Claimant has a GED. Therefore, the appropriate formal education value is 0. Former OAR 436-35-300(3). The parties stipulated that the appropriate value for skills is 3. Former OAR 436-35-300(4). We do not disturb that finding. The training value is dependent upon whether or not claimant has documentation demonstrating competence in some specific vocational pursuit. Here, claimant has a certificate of completion from a business college. That certificate, however, as it is general in nature, does not demonstrate competence in any specific vocational pursuit. Therefore, the appropriate training value is 1. Former OAR 436-35-300(5).

Claimant's total age and education value is, therefore, 5.

Adaptability

Claimant is not working as a result of the injury. Further, no employment has been offered. Therefore, claimant's adaptability value is based on former OAR 436-35-310(4).

Because claimant is capable of performing sedentary work, the appropriate adaptability value is 8. Former OAR 436-35-310(4).

Impairment

Claimant contends entitlement to disability for her right shoulder, left shoulder, neck and back conditions.

First, we note that claimant contends that her right shoulder condition is compensably related to her current injury. The employer, on the other hand, contends that claimant failed to prove that her right shoulder condition is caused by or related to her compensable injury. We agree with the employer.

There is no persuasive lay or medical evidence establishing that claimant's current right shoulder symptoms are compensably related to claimant's current claim for neck and back conditions. Therefore, we are not persuaded that claimant's right shoulder condition is related to or caused by claimant's neck and back injury. Consequently, we do not assess disability based on that condition.

Claimant also contends entitlement to disability resulting from her current left shoulder condition. Claimant essentially argues that her current left shoulder condition is a result of her compensable 1987 neck and back injury. We disagree.

Claimant testified that she has continued to have left shoulder symptoms since the May 6, 1980 injury. She also testified that she continues to treat for this condition. (Tr. 25). Furthermore, there is no evidence that claimant's November 1987 injury resulted in a worsened left shoulder condition. The preponderance of the medical evidence establishes that claimant's left shoulder complaints are related solely to her 1980 injury. Moreover, it was as a result of that 1980 injury that claimant was limited to performing sedentary work. Based on these findings, we find that claimant's left shoulder condition was not caused or worsened by her 1987 neck and back injury. Consequently, we do not consider claimant's current left shoulder condition in rating the extent of disability due to claimant's compensable 1987 neck and back injury.

Claimant also contends entitlement to disability for her neck and back conditions, i.e., cervical impairment. As the record establishes that claimant's neck and back conditions were caused by her 1987 compensable injury, we proceed to rate claimant's permanent impairment resulting from these conditions.

Claimant currently suffers from loss of cervical range of motion and disabling pain, both of which are ratable under the standards.

Claimant's ratable loss of cervical range of motion includes 30 degrees left lateral flexion, for a value of 1. Former OAR 436-35-360(4). Claimant's total loss of cervical range of motion is 1 percent.

Disabling pain which results in permanent loss of use or function is ratable under the standards as impairment. Former OAR 436-35-320(1)(a); Daniel M. Alire, 41 Van Natta 752 (1989). The record establishes that claimant suffers disabling pain which permanently restricts her ability to work and to perform everyday tasks around her home. Therefore, we find that claimant suffers 5 percent disabling pain resulting from her injury.

After combining claimant's multiple residuals, 1 percent for loss of cervical range of motion and 5 percent for disabling pain, we find that claimant's total impairment is 6.

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 8, the product is 40. When that value is added to claimant's impairment value 6, the result is 46 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 46 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 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 (1987).

Here, however, there is no evidence that claimant suffers permanent disability in excess of that awarded under the standards. Therefore, we do not find clear and convincing evidence that claimant suffers more than 46 percent unscheduled permanent disability.

Application of former ORS 656.214(5)

The employer contends that because claimant already has been compensated for the loss of earning capacity resulting from claimant's left shoulder condition, by the previous October 31, 1984 Determination Order, claimant should not again be compensated for that same loss of earning capacity.

Claimant contends that her conditions are not the same as resulted from her compensable 1984 injury, and therefore, could not have been compensated for by an earlier award.

In Mary A. Vogelaar, 42 Van Natta 2846 (1990), we analyzed both former ORS 656.214(5) and ORS 656.222 and determined, essentially, that regardless of whether or not ORS 656.222 is interpreted by the Court of Appeals to apply only to scheduled permanent disability awards, former ORS 656.214(5), itself, provides that an injured worker is entitled to that unscheduled permanent disability which results from the injury in question. However, we further reasoned in Vogelaar that the worker is not entitled to be doubly compensated for a permanent loss of earning capacity which would have resulted from the injury in question, but which had already been produced by an earlier accident and compensated by a prior award. Mary A. Vogelaar, supra; See Thomason v. SAIF, 73 Or App 319, 322 (1985); Lawrence W. Scott, 40 Van Natta 1721 (1988).

In Vogelaar, we determined the extent of the claimant's unscheduled permanent disability by first determining the extent of disability under the "standards" or by clear and convincing evidence. Then, a determination was made whether, and to what extent, that determination included unscheduled permanent disability which was not due to the current injury because it was already existing before the current injury. Therefore, in cases where the claimant has prior unscheduled permanent disability, extent of permanent disability is determined by both an application of the standards and by consideration of any prior permanent disability awards. Mary A. Vogelaar, supra.

We proceed with our determination. Previously, claimant received 30 percent for her compensable 1980 left shoulder injury. This award was calculated under the "guidelines" and was based on the fact that claimant's left shoulder injury limited claimant to sedentary work.

Here, we have found that claimant is entitled to 46 percent unscheduled permanent disability under an application of the "standards." We have found that there is no clear and convincing evidence that claimant suffers more than that amount. Further, our "standards" calculation was computed based on the fact that claimant remains capable of performing sedentary work. We note that the neck and back injury did not increase claimant's work restrictions.

Where either of two or more awards are determined by methods other than application of the "standards," the best we can do is to attempt to determine and consider to what extent a prior award and loss of earning capacity is based on the same permanent limitations and vocational factors as where relied on in the subsequent evaluation of permanent disability. Here, we have found that claimant's current limitation to sedentary work has been previously considered and compensated by the 1980 permanent disability award.

We note that consideration of claimant's prior award in determining claimant's current award cannot be performed with mathematical precision. We also refrain from undertaking a mechanical offset. Norby v. SAIF, 303 Or 536 (1987). Under such circumstances, we find consideration of this loss of earning capacity to approximate 20 percent of the prior award. To avoid doubly compensating claimant for the same loss of earning capacity, we reduce claimant's current disability award of 46 percent, as calculated under the standards, by 20

percent. Accordingly, we conclude that 26 percent of the current award determined by the "standards" represents claimant's permanent disability which was not present prior to the 1988 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 October 31, 1984 Determination Order, claimant is awarded 26 percent (83.2 degrees) unscheduled permanent disability, which is her total award to date for her neck and back injury. Claimant's attorney fee payable out of compensation shall be adjusted accordingly.

January 9, 1991 Cite as 43 Van Natta 34 (1991)

In the Matter of the Compensation of
EDWARD R. MONTPART, Claimant
WCB Case No. 89-20402
ORDER ON REVIEW
Phil H. Ringle, Jr., Claimant Attorney
Stoel, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The self-insured employer requests review of Referee Crumme's order which set aside its denial of an industrial injury claim. On review the issues are whether the claim is barred due to late filing and compensability. We reverse.

FINDINGS OF FACT

Claimant has a preexisting low back condition which resulted in a laminectomy in 1985. Claimant's back pain resolved after the surgery.

On November 29, 1987, claimant fell and twisted at work when a chair back gave way. Claimant felt a wrenching sensation. Claimant reported the incident to the company nurse the following day.

A few days later, claimant was experiencing low back and right leg pain. Claimant lost no time from work. He did not seek medical treatment for back problems until he saw a chiropractor on June 30, 1989. In September 1989 he began treating at Kaiser.

CONCLUSIONS OF LAW AND OPINION

We adopt those portions of the Referee's order on reconsideration under the heading "Timely Notice of Injury."

We conclude that claimant has failed to sustain his burden of proving that the incident in November 1987 was a material cause of disability or of a need for medical treatment.

The Referee concluded that claimant's credible testimony was sufficient to establish that the incident in November 1987 was a material cause of claimant's need for treatment in June 1989. We disagree. Notwithstanding the fact that claimant noticed pain just a few days after the incident, the pain did not cause him to seek medical attention for well over one year. Under these circumstances, we conclude that the causation of claimant's problems for which he sought medical treatment in June 1989 is a complex medical question which requires expert evidence.

There is no expert opinion that the incident in November 1987 is a material cause of claimant's need for treatment in June 1989. The fact that the Western Medical Consultants opined that the November 1987 incident was not the sole cause of claimant's problem is not sufficient to draw the inference that the incident is a material cause. Accordingly, claimant has failed to sustain his burden of proof. The denial will be reinstated.

ORDER

The Referee's order dated March 2, 1990, as amended April 11, 1990 is reversed. The self-insured employer's denial of September 1, 1989 is reinstated and upheld.

January 9, 1991 Cite as 43 Van Natta 35 (1991)

In the Matter of the Compensation of
CHUCK NORTHCUTT, Claimant
WCB Case No. 89-14670
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Black's order that awarded an assessed attorney fee for services rendered by claimant's counsel before SAIF rescinded its denial. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

Claimant injured his low back in 1983, while working for an employer in the state of Idaho. As a result of the injury, he underwent a laminectomy and discectomy at the L-5, S-1 level.

On July 12, 1989, claimant filed a claim against his Oregon employer, stating that when he bent over to pick up cartons at work, he felt pain in his lower back.

A July 17, 1989 CT scan of the lumbosacral spine showed disc bulging at L3-4 and L4-5, with some element of herniated disc material at both levels. Other than degenerative change, no other abnormalities were seen.

On July 25, 1989, SAIF denied claimant's claim for a back strain and ruptured disc.

A hearing was scheduled to be held on November 6, 1989, on the issue of SAIF's denial of compensability. Prior to hearing, SAIF rescinded its denial and the parties entered into a stipulated settlement.

The remaining issue to be determined by the Referee was that of claimant's entitlement to an assessed fee for services rendered before SAIF rescinded its denial. In a December 26, 1989 Opinion and Order, the Referee awarded an assessed attorney fee of $3,037.50, payable by SAIF.

CONCLUSIONS OF LAW AND OPINION

The Referee awarded an assessed attorney fee although SAIF had rescinded its denial before the hearing. He held that an administrative rule, OAR 438-15-

030(1), provided a basis for an award where the attorney is instrumental in obtaining compensation for a claimant without a hearing. Alternatively, the Referee held that, in this case, claimant had finally prevailed by means of a stipulation. Finally, the Referee held that, for policy reasons, an attorney fee should be assessed in such circumstances. We disagree.

On review, SAIF argues that the present case is controlled by Duane L. Jones, 42 Van Natta 875 (1990), a case which issued subsequent to the Referee's order. In Jones, we held that a claimant's attorney would not be entitled to an assessed fee when the insurer reasonably issues and then rescinds a denial before a hearing. Duane L. Jones, supra.

SAIF contends that, under the Jones case, there is no basis for an assessed fee where it has rescinded its denial prior to hearing. SAIF also notes that the Jones case invalidated that portion of OAR 438-15-030(1) which allowed a carrier-paid attorney fee without a hearing.

Claimant argues that the question in this case is not simply whether SAIF must pay an assessed fee when it rescinds a denial prior to hearing, but whether it must pay an assessed fee when it rescinds an unreasonable denial. In the present case, claimant argues that the parties stipulated that SAIF's denial was unreasonable and that claimant was entitled to a 15 percent penalty of all compensation then due at the time the denial was rescinded. Claimant contends that, for this reason, an assessed fee under ORS 656.382(1) is appropriate.

Claimant argues that, in this case, SAIF presented no reason at hearing to support its denial. Claimant contends that no investigation was conducted and SAIF had no reason to issue the denial. Claimant asserts that it was his counsel that was required to conduct the investigation, which involved obtaining medical documents from a different state and having the treating physician document the compensability of the claim.

In the present case, although claimant has asserted that SAIF stipulated that its denial was unreasonable, we are unable to find such a stipulation in the record. Our review is limited to the record before us. ORS 656.295(5). The Referee found, and we agree, that there is not adequate evidence in the record to establish entitlement to a fee under ORS 656.382(1). In other words, we are unable to conclude that SAIF's denial was unreasonable and we decline to assess an attorney fee on that basis.

The remainder of claimant's brief addresses the validity of the Duane L. Jones decision. We adhere to our ruling in that case. We, therefore, reverse the Referee's award of an assessed attorney fee for services rendered by claimant's counsel before SAIF rescinded its denial.

ORDER

The Referee's order dated December 26, 1989, as reconsidered by the March 6, 1990 order, is reversed. The $3,037.50 assessed attorney fee awarded by the Referee, to be paid by the SAIF Corporation, is reversed.

In the Matter of the Compensation of
MARY SALAZAR, Claimant,
and In the Matter of the Complying Status of
JOSE V. C. MARTINEZ, dba The Bull Ring Restaurant, Employer
WCB Case No. 89-06316
ORDER OF DISMISSAL (REMANDING)
Vick & Gutzler, Claimant Attorneys
Wittrock & O'Brien, Attorneys
David Fowler (Saif), Defense Attorney

The alleged noncomplying employer, Jose V. C. Martinez, has requested review of the Referee's July 28, 1989 order, as amended August 18, 1989, which dismissed his request for hearing concerning the SAIF Corporation's acceptance, on his behalf, of claimant's injury claim.

The employer concedes that his request for review is submitted more than 30 days after the date of the Referee's orders. However, he notes that he was not mailed a copy of either of those orders and only recently received notice of the orders after he retained legal counsel who was able to provide him with copies of the orders. We return this matter to the Referee.

FINDINGS OF FACT

The employer, pro se, requested a hearing concerning SAIF's acceptance, on his behalf, of claimant's injury claim. The Referee granted claimant's and SAIF's motion to dismiss the hearing request.

On July 28, 1990, the Referee issued an Opinion and Order, dismissing the employer's hearing request. On August 18, 1990, the Referee issued an amended order providing that SAIF pay claimant's reasonable attorney fee on the employer's behalf. Neither order indicated that a copy had been mailed to the employer.

On approximately November 16, 1990, the employer's attorney obtained copies of the Referee's orders. Thereafter, the employer requested Board review of the orders.

ULTIMATE FINDING OF FACT

The alleged noncomplying employer was not mailed a copy of the Referee's orders.

CONCLUSIONS OF LAW

A Referee's order shall be mailed to all parties in interest. ORS 656.289(2). "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).

Here, the employer, a party in interest to the proceeding, was not mailed a copy of the Referee's orders. Therefore, the orders are not final and are not subject to our review. ORS 656.289(2), (3); Richard F. Taylor, 40 Van Natta 384 (1988); Martin N. Manning, 40 Van Natta 374 (1988).

Inasmuch as the Referee's orders are not final, the noncomplying employer's request for Board review is premature. Accordingly, the request for review is dismissed.

We note that the Referee who issued these orders is no longer with the Board. Therefore, this matter is referred to the Presiding Referee with instructions to issue a republished and final order bearing a new date of actual mailing to all parties to this proceeding, including their respective representatives.

IT IS SO ORDERED.

In the Matter of the Compensation of
RAYMUN B. SAVALAS, Claimant
WCB Case No. 90-0303M
OWN MOTION DETERMINATION ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

On December 13, 1990, we abated our November 14, 1990 order that declined to close claimant's own motion claim because the self-insured employer had not issued a notice of closure. See OAR 438-12-055. We took this action to further consider the employer's request for reimbursement from the Reopened Claims Reserve for temporary disability benefits commencing upon the employer's August 17, 1987 voluntary reopening or, alternatively, beginning with claimant's March 9, 1989 surgery. We deny the request for reimbursement authorization.

The relevant facts follow. Claimant's aggravation rights under a 1980 right knee injury claim expired in April 1987. In June 1987, Dr. Bert, orthopedist, requested authorization to perform a total knee replacement. Medical opinions recommending against such a surgical procedure were also received. The employer voluntarily reopened the claim and began paying temporary disability benefits effective August 17, 1987. On September 23, 1987, claimant underwent a right knee arthroscopic debridement performed by Dr. Schroeder, orthopedist.

On November 2, 1987, claimant returned to light duty work. The employer ceased paying temporary disability benefits effective November 1, 1987, without seeking a Board own motion determination. The employer reinstated these benefits on February 12, 1988 and continued with these payments until April 14, 1988. Once again, no closure order was sought or issued.

On October 31, 1988, Dr. Bert took claimant off work until further notice. On November 1, 1988, Dr. Bert again recommended a total knee replacement. The employer reinstituted temporary disability benefits. The surgery was eventually performed on March 9, 1989.

On April 4, 1990, the employer requested the issuance of a Determination Order. Since claimant's own motion rights had expired, the request was forwarded to the Board. On November 14, 1990, we issued our order, concluding that no determination could be made until the employer issued a Notice of Closure under OAR 438-12-055. On November 28, 1990, the employer issued its closure notice. To date, no request for review of that notice pursuant to OAR 438-12-060 has been received.

The employer now seeks a Board order reopening this claim and authorization to recover reimbursement from the Reopened Claim Reserve. Inasmuch as the employer voluntarily reopened this claim in August 1987 and the claim has remained reopened since that time, we conclude that it is unnecessary for the Board to order reopening of the claim. Furthermore, were we to award temporary disability benefits under our Own Motion authority, we would decline to grant authorization to recover the benefits paid since August 1987 from the Reopened Claims Reserve. We reach these conclusions based on the following reasoning.

ORS 656.625(1) provides that the Director "shall establish a Reopened Claims Reserve within the Insurance and Finance Fund for the purpose of reimbursing the additional amounts of compensation payable to injured workers that results from any award made by the board pursuant to ORS 656.278 after January 1, 1988." Notwithstanding any other provision of law, any reimbursement from the Reopened Claims Reserve shall be in such amounts as the Board prescribes and only to the extent that funds are available in the reserve. ORS 656.625(1).

These provisions became operative January 1, 1988. Oregon Laws 1987, Chapter 884, Section 63; Andy Webb, 40 Van Natta 586 (1988).

To promote the voluntary reopening of own motion claims, we have authorized reimbursement from the reserve to carriers who have voluntarily reopened claims after January 1, 1988 provided that the circumstances satisfy the requirements for temporary disability awards under ORS 656.278(1). We have taken such an approach to assure carriers who are otherwise wary of reopening claims without a Board order that their entitlement to reimbursement pursuant to ORS 656.625 will not be impacted by their decision to voluntarily reopen.

Yet, our authorization has not been extended to claims which have been voluntarily reopened prior to the adoption of ORS 656.625 and the creation of the Reopened Claims Reserve. Were we to extend authorization to pre-January 1, 1988 voluntary reopenings, we would be permitting carriers to receive reimbursement for payments that they had no expectation of recovering from a source that did not exist at the time the decision was made to pay the benefits. We decline to apply the statute retroactively.

In any event, we are not persuaded that a claim reopening before January 1, 1988, can qualify as an award made "pursuant to ORS 656.278 after January 1, 1988," as provided in ORS 656.625. Effective January 1, 1988, ORS 656.278 was amended to limit the availability of own motion relief. That amendment coincided with the creation of the Reopened Claims Reserve, evidencing legislative intent to allow reimbursement for only those awards made pursuant to the current version of ORS 656.278. Inasmuch as claims reopened before January 1, 1988, were reopened under the former version of ORS 656.278, they cannot qualify for reimbursement under ORS 656.625.

Here, the employer voluntarily reopened the claim in August 1987. Although it terminated claimant's temporary disability in November 1987 and subsequently reinstituted his benefits in 1988, the claim was never closed after the August 1987 reopening. Under such circumstances, notwithstanding our statements in our November 14, 1990 order that the claim was "voluntarily reopened" as of February 12, 1988, we conclude that the claim has remained in open status since August 1987. Thus, because the claim was voluntarily reopened in 1987, before the adoption of ORS 656.625, we further hold that the employer is not entitled to reimbursement from the Reopened Claim Reserve.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our November 14, 1990 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

January 10, 1991 Cite as 43 Van Natta 39 (1991)

In the Matter of the Compensation of
DONNA L. BARTRUFF, Claimant
WCB Case No. 89-14710
ORDER OF ABATEMENT
Michael B. Dye, Claimant Attorney
Alan L. Ludwick (Saif), Defense Attorney

The Board has received claimant's motion for reconsideration of our Order on Review dated December 14, 1990.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and withdrawn. The SAIF Corporation is requested to file a response, if any, to the motion within ten days. Thereafter, this matter will be taken under advisement.

IT IS SO ORDERED.

January 10, 1991 Cite as 43 Van Natta 40 (1991)

In the Matter of the Compensation of
LLOYD G. CROWLEY, Claimant
WCB Case No. 89-01325
ORDER ON REVIEW
Rick A. Roll, Claimant Attorney
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Nichols, Brittingham, and Crider.

The SAIF Corporation requests review of Referee Fink's order that set aside its denial of claimant's occupational disease claim for a mental disorder. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" with the exception of paragraph ten and the following correction. The first sentence of the fourth paragraph should read: "An investigation of the charges was made by claimant's supervisor, who determined that there was some validity to the complaint of verbal sexual harassment." (Tr. 72 & 93, Ex. 1).

ULTIMATE FINDINGS OF FACT

The employee conference, during which claimant's supervisor informed him about the sexual harassment charge, was an employment condition which produced claimant's mental condition.

The employee conference was a reasonable corrective action taken by the employer.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside SAIF's denial, concluding that claimant has a mental disorder which is compensable as an occupational disease. On review, claimant contends that the Referee's order should be affirmed because claimant's condition is compensable either as an occupational injury or disease. We disagree.

The date of "injury" for purposes of determining the compensability of an occupational disease is the date upon which the claimant was last exposed to the employment conditions that caused the disease. Johnson v. SAIF, 78 Or App 143, 146-48, rev den 301 Or 240 (1986). Claimant's last exposure to the work-related condition which he alleges caused his mental disorder was August 19, 1988. If we find that claimant suffers from a disease, we must 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 1257 (1989).

Former ORS 656.802 provides, in part, that an occupational disease arising out of and in the course of employment which requires medical services will not be compensable:

> "(2)(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."

Claimant argues that his mental disorder came about over a short, discrete period, and therefore, should be analyzed as an occupational injury rather than an occupational disease. Under this analysis, claimant argues, former ORS 656.802 is inapplicable and he needs to prove only that the event causing the mental illness arose out of and within the scope of employment. We disagree.

Former ORS 656.802(2) states that "[n]notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter" unless the four conditions listed above are met. Thus, although a mental disorder can be an occupational injury, former ORS 656.802(2) would still apply and would require that such a mental disorder meet the four listed conditions.

However, an original mental disorder claim, such as the one here, must be distinguished from a mental disorder claim which arises as psychological sequelae from a compensable occupational injury. Randolph P. Gaul, 42 Van Natta 592 (1990). In the latter case, former ORS 656.802 does not apply because the claim relates to the original occupational injury or disease; and a claimant satisfies his or her burden by proving, by a preponderance of the evidence, that the compensable condition is a material cause of the psychological condition. Id. Here, former ORS 656.802 applies because claimant is not claiming that his mental disorder is the result of psychological sequelae from a compensable occupational injury.

We proceed to apply former ORS 656.802 to this case. Based on demeanor, the Referee found claimant credible. The Referee also found that claimant denied the sexual harassment charge and stated that the accusation was false. We do not disturb those findings. However, the dispositive factor here is whether the employment conditions producing claimant's mental condition were reasonable disciplinary or corrective actions by the employer. Former ORS 656.802(2)(b).

Claimant argues that his mental disorder was caused by the knowledge that a co-worker alleged sexual harassment, not by his supervisor informing him about this allegation. The record does not support this argument.

Claimant found out about the sexual harassment complaint during the employee conference with his supervisor. (Tr. 125). Dr. Duncan, M.D., claimant's treating psychiatrist, opined that "the allegations made against Mr. Crowley, by his employer, involving sexual innuendo of a fellow employee, is the major factor" which caused his mental disorder. (Ex. 7-2) (emphasis added). Dr. Turco, M.D., examining psychiatrist, opined that claimant's perception of being

harassed himself at work appears to be the major contributing cause of his upsurge of anger and depression. (Ex. 4-5/6) (emphasis in original). We find these statements persuasively demonstrate that it was the supervisor's confrontation of claimant within the employee conference that produced claimant's mental disorder. Thus, an employment condition, the employee conference, produced claimant's mental disorder.

The record is replete with indications that the employee conference was a prelude to any direct disciplinary action. Both claimant's union steward and claimant's supervisor agreed that other than a warning, there was no disciplinary action at the employee conference stage. (Tr. 54, 82).

Assuming there is a difference between a disciplinary and corrective conference, this meeting was more of a corrective action conference. The union steward and supervisor testified that the purpose of an employee conference was to give the employee a chance to correct any possible problem so that claimant could adjust his behavior before disciplinary action was necessary. (Tr. 57, 104). Claimant's supervisor testified that the employee conference was intended to correct any possible problems by bringing the sexual harassment accusations to claimant's attention so that claimant could adjust his behavior. (Tr. 104).

The record also shows that the employer's actions were reasonable. There was no evidence that claimant's supervisor publicly corrected claimant. In fact, claimant testified that the employee conference was held in the "back office." (Tr. 125).

Claimant's supervisor testified that the union required that some action be taken and documented in writing prior to any disciplinary action. (Tr. 86-87 & 100-101). He stated that the employee conference form was developed by the state to comply with the union requirements. (Id.) This form was used for claimant's employee conference. (Ex. 8). Claimant's union steward also testified that the union contract requires the supervisor to take the actions that he took. (Tr. 38).

Also, after receiving the complaint from claimant's co-worker, the supervisor performed a thorough investigation, followed correct personnel procedures, and explained the charges/procedures to claimant. (Tr. 72, 73, 88, 93, 96, Ex. 8).

All four elements of former ORS 656.802(2)(a)-(d) must be proven to establish a mental disorder as an occupational disease. Because claimant's mental disorder resulted from a reasonable corrective action by the employer, and therefore former ORS 656.802(2)(b) is not satisfied, we do not address the remaining elements.

ORDER

The Referee's order dated December 4, 1989 is reversed. The SAIF Corporation's denial of December 22, 1988 is reinstated and upheld. The Referee's award of an assessed fee of $2,465 is reversed.

Board Member Crider dissenting.

Claimant, without doubt, suffered a mental disorder as a result of his awareness that fellow employes had accused him of sexual harassment. The question is whether this work-related condition is noncompensable because it is a product of "reasonable disciplinary, corrective or job performance evaluation actions by the employer" within the meaning of ORS 656.802(2)(b). I conclude

that claimant's condition was not a product of such employer action for two reasons.

First, unlike the majority, I believe that the evidence, particularly the chart notes of the treating physicians and the detailed accounts by the examining physician, establishes that claimant was upset by the accusations of his coworkers and the consequences for his reputation in the community, not by his supervisor's corrective action.

Second, assuming that the mental disorder was in fact caused by the corrective action, I am not persuaded that the corrective action was reasonable. No matter how well-intentioned an employer's corrective action, it is not reasonable if, as here, it is undertaken after an investigation which fails to include an opportunity for the worker whose actions are in question to tell his side of the story. I note, in this regard, that the personnel rules promulgated by the Executive Department of the State of Oregon pursuant to ORS 184.340, which governed this place of employment, specifically provide that "An appointing authority shall base the decision as to appropriate disciplinary action to be taken in a particular situation on the following factors: (1) Sound evaluation of all facts [including]...the employe's statement in which the employe admits, denies or explains the alleged improper actions..." Rule 8.1.1.1a.[1] This employer counselled claimant to change his behavior without first allowing claimant to address the accusations. In the absence of any reason for the failure to contact claimant as part of the investigatory process, I conclude that the employer's conduct was unreasonable.

For these reasons, I would affirm the Referee's decision setting aside the denial. Therefore, I dissent.

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1) Under the personnel rules, an unofficial reprimand which is not placed in an employe's personnel file, is a form of disciplinary action when it results in corrective action. Rule 8.1.1.1d(1).

In the Matter of the Compensation of
WALTER L. EGGLESTON JR., Claimant
WCB Case No. 89-23698
ORDER ON REVIEW
J. W. McCracken, Jr., Claimant Attorney
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Cushing and Myers.

Claimant requests review of that portion of Referee Black's order that: (1) denied his motion to exclude the insurer's exhibits as untimely; and (2) upheld the insurer's partial denial of his current right carpal tunnel condition. On review, the issues are admission of evidence and compensability. We affirm.

FINDINGS OF FACT

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

Claimant timely requested a hearing. The hearing was initially scheduled for December 22, 1989, and then rescheduled for January 26, 1990.

On January 10, 1990, the insurer submitted its exhibits by transmittal letter. This was less than twenty days before the hearing date.

At hearing, claimant objected to the admission of all of the insurer's exhibits, except exhibits 21, 27, and 28. Claimant had all the pertinent documents 20 days before the hearing date. However, he did not receive an exhibit list 20 days prior to hearing.

Claimant acknowledged that he experienced no prejudice resulting from the late disclosure of the exhibit list.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Ruling - Admission of Evidence

The Referee found that claimant had failed to establish prejudice because he had not received an exhibit list 20 days prior to hearing. We agree.

After our review of the relevant rules, OAR 438-07-015 and OAR 438-07-018, we find that, in this instance, the Referee did not have discretion to exclude the exhibits. OAR 438-07-015 regulates entitlement to claims information and discovery. Failure to provide timely discovery may be sanctioned. OAR 438-07-015(5); OAR 438-07-018(4).

OAR 438-07-018, however, pertains to the exchange and admission of exhibits at hearing. OAR 438-07-018(1) requires the insurer to submit its exhibits not later than 20 days before the hearing. While OAR 438-07-018(4) does provide for sanctions for untimely discovery under OAR 438-07-015, those sanctions do not pertain to OAR 438-07-018(1)-(3). Therefore, nothing in the rule precludes admission of other documents provided they have been timely disclosed to the other party. See Oliver F. Coon, 42 Van Natta 1845, 1846 (1990). Further, OAR 438-07-018(4) does not give the Referee discretion to exclude timely-disclosed documents merely because the documents could have been submitted at an earlier time. Coon, supra; Sabeth Sok, 42 Van Natta 2791 (1990); T. S. Nacoste, 42 Van Natta 1855 (1990).

In this case, claimant had possession of the pertinent documents more than 20 days prior to the hearing date. The only item missing was an exhibit list. At hearing, claimant conceded that he was not prejudiced by not having the exhibit list. (Tr. 3-4). The Referee was correct in admitting into evidence the insurer's exhibits. See OAR 438-07-018(4).

Compensability

We adopt the Referee's reasoning associated with this issue.

ORDER

The Referee's order dated February 26, 1990 is affirmed.

In the Matter of the Compensation of
LEE R. GILSON, Claimant
WCB Case No. C0-00474
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Welch, Bruun & Green, Claimant Attorneys

Reviewed by Board Members Howell and Speer.

On December 13, 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 $2,500 by Industrial Indemnity Co., claimant fully releases his right to future workers' compensation benefits, except medical services, for his compensable injury. In addition, claimant agrees that his accepted May 30, 1989 claim "has combined with and supersedes all other prior injuries to the same body part, such that the present injury and all prior injuries are inextricably intertwined and intermingled." Similarly, claimant agrees that another injury, dated March 8, 1990, "supersedes and combines with any and all prior injuries claimant may have suffered to the same body part, such that all prior injuries are indistinguishable to the existing condition and injury of March 8, 1990." 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).

Here, the proposed disposition purports to release claimant's right not only under is accepted May 30, 1989 claim, but it also attempts to "merge" "any and all" prior claims to the same body part with the accepted claim. Moreover, the proposed agreement attempts to have a separate March 8, 1990 injury "supersede and combine" with any prior injuries claimant "may" have suffered to the same body part. We unable to determine from the proposed disposition whether there are, in fact, any prior injuries to the same body parts. If claimant has suffered any such injuries, we are unable to determine whether those injuries have been accepted, denied or not claimed. Moreover, if such injuries have occurred and been accepted, then the proposed disposition fails to set forth information regarding such injuries as required by OAR 436-60-145(6). Finally, if such injuries have been denied, then this portion of the release does not pertain to an accepted claim and, as such, is not a proper matter for disposition under ORS 656.236 and the aforementioned administrative rules. See Eugene P. Gaudio, 43 Van Natta 24 (1991); see also Victor F. Lambert, 42 Van Natta 2707, 2708 (1990).

We also consider the proposed disposition contrary to administrative prerequisites for an additional reason. Specifically, OAR 436-60-145(6)(i) requires that proposed dispositions state that the worker was provided with the notice containing all of the information about claims dispositions prescribed in subsection (3) of that provision. This proposed disposition lack a statement to that effect.

Inasmuch as the offensive portions of the parties' agreement cannot be excised without substantially altering the bargain underlying the exchange of consideration, we are without authority to approve any portion of the proposed disposition. Karen A. Vearrier, 42 Van Natta 2071 (1990). Consequently, the disposition is set aside. Following our standard procedure, we would be willing to

consider a revised agreement including all of the elements set forth in OAR 436-60-145(6) and which does not contain provisions exceeding our authority under ORS 656.236 and OAR 438-09-001 et seq.

IT IS SO ORDERED.

January 10, 1991 Cite as 43 Van Natta 46 (1991)

In the Matter of the Compensation of
GENE E. HANSEN, Claimant
WCB Case Nos. C0-00386 & C0-00387
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Patrick Lavis, Claimant Attorney
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Cushing and Myers.

On November 28, 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 $19,475 by the SAIF Corporation, claimant fully releases his right to future workers' compensation benefits, except medical services, for both his December 31, 1968 and March 19, 1985 compensable injuries. We set aside the proposed disposition.

We will 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 the 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 the rules promulgated thereunder. See OAR 436-60-145(1); 438--09-001(1).

Here, the proposed disposition purports to release all workers' compensation benefits, except medical services, in regard to claimant's March 19, 1985 compensable injury. The disposition then provides that all medical treatment relating to claimant's low back condition would be related to the March 1985 compensable injury. This language could reasonably be interpreted to limit claimant's right to medical services under ORS 656.245 for his December 31, 1968 compensable injury. Any limitation on that right exceeds the bounds of ORS 656.236 and OAR 436-60-145(1) and 438-09-001(1). Accordingly, the proposed disposition is unreasonable as a matter of law and is set aside on this basis. See ORS 656.236(2).

Further, the proposed disposition also purports to release claimant's rights and obligations under his December 31, 1968 compensable injury, however it does not provide for any consideration for release of those rights and obligation. Accordingly, the provision is also unreasonable as a matter of law on this basis. See OAR 436-60-145(6)(h).

For the reasons noted above, we are unable to approve the parties' proposed disposition. Following our standard acknowledgment procedures, we would be willing to consider a revised agreement which does not contain provisions exceeding the bounds of the statutes and rules.

IT IS SO ORDERED.

In the Matter of the Compensation of
ANN F. LOWE, Claimant
WCB Case No. C0-00432
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Calvert & Calvert, Claimant Attorneys
Nelson, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

On December 10, 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 $10,000 by Liberty Northwest Insurance Corporation, claimant fully releases her right to future workers' compensation benefits, except medical services, for her compensable injury. We set aside the proposed disposition.

A proposed disposition must be set aside if we find that it is unreasonable as a matter of law. ORS 656.236(1)(a). A disposition is unreasonable as a matter of law if a reasonable fact-finder could only conclude that the agreement is unreasonable as a matter of fact. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990).

Here, claimant has been awarded a total of 70 percent (224 degrees) unscheduled permanent disability for her low back, 10 percent (15 degrees) scheduled permanent disability for her right leg and 5 percent (7.5 degrees) scheduled permanent disability for her left leg by a July 30, 1990 Determination Order. The Determination Order has not been appealed. The total award is for a sum in excess of $25,000. There is no evidence that the award has been paid in full. Because of claimant's rate of compensation and the amount of time since the award, claimant is presently entitled to a sum much greater than the $10,000 offered by the insurer to settle her claim. We thus find the consideration offered by the insurer to be grossly disproportionate to the value of claimant's claim. Furthermore, there is no evidence in the record that claimant is aware that she could petition for a lump sum payment from the insurer on her award. ORS 656.230. Based on these facts, we are persuaded that a reasonable fact-finder could only conclude that the agreement was unreasonable as a matter of fact. Accordingly, we find that the agreement is unreasonable as a matter of law and set it aside. Louis R. Anaya, supra.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROY L. PLUMLEE, Claimant
WCB Case No. C0-00515
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Bischoff & Strooband, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Myers and Cushing.

On December 18, 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 $10,500 by Aetna Casualty Company, claimant fully releases his right to future workers' compensation benefits, except medical services, for his compensable injury. In addition, claimant agrees to relinquish all rights to claim any other mental of physical condition

alleged to be a consequence of the compensable injury. Further, claimant agrees to withdraw his hearing request regarding the insurer's February 9, 1990 partial denial. 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 the 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).

Here, the proposed agreement purports to release claimant's further rights to workers' compensation benefits of any type, except medical services payable under his workers' compensation claim. The disposition then provides that claimant releases all rights to claim any physical or mental conditions alleged to be a consequence of the compensable injury. That language could reasonably be interpreted to limit claimant's right to medical services under ORS 656.245 for conditions related to the compensable injury. Any limitation on that right exceeds the bounds of ORS 656.236 and OAR 436-60-145(1) and 438-09-001(1). Accordingly, the proposed disposition is unreasonable as a matter of law and is set aside on this basis. See ORS 656.236(2).

Further, the proposed disposition also purports to release claimant's rights and obligations not only under his accepted claim, but also attempts to resolve a February 9, 1990 denial of the compensability of claimant's current condition, issued by the insurer. The latter portion of this release does not pertain to an accepted claim and, as such, is not a proper matter for dispostion under ORS 656.236 and OAR 436-60-005(9). See Victor F. Lambert, 42 Van Natta 2707, 2708 (1990). For this reason, the proposed disposition is not a "claims disposition agreement" as defined by OAR 438-09-001(1).

For the reasons noted above, we are unable to approve the parties' proposed disposition. Following our standard acknowledgment procedures, we would be willing to consider a revised agreement which does not contain provisions exceeding the bounds of the statutes and rules.

IT IS SO ORDERED.

In the Matter of the Compensation of
JERRY H. FOSS, Claimant
WCB Case No. C0-00439
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Roger D. Wallingford, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

On December 11, 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 $10,000 by Louisiana-Pacific Corporation, the self-insured employer, claimant agrees to release his right to future workers' compensation benefits, except medical services, for his December 18, 1981, compensable injury. Additionally, in exchange for "other consideration," claimant agrees to release his right to future workers' compensation benefits,

except medical services, for his November 28, 1979, compensable injury. We set aside the proposed disposition.

A claim disposition agreement must be set aside if we find that it is unreasonable as a matter of law. ORS 656.236(1)(a). An agreement is "unreasonable as a matter of law" if it exceeds the bounds of applicable administrative rules, or if a reasonalbe fact-finder could only conclude that the agreement was unreasonable as a matter of fact. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990). Former OAR 436-60-145(6)(h) (Temp.) and former OAR 438-09-020(2)(a) (now OAR 438-09-020(1)(a)), which apply here, required that an agreement provide the amount of consideration to be paid claimant for his release of benefits.

Here, the agreement consists of two separate claims disposition and provides that the amount of consideration for claimant's release is $10,000, but states that "[t]he settlement amount will be paid under the December 18, 1981 claim" and that "[o]ther consideration will be paid on the November 28, 1979 claim." The agreement itself does not identify the "other consideration." By letter, the employer's attorney explains that "other consideration" is the claim disposition agreement entered on the 1981 injury claim.

The agreement contains an amount of consideration for the release of claimant's 1981 claim, but none is provided for claimant's release of the 1979 claim. Although the aforementioned rules do not expressly require an amount of consideration for each disposition of a claim, we are persuaded that that is the most reasonable interpretation of the rules. Because no amount of consideration was provided for the 1979 claim, we find its disposition to have exceeded the bounds of former OAR 436-60-145(6)(h) and former OAR 438-09-020(1)(a).

We further find that a reasonable fact-finder could only conclude that the disposition of the 1979 claim was unreasonable as a matter of fact. Claimant's 1979 claim was accepted; therefore, he is entitled to workers' compensation benefits for that claim. Those potential benefits are the value of the claim. Yet, the parties purport to dispose of the claim in exchange for unspecified "other consideration" which is, in fact, no consideration beyond that provided for disposition of the 1981 claim.

For the above reasons, we find the agreement relating to the 1979 claim to be unreasonable as a matter of law. See Louis R. Anaya, supra. Inasmuch as the offensive portion of the parties' agreement cannot be excised without substantially altering the bargain underlying the exchange of consideration, we are without authority to approve any portion of the proposed disposition. Karen A. Vearrier, 42 Van Natta 2071 (1990). Accordingly, the disposition is set aside. Following our standard procedure, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
GARY B. KINGERY, Claimant
WCB Case No. 89-15522
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The insurer requests review of those portions of Referee McWilliams' order which: (1) set aside its "de facto" denial of a psychiatric condition; and (2) set aside a Determination Order as premature. Claimant, in his respondent's brief, contends that if the claim was not prematurely closed, then he is entitled to a greater award for permanent disability. On review, the issues are compensability, premature closure and extent of unscheduled permanent disability. We reverse in part and affirm in part.

FINDINGS OF FACT

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

Claimant sought psychiatric treatment for a psychological condition which was materially related to a chronic pain problem resulting from the compensable 1983 injury.

Claimant's aggravation claim was properly closed and he has not suffered a permanent worsening of his accepted back condition.

CONCLUSIONS OF LAW AND OPINION

Compensability of Psychological Condition

The Referee concluded that claimant's need for psychotherapy was materially caused by his compensable 1983 back injury and set aside the insurer's "de facto" denial of compensability of that condition. We agree, but do so for different reasons.

In order to establish the compensability of a psychiatric condition following an industrial injury, claimant must prove by a preponderance of the evidence that the work-related injury was a material contributing cause of the condition, or, if the claimant's mental condition predated the injury, that the injury worsened that preexisting condition. Jeld-Wen v. Page, 73 Or App 136, 139 (1985). Although the compensable injury need not be the sole cause or the most significant cause, it must be material. See Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987).

On March 13, 1983, claimant sustained a compensable lumbosacral strain while working as a nurse's aide. Throughout the years claimant has availed himself of medical care for continuing pain problems.

A neurologic consultation was performed by Dr. Herring on November 5, 1988. Dr. Herring noted that claimant reported depression associated with constant pain. Dr. Herring also indicated that claimant did not manifest pain behavior or functional interference.

Beginning sometime in early 1989, claimant sought psychological treatment from Dr. Brown, a psychiatrist. Claimant received four psychotherapy sessions with Dr. Brown, the last one being on April 14, 1989. In his subsequent November 27, 1989 report, Dr. Brown noted symptoms of intermittent despondency,

nausea, drowsiness, muscle weakness, pain, headaches, and numbness. In addition, Dr. Brown noted that claimant was angry and frustrated. He opined that claimant's primary way of expressing his feelings was through somatic symptoms.

In diagnosing claimant's psychological condition, Dr. Brown stated, "Since the symptoms do not meet [the] criteria for a somatization (sic) disorder and since his symptoms exceed the pain disorder I would categorize his condition to be best described as 300.70 undifferentiated pain disorder." Relying on his own observations, as well as noting Dr. Herring's reports, Dr. Brown concluded that claimant's four years of pain problems were materially related to the compensable injury.

On September 8, 1989, claimant underwent an independent medical examination with Dr. Klecan, a psychiatrist, who found claimant had no psychological condition, was psychiatrically medically stationary, and had no permanent residuals resulting from a psychological condition. Dr. Brown concurred with this report.

We do not find the opinions of Drs. Brown and Klecan to be in conflict. As an initial matter, we note that Dr. Klecan's report primarily addressed claimant's current psychological condition. Whereas, Dr. Brown's report reflected claimant's condition at the time he was being treated. Thus, based upon the above medical record, we conclude that claimant sought psychological treatment for an undifferentiated pain disorder which was materially related to claimant's chronic pain problems due to the compensable 1983 injury. However, by the time the independent medical examination was performed, this disorder had stabilized without permanent residuals.

Insofar as these opinions could be construed to be in conflict, we are impressed by the fact that Dr. Klecan did not have the benefit of Dr. Brown's November 27, 1989 report when he rendered his September 8, 1989 opinion. For this reason, we find Dr. Brown's opinion more well reasoned and persuasive. We also rely on the fact that Dr. Brown as the treating physician was in a superior position to evaluate claimant. Consequently, claimant has met his burden of proving a compensable psychological condition.

Premature Closure

The Referee found that claimant's claim was prematurely closed. We disagree.

Claimant's back claim was prematurely closed if his condition was not medically stationary at the time the claim was closed by Determination Order. "Medically stationary" means no further material improvement would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17). It is claimant's burden to prove that his claim was prematurely closed.

In determining whether a claim was prematurely closed, we determine whether the claimant's condition was medically stationary on the date of closure, without considering subsequent changes in her condition. Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985). However, medical reports authored after closure may be considered where there has been no post-closure change in claimant's condition and the only question is whether claimant was medically stationary at the time of closure. Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987).

Claimant's aggravation claim was closed by Determination Order dated October 26, 1989, indicating a medically stationary date of September 8, 1989.

The record establishes that claimant last received treatment for his back condition sometime in March 1989. There is nothing in the record to establish treatment after that date until October 27, 1989, the date after claim closure.

The Western Medical Consultants performed an independent evaluation on September 8, 1989. At that time, claimant reported that he was not under any form of treatment and noted that chiropractic treatment worsened, rather than helped, his overall status. The Consultants concluded, after a thorough evaluation, that there were no objective orthopaedic or neurologic findings. The Consultants further specifically noted that claimant's condition was medically stationary.

There is no other evidence in the record regarding claimant's condition at the time of claim closure other than a November 1989 report from Dr. Herring, neurologist. Herring reported that claimant complained on October 27, 1989 of severe back pain stemming from several days prior. Herring, however, had not seen claimant since March 1989. Inasmuch as Herring noted that claimant was not medically stationary on October 27, 1989, he did not render an opinion regarding claimant's condition on the date of closure.

Based on the only timely medical report in the record, that of the Consultants, we find that at the time of claim closure, no further material improvement would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17). Consequently, we find that claimant's condition was medically stationary on September 8, 1989, the date of the Consultants' examination. Thus, claimant has failed to establish that his condition was not medically stationary on the date of closure. Therefore, we find that claimant's claim was properly closed.

Extent of Unscheduled Permanent Disability

Because we have found that claimant's aggravation claim was properly closed and since there is no contention that claimant's condition was not medically stationary at the hearing, we proceed to determine whether claimant is entitled to an additional unscheduled permanent disability award.

Claimant has previously been awarded a total of 35 percent unscheduled permanent disability resulting from his compensable 1983 injury. We conclude that that award shall stand.

In order to receive an increased award of permanent disability upon the closure of his aggravation claim, it is claimant's burden to prove that his compensable condition has permanently worsened since the last arrangement of compensation, which in this case is the April 1, 1985 Opinion and Order which increased claimant's unscheduled permanent disability award from 5 percent to 35 percent. Stepp v. SAIF, 304 Or 375 (1987); See Luz E. Rodriguez, 42 Van Natta 2033 (1990). We find that claimant has failed to meet his burden.

At the time of the April 1985 Opinion and Order, claimant was restricted from performing heavy work and he had returned to light work. He was also restricted from lifting in excess of 20 pounds and restricted in bending and twisting. At that time, claimant continued to have persistent back pain, which prevented him from performing heavy lifting, and some decreased lumbar flexion.

At the time of the Consultants' evaluation, September 8, 1989, claimant complained of ongoing persistent back pain. He reported to the Consultants that he was unable to lift more than 20 pounds without difficulty, had difficulty in bending and twisting, and was unable to lift heavy objects. Finally, and most

important, claimant admitted that his physical status had not changed for several years.

Under the circumstances, we find that claimant has failed to establish that he has suffered a permanent worsening of his compensable condition since the last arrangement of compensation. Therefore, claimant is not entitled to any additional unscheduled permanent disability.

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 $700, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, the risk that counsel's services might go uncompensated, and the value of the interest involved.

Finally, we note that the Referee declined to award an insurer-paid attorney fee for claimant's counsel's services at hearing concerning the compensability issue because no statement of service had been received. By the time a statement of service had been received and the Referee attempted to reconsider her order, the insurer had requested Board review.

Under such circumstances, the Referee was without jurisdiction to further consider claimant's entitlement to an assessed fee. See Orozco v. U & I Group, Inc., 103 Or App 634 (1990); Kyong C. Lewis, 42 Van Natta 454 (1990); OAR 438-07-025(1). However, because the Referee's appealed order addressed both the merits of the compensability issue as well as claimant's entitlement to an assessed attorney fee, we are authorized to award a reasonable attorney fee for claimant's counsel's efforts both at hearing and on Board review. See Billy J. McAdams, 41 Van Natta 2019 (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's services at hearing concerning the compensability issue is $2,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the documentary record and hearing transcript, the complexity of the issue, the risk that counsel's services might go uncompensated, and the value of the interest involved.

ORDER

The Referee's order dated December 28, 1989 is reversed in part and affirmed in part. The Determination Order is reinstated and affirmed. The remainder of the order is affirmed. For services at hearing and on Board review regarding the compensability issue, claimant's attorney is awarded an assessed fee of $3,200, to be paid by the insurer.

In the Matter of the Compensation of
KEITH B. LINT, Claimant
Own Motion No. 90-0624M
OWN MOTION ORDER
Dennis Henninger, Claimant Attorney
SAIF Legal Department, Defense Attorney

The SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his January 31, 1980, industrial injury. Claimant's aggravation rights expired June 13, 1985. SAIF has accepted responsibility for

the proposed cervical surgery, but opposes reopening of his claim for temporary disability benefits on the ground that claimant has withdrawn from the work force.

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

We are persuaded that claimant's compensable cervical condition has worsened requiring surgery. However, the record shows that claimant has not worked since late 1988. Therefore, in order to prove that he was in the work force at the time of his worsening, claimant must prove that he is willing to work and that either: (1) he has been making reasonable efforts to obtain work; or (2) reasonable efforts to obtain work were futile due to the compensable injury. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

Claimant's original, compensable injury involved the low back and left leg. In 1987 claimant's claim was reopened for an authorized training program. After training ended in September, 1988, he began employment with the training employer. He worked until October 24, 1988, when he fell down a flight of stairs and injured his neck. The fall resulted when his injured left leg gave way. Vocational services were subsequently terminated because claimant's lack of employment could not be resolved by further vocational assistance. An MRI scan in December, 1988, revealed a herniated cervical disc. The claim was closed by Determination Order on April 20, 1989, with an award of temporary total disability benefits. Subsequent chart notes by Drs. Aversano and Sirounian show that claimant continued to have headaches, severe neck pain and bilateral arm symptoms resulting from the compensable cervical condition as late as June, 1990. Those symptoms rendered him unable to perform the activities of daily living. Under these circumstances, we find that, at the time of his worsening, claimant was willing to work, but reasonable efforts to find work would have been futile due to the compensable injury. We conclude, therefore, that claimant was in the work force at the time of his worsening. See id. Accordingly, claimant's claim is reopened with temporary disability benefits to commence the date he is hospitalized for the proposed cervical surgery.

SAIF 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.

In the Matter of the Compensation of
RUDOLPH A. BEEMAN, Claimant
WCB Case Nos. 89-24493 & 89-09182
ORDER DENYING MOTION TO DISMISS
Malagon, et al., Claimant Attorneys
James Dodge (Saif), Defense Attorney

Claimant has moved for an order dismissing the SAIF Corporation's request for Board review, contending that SAIF has not timely filed a request for review in accordance with statutory requirements. We deny the motion.

FINDINGS OF FACT

The Referee's order was dated June 29, 1990. Thereafter, SAIF requested abatement and reconsideration of the Referee's order. On July 30, 1990, while the Referee still retained jurisdiction over the case, he granted the request and abated his order. The Referee also asked that claimant respond to the motion, which he did on August 8, 1990.

The Referee issued an Order on Reconsideration on November 20, 1990, addressing the arguments raised by SAIF's motion. As supplemented by his reconsideration order, the Referee "republished in its entirety" his June 29, 1990 order. The November 20, 1990 order contained a statement explaining the rights of the parties under ORS 656.289(3) and 656.295.

On December 12, 1990, SAIF mailed a request for review to the Board. The request stated that SAIF was seeking Board review of "the Referee's Opinion and Order made and entered on June 29, 1990, less than 30 days before this Request for Review." The request, which carried the appropriate WCB case numbers, also indicated that copies had been provided to all parties to the proceeding before the Referee.

On December 17, 1990, the Board mailed a computer-generated letter to the parties acknowledging the request for review.

CONCLUSIONS OF LAW

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

Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed and actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983). The necessary function of notice statutes is to inform the parties of the issues in sufficient time to prepare for an adjudication. Nollen v. SAIF, 23 Or App 420, 423 (1975) rev den (1976).

The time within which to appeal an order continues to run, unless the order had been "stayed," withdrawn or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986). In order to abate and allow reconsideration of an order issued under ORS 656.289(1), at the very least, the language of the second order must be specific. Farmers Insurance Group v. SAIF, 301 Or 612, 619 (1986).

Here, claimant asserts that SAIF has untimely requested review of the Referee's June 29, 1990 order and failed to request review of the Referee's

November 20, 1990 reconsideration order within 30 days of its issuance. Under such circumstances, claimant contends that we lack jurisdiction to consider this matter. We disagree.

SAIF's December 12, 1990 request did state that it was seeking review of the Referee's "June 29, 1990 order." However, SAIF further declared that the Referee's order from which it was appealing had issued "less than 30 days before [its] request for review." The only order issued in this case fitting such a description was the Referee's November 20, 1990 reconsideration order.

Moreover, since the Referee's June 29, 1990 order had been expressly abated and, eventually, was specifically "republished in its entirety as supplemented" by the November 20, 1990 Order on Reconsideration, we conclude that SAIF's intention in requesting review within 30 days of the issuance of the November 20, 1990 order was unmistakeable. It was seeking Board review of the Referee's June 29, 1990 order, as supplemented and republished by the November 20, 1990 reconsideration order. Inasmuch as SAIF's request was mailed within 30 days of the issuance of the Referee's November 20, 1990 Order on Reconsideration and because that reconsideration order supplemented and republished the Referee's June 29, 1990 order, we conclude that we have jurisdiction to consider this matter. See ORS 656.289(3); Farmers Insurance Group v. SAIF, supra; Mary G. Chard, 39 Van Natta 786 (1987).

Accordingly, the motion to dismiss is denied. Once a transcript is obtained and copies are distributed to the parties, a briefing schedule will be implemented. Upon completion of the briefing schedule, this case will be docketed for Board review.

IT IS SO ORDERED.

January 15, 1991 Cite as 43 Van Natta 56 (1991)

In the Matter of the Compensation of
CHARLES L. BROWN, Claimant
WCB Case No. 89-15235
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Menashe's order which increased his unscheduled permanent disability for a low back/right hip injury from 9 percent (28.8 degrees), as awarded by Determination Order, to 22 percent (70.4 degrees). On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

With the exception of the second paragraph, page two, we adopt the Referee's "Findings of Fact" with the following supplementation.

On August 7, 1987, claimant's right hip and inner thigh were compensably injured when he was hit by a car. (Exs. 1-8). Claimant was treated conservatively with Motrin, but lost no time from work. (Exs. 1-8). Claimant filed his "801" injury claim form with his employer's secretary/bookkeeper/administrative assistant which was the normal procedure. (Tr. 92).

At 6:30 p.m., September 15, 1987, claimant told the emergency room physicians that he had been lifting garbage cans at work all day and developed "severe pain in his lumbar and gluteal and hip area on the right [side]...." (Exs. 6, 7, 8). Although claimant reported in to his employer's administrative assistant after he finished his route on September 15, 1987, claimant did not tell her that his back and leg were bothering him nor that he needed medical treatment. (Tr. 91-97). Claimant later told the examining physicians at the Orthopaedic Consultants that, after working two days picking up garbage cans, he noted on September 15, 1987 "'paralysis' of his right lower extremity when he attempted to get out of bed." (Ex. 78-2).

Claimant was taken off work as of September 15, 1987 by Dr. Steinmann, M.D., his family physician, and subsequently treated by Dr. Steinmann and a physical therapist. Claimant began vocational rehabilitation in January 1988. (Ex. 28). Claimant was released to light duty work by Dr. Steinmann on February 22, 1988. (Ex. 33). From the beginning, the September 15, 1987 incident was diagnosed and treated as an aggravation of the initial compensable injury of August 1987. (Ex. 8).

As of the end of November 1988, claimant was not following through with a job search in his rehabilitation program. (Exs. 61-2, 63). Claimant's rehabilitation file was closed in January 1989, because of claimant's lack of participation. His file was reopened in March 1989. (Ex. 70). In June 1989, claimant again failed to participate as required in his rehabilitation program. (Ex. 83).

On April 21, 1989, Dr. Fieldler, M.D., (in the same office with Dr. Steinmann, who was ill) indicated that claimant was medically stationary and released to modified work with no heavy lifting, overhead reaching or prolonged standing or walking. (Ex. 76).

Claimant was examined by the Orthopaedic Consultants in April 1989. All x-rays were in the normal limits. (Ex. 78-6).

Claimant changed treating physicians and began seeing Dr. Sears, D.C. on May 1, 1989. (Ex. 79). In July 1989, Dr. Sears signed a Physical Capacities and Restrictions Report indicating impairment where the Orthopaedic Consultants had not. (Ex. 87). In August 1989, Dr. Sears wrote that he was no longer treating claimant because it was hard for him to differentiate between claimant's organic complaints and his "possible" functional overlay. (Ex. 89).

While claimant was off work due to his disabilities from the compensable injury, claimant lived a physically normal life. (Ex. 93-41). In October 1988, claimant told a physician that he had been digging on a hillside and working on his car. (Exs. 55-2; 93-41 & 93-42).

Dr. Turco, psychiatrist, examined claimant and reviewed claimant's medical and vocational files. Dr. Turco stated that claimant has a history of major drug abuse and criminal activity and that secondary gain elements, both conscious and unconscious, play a major role in claimant's physical complaints. (Ex. 78-6 & 7).

Claimant was medically stationary on April 28, 1989, and his claim closed by Determination Order on June 22, 1989 awarding him temporary disability and 9 percent permanent partial disability. (Ex. 85).

ULTIMATE FINDINGS OF FACT

Claimant is not credible based on inconsistencies in the record and the substance of his testimony.

CONCLUSIONS OF LAW AND OPINION

On review, the sole issue is whether claimant, under the "standards" calculations, is entitled to two values of 5 pursuant to former OAR 436-35-320(4) -- one for his back and another for his hip because he has a chronic condition limiting repetitive use of his back and hip.

As the Referee found, there is no medical evidence to support separate findings for claimant's hip and his back.

Furthermore, we conclude that claimant is not a credible witness. Claimant gave physicians different renditions of the September 15, 1987 incident. The administrative assistant testified that claimant, at the end of the day on September 15, 1987, did not mention to her that he was in pain and in need of medical treatment. At the hearing and in an earlier deposition, claimant gave distinctly different renditions of his communications with his employer's administrative assistant on September 15, 1987. (Tr. 58, 82, 83). Dr. Turco wrote that he suspects that claimant is not truthful regarding the September 1987 accident. (Ex. 90-4, 90-5). Dr. Sears, claimant's treating physician, did not feel he could treat claimant anymore because he could not trust claimant's complaints. Additionally, the Orthopaedic Consultants could find no objective pathological reason for claimant's complaints and no impairment. (Ex. 78-6 & 78-7). Claimant's testimony regarding subjective limitations in both his low back and hip is not reliable.

Consequently, there is no persuasive evidence to establish that claimant is entitled to a greater impairment value under former OAR 436-35-320(4) than was utilized by the Referee. The insurer does not request a reduction in the disability award, therefore, we affirm the Referee.

ORDER

The Referee's order dated December 8, 1989 is affirmed.

In the Matter of the Compensation of
TANA M. BURNS, Claimant
WCB Case No. 89-21523
ORDER ON REVIEW
Ralph C. Barker, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Mills order that upheld the self-insured employer's denial of claimant's bilateral wrist neuropathy. Claimant also seeks remand for the admission of an additional medical report. The issues on review are remand and compensability.

The Board affirms and adopts the order of the Referee with the following comment regarding the remand issue.

We may remand when the record is incompletely, inappropriately 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).

Here, we are not persuaded that the record has been improperly, incompletely or otherwise insufficiently developed. Moreover, we are not persuaded that the additional medical report was not obtainable with due diligence at the time of hearing. Claimant argues that because his attorney came on the case late, he did not have time to obtain the necessary medical report prior to the hearing. There is no evidence in the record of when the attorney actually took the case, although the retainer agreement is signed in October 1989 and the hearing was held in late February 1990. Nor is there evidence of when the report was requested from the treating doctor. Thus, there is no showing of due diligence in attempting to obtain this report.

ORDER

The Referee's order dated March 19, 1990 is affirmed.

In the Matter of the Compensation of
SHIRLEY A. BUSH, Claimant
WCB Case No. 89-16261
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Peterson's order which: (1) upheld the SAIF Corporation's denial of her occupational disease claim for a stress condition; (2) declined to assess a penalty and associated attorney fee for an allegedly unreasonable denial; (3) found that claimant was not entitled to interim compensation; and (4) did not assess a penalty and attorney fee for unreasonable failure to pay interim compensation. On review, the issues are compensability, interim compensation and penalty and associated attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

The Board adopts the Referee's "Conclusions of Law and Opinion" with respect to the compensability issue, with the following comments.

An occupational disease claim for a mental disorder is not compensable unless there is clear and convincing evidence that the mental disorder arose out of and in the course of employment. Former ORS 656.802(2)(d). "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 this case, two psychiatrists have offered their opinions as to whether claimant's working conditions are a material contributing cause of her mental disorder. Dr. Parvaresh stated that the working conditions were not a material factor, considering all of claimant's nonwork-related stressors, among which are her ill husband and drug addicted son.

The second psychiatrist, Dr. Deale, stated that factors in claimant's work situation contributed to her depression, but also acknowledged that some of her difficulties are the result of her emotionally deprived childhood and punitive mother. (Ex. 19-4.)

After de novo review of the psychiatrist's reports, we do not find that claimant has met her burden of proving by clear and convincing evidence that her mental disorder arose out of and in the course of her employment.

Interim Compensation

A claimant is entitled to temporary disability compensation pending acceptance or denial of a claim for a disabling injury if she "leaves work" within the meaning of ORS 656.210. Bono v. SAIF, 298 Or 405, 408-10 (1984); see also Jones v. Emanuel Hospital, 280 Or 147, 150-52 (1977). Such compensation, called "interim compensation" for convenience, is due beginning 14 days after the date upon which the employer or its insurer receives notice or knowledge of the claimant's claim. ORS 656.262(4).

The Referee concluded that interim compensation was not due, in part because there was no medical verification of claimant's inability to work. We note that the statute applicable to an initial claim for benefits, ORS 656.262, does not require medical verification of inability to work before interim compensation is due. Nevertheless, as explained above, claimant must leave work allegedly because of a compensable condition in order to receive interim compensation.

Here, claimant was terminated from her job on May 7, 1989. However, she was terminated for reasons related to the condition that she subsequently claimed was compensable. We conclude that claimant did "leave work" within the meaning of ORS 656.210. Accordingly, claimant is entitled to interim compensation for the period beginning July 18, 1989, when SAIF received notice of her claim, and ending September 13, 1989, when SAIF denied the claim.

Penalties and Attorney Fees Relating to Interim Compensation

Claimant argues that she is entitled to a penalty and associated attorney fee for unreasonable resistance to the payment of interim compensation. We agree. If a carrier unreasonably delays payment of temporary disability benefits, it is liable for an additional amount, up to 25 percent of the benefits then due, plus a reasonable attorney fee. See ORS 656.262(10); 656.382(1).

Claimant was terminated from her job for reasons related to the condition which she subsequently claimed to be compensable. The employer, of course, knew of the reason claimant was terminated, and that knowledge will be imputed to SAIF. Nix v. SAIF, 80 Or App 656, 660 (1986). Thus, after claimant filed her mental stress claim, SAIF should have known that she left work for reasons related to her condition. Accordingly, SAIF's failure to begin paying interim compensation was an unreasonable resistance to the payment of compensation and claimant is entitled to a penalty equal to 15 percent of all interim compensation due from July 18, 1989 through September 13, 1989.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable penalty-related attorney fee for claimant's counsel's services concerning the interim compensation issue is $300,

to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated March 20, 1990 is affirmed in part and reversed in part. That portion which declined to award interim compensation is reversed. The remainder of the order is affirmed. Claimant is awarded temporary disability from July 18, 1989 through September 13, 1989. Claimant's attorney is awarded 25 percent of the increased temporary disability compensation created by this order, not to exceed $3,800. Claimant is awarded a 15 percent penalty on all interim compensation awarded by this order. For services concerning the penalty-related issue of interim compensation, claimant's counsel is awarded an assessed attorney fee of $300, payable by the SAIF Corporation.

January 15, 1991 Cite as 43 Van Natta 61 (1991)

In the Matter of the Compensation of
MICHAEL L. CLARK, Claimant
WCB Case No. C0-00263
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

On November 1, 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 $60,000 by Boise Cascade Corporation, the self-insured employer, claimant agrees to release his right to future workers' compensation benefits, except medical services, for his compensable injury. We set aside the proposed disposition.

A proposed claim disposition agreement must be set aside if we find that it is the result of an intentional misrepresentation of material fact. ORS 656.236(1)(b). Misrepresentation is an intentional, false statement of a substantive fact, or any conduct which leads to a belief of a substantive fact material to a proper understanding of the matter in hand, made with the intent to deceive or mislead. Louis R. Anaya, 42 Van Natta 1843 (1990).

The self-insured employer alleges that, when the parties entered this agreement in July, 1990, claimant exhibited an obvious list and declared himself permanently and totally disabled because he could perform only sedentary work and could not obtain any employment. Claimant does not deny those allegations. Therefore, we find that claimant made the aforementioned representations and that those representations were material to the parties' understanding of the value of claimant's claim.

The employer also submits employment records dated December, 1988, and July, 1990, in which claimant declares that he has no physical impairment and is able to perform heavy work. Those records also show that claimant was self-employed in landscaping from 1984 through June, 1990, and has been employed as a residential electrician apprentice since September, 1990. Claimant does not adequately explain the discrepancy between those employment records and his representations during the negotiation of this agreement. Accordingly, we find that claimant's representations were false and made with the intent to deceive or mislead. We conclude, therefore, that this agreement is the result of an

intentional misrepresentation of material fact and set it aside. See Louis R. Anaya, supra.

IT IS SO ORDERED.

January 15, 1991 Cite as 43 Van Natta 62 (1991)

In the Matter of the Compensation of
LYLE E. ESTES, Claimant
WCB Case No. 89-10740
ORDER ON REVIEW
James Edmonson, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Nichols and Crider.

Claimant requests review of Referee Knapp's order which found that claimant was not a subject worker in Oregon. On review, the issue is subjectivity. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and supplement with the following facts.

Claimant occasionally worked for the insured on a job-by-job basis--in October and November 1969, in 1981 or 1982, and again beginning January 1987. Simultaneously, claimant was self-employed in construction maintenance.

FINDING OF ULTIMATE FACT

Claimant was not employed in Oregon by the insured when he was injured while working out of state.

CONCLUSIONS OF LAW AND OPINION

Finding that claimant was a temporary rather than a permanent employee, the Referee concluded that claimant was not a subject worker in Oregon. Claimant asserts that the statute does not require "permanent" employment status in order to qualify for coverage under ORS 656.126(1). We agree. Salvador Cervantes-Ochoa, 42 Van Natta 2716 (1990). Nevertheless, although we clarify the applicable law, we affirm the Referee's conclusion.

In construing ORS 656.126(1), Oregon courts have applied a "permanent employment relation test." Under this test, the key inquiry is the "extent to which claimant's work outside the state was temporary." Power Master Inc. v. Blanchard, 103 Or App 467 (1990) citing Phelan v. H.S.C. Logging, Inc., 84 Or App 632 (1988); Hobson v. Ore Dressing, Inc., 87 Or App 397, 400 , rev den 304 Or 437 (1987). [emphasis supplied].

To determine whether a claimant is an Oregon worker under this test, we consider numerous factors such as where claimant was hired, where he actually worked, where his paychecks were issued, where the operation was run, where supervisory control was exercised, and whether claimant had a reasonable expectation of working for the insured in Oregon after the out-of-state job was completed. Blanchard, supra.

Claimant occasionally worked for the insured on a job-by-job basis. In 1987, he accepted a series of employments with the insured in Washington. Claimant was hired in Moses Lake, Washington to work on the Walla Walla, Washington job during which he injured his back. Corporate control was exercised and claimant's paycheck was issued from the insured's corporate office in Merced, California. Claimant was supervised on-site in Washington. After claimant's Walla Walla, Washington job assignment ended, he no longer would have been an employee of the insured. Therefore, although claimant may have anticipated being rehired for another job assignment, he could not have a reasonable expectation of returning to work for the insured in Oregon after the Washington job was completed.

Claimant has proven neither that he was employed in Oregon by the insured nor that the insured sent him to work in Washington. Therefore, claimant's work temporarily in Washington was not "incidental" to Oregon employment for this employer. Consequently, we conclude that claimant was not a subject worker in Oregon when he was injured in Washington.

ORDER

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

January 15, 1991 Cite as 43 Van Natta 63 (1991)

In the Matter of the Compensation of
JOHN C. LAPPEN, Claimant
WCB Case No. TP-90046
THIRD PARTY DISTRIBUTION
Coons, et al., Claimant Attorneys
Hallmark, et al., Defense Attorneys

Claimant has petitioned the Board for resolution of a dispute concerning a proposed settlement of a third party action. See ORS 656.587. We approve the settlement.

FINDINGS OF FACT

In August 1987, claimant, a salesman for a restaurant supply and equipment company, sustained a compensable injury while making a business call. Specifically, he fell while walking down a ramp at a restaurant. CNA Insurance Company, as insurer for claimant's employer, has accepted the claim and provided compensation.

As a result of the accident, claimant sustained injuries to his left hand, arm, and shoulder. He also suffered lacerations to his right knee and leg, in addition to experiencing muscle spasms in his neck. Claimant continued to work until November 1987, when his complaints became too debilitating.

In December 1987, surgery was performed on his left shoulder. Specifically, claimant underwent an acromioplasty and rotator cuff repair. CNA accepted responsibility for this procedure.

Claimant also underwent surgery for a right inguinal hernia. CNA did not accept responsibility for the hernia and its treatment. A March 10, 1989 Referee's order found that claimant's hernia condition and treatment were not related to his compensable injury. The Referee's order was affirmed and adopted by the Board on June 14, 1990.

Claimant has not returned to his job as a salesman for CNA's insured. Instead, in July 1989, he obtained employment as a warehouse material and equipment salesman for another employer. Claimant currently resides in Albuquerque, New Mexico.

A November 7, 1988 Determination Order closed claimant's claim. He was found medically stationary as of August 3, 1988. Claimant was awarded approximately 4 months of temporary partial disability and 7 months of temporary total disability. In addition, 13 percent unscheduled permanent disability was granted. The Determination Order was affirmed by the March 1989 Referee's order, which has since been affirmed and adopted by the Board's June 1990 order.

To date, CNA, as paying agency, represents that it has incurred actual claim costs totalling $31,705.53. These costs include medical and indemnity benefits. In addition, CNA asserts that it has set future reserves of $32,511 for "indemnity" and $22,142 for "medical."

Claimant engaged legal representation to pursue a cause of action for negligence against the restaurant and the owner of the property. Thereafter, he filed a complaint alleging that the aforementioned third parties were negligent in the following manner: (1) in failing to warn claimant of the faulty ramp; (2) in failing to provide safety devices such as guardrails, handrails, or slip-guards; (3) in failing to repair metal brads which protruded through the metal surface of the ramp; and (4) in failing to inspect and remedy the conditions present at the ramp.

Claimant's third party complaint sought economic and non-economic damages. These damages included compensation for permanent injuries to his left leg, left shoulder, cervical spine, and groin, as well as medical expenses and lost earnings attributable to these injuries.

While conducting discovery procedures, the following information was compiled. In 1979, claimant was involved in an automobile accident, causing him to bump his head on his car's windshield. Other than a "knot" on the top of his head, he was uninjured and experienced no physical complaints. Claimant also underwent arthroscopic surgery in August 1985 to repair damaged cartilage in his left knee. However, he immediately returned to work following this outpatient surgical procedure and had experienced no subsequent problems with the knee.

The surface of the ramp at the restaurant was composed of a stressed metal material. The height of the ramp is less than 4 feet. The slope of the ramp is minimal and gradual. The ramp does not have a handrail or guardrail.

While descending the ramp, claimant was holding a sales order book, as well as a catalog and/or a small briefcase. In addition, he held a paper bag containing a hamburger, fries, and a Coke. These items were being carried in both of his hands.

Upon taking one step onto the ramp, claimant's feet went out from under him. Because it happened so fast, he does not know whether he slipped or tripped. However, he recalled reaching in vain for something to hold onto. No foreign material was observed on the ramp.

During a subsequent visit to the restaurant, claimant recalled the proprietor stating that claimant was not the first person to have fallen on the ramp. The proprietor denied making such a statement and insisted that there had never been a problem with walking on the ramp. A list of restaurant employees since 1985 was provided to claimant. Attempts to identify any employee who could recount the existence of prior ramp falls have been unsuccessful.

The third party insurer and claimant have agreed to settle the action for $15,000. Wary of the possibility of an adverse jury verdict, claimant desires to avoid the time and expense of traveling from his Albuquerque, New Mexico home, as well as incurring additional litigation expenses resulting from the Roseburg, Oregon trial.

If the $15,000 settlement is approved, following the distribution of claimant's attorney fee, litigation expenses, and statutory 1/3 share, CNA would receive $6,486.33. Such a recovery would be approximately 20 percent of CNA's $31,705.53 in actual claim costs.

CNA has declined to approve the settlement, contending that such a recovery would result in it receiving approximately 7.5 percent of its "payout and reserves." CNA further asserts that claimant has a "strong liability case" because the ramp violates OSHA standards requiring a railing for ramps in excess of 4 feet in height and that claimant's contributory negligence would be "probably about 20 to 30 percent." CNA also surmises that the recovery could be enhanced if claimant could uncover a "past employee who has fallen or witnessed a fall on this ramp." Finally, CNA recommends that claimant file an amended complaint, asserting that his activity at the time of the injury involved the "risk" or "danger" necessary to bring a claim under the Employers' Liability Act (ORS 654.305 et seq).

FINDINGS OF ULTIMATE FACT

The third party settlement offer of $15,000 is reasonable.

CONCLUSIONS OF LAW AND OPINION

Pursuant to ORS 656.587, the Board is authorized to resolve disputes concerning the approval of any compromise of a third party action. In exercising this authority, we employ our independent judgment to determine whether the compromise is reasonable. Natasha D. Lenhart, 38 Van Natta 1496 (1986).

Generally, we will approve settlements negotiated between a claimant/plaintiff and a third party defendant, unless the settlement appears to be grossly unreasonable. Dorotha M. Clarke, 40 Van Natta 1125 (1988); Kathryn I. Looney, 39 Van Natta 1140 (1987).

After reviewing the record, as well as the parties' respective positions, and considering the aforementioned standard, we conclude that a settlement offer of $15,000 is reasonable. We base our conclusion on the following reasoning.

To begin, CNA complains that, if the settlement is approved, it will receive "approximately 7.5 percent of its payout and reserve." In so doing, CNA asserts entitlement to $32,511 in "future reserves" for "indemnity" payments. Presumably, these reserves are designed to provide for future payments of temporary and permanent disability should the claim be subsequently reopened. Yet, such benefits are expressly excluded from future compensation which is lienable under ORS 656.593(1)(c). Thus, regardless of the amount CNA has reserved for these projected future expenditures, such costs would not be reimbursable.

If the $15,000 settlement is approved, CNA would recover $6,486.33, approximately 20 percent of its $31,705.53 in actual claim costs. CNA contends that claimant's recovery and its proportional share could be significantly increased if he proceeded to trial. However, to do so, claimant would be required to incur additional litigation expenses to subpoena witnesses, as well as to travel to the Roseburg trial from his Albuquerque residence. Such increased expenses, along with claimant's attorney fee and statutory 1/3 share, would be

deducted from any third party recovery before the remainder would become subject to CNA's lien pursuant to ORS 656.593(1)(c). See Thomas Lund, 41 Van Natta 1352 (1989). Thus, an increase in claimant's gross third party recovery would not automatically assure CNA that its eventual portion of the recovery would exceed its current share of the proposed settlement.

In any event, CNA's arguments for proceeding with the litigation are not supported by the record. To be sure, there is no reason to doubt CNA's assertion that claimant "would make a good jury appearance and could garner some jury sympathy." Yet, similar assertions could likewise be registered concerning the testimony of the restaurant proprietor. Moreover, considering claimant's prior medical history, the unexplained nature of his fall, and the lack of a witness to refute the proprietor's statement of no prior ramp mishaps, a jury finding of significant contributory negligence on claimant's part would not be an unrealistic outcome.

Finally, CNA's recommended inclusions of an OSHA violation and a claim under the Employers' Liability Act are similarly unsupported by the record. The photographs submitted with claimant's reply brief persuasively establish that the height of the ramp does not approximate four feet. Therefore, OSHA ramp and railing requirements would not be applicable. In addition, there is nothing in the record to substantiate CNA's suggestion that claimant's work activity at the time of his injury could involve the necessary "risk" or "danger" to support a claim under the Employer's Liability Act. In fact, even CNA acknowledges the possibility that a judge could strike such a claim as a matter of law.

In conclusion, we find the proposed settlement to be reasonable. Consequently, we approve the settlement. ORS 656.587. Accordingly, proceeds of the settlement shall be distributed in accordance with ORS 656.593(3), which results in CNA's recovery of $6,486.33. Claimant's counsel shall immediately forward a check in the aforementioned amount to CNA's counsel.

IT IS SO ORDERED.

In the Matter of the Compensation of
RUBY PARMENTER, Claimant
WCB Case No. 86-15727
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Mills' order that: (1) upheld the SAIF Corporation's denial of medical services for claimant's current low back condition; and (2) declined to assess a penalty and related attorney fee for an allegedly unreasonable denial. On review, the issues are medical services and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Citing Bauman v. SAIF, 295 Or 788 (1983) and Georgia-Pacific Corporation v. Piwowar, 305 Or 494 (1988), claimant argues that SAIF's denial was an impermissible "back-up" denial. In this regard, claimant contends that she has been treating with Dr. Gorman for the same condition since 1979; that SAIF accepted

that condition and treatment pursuant to a 1981 Stipulation; and, therefore, that SAIF may not now deny the treatment. SAIF characterizes its denial as a denial of "compensability of claimant's current protruded disc condition." SAIF asserts that claimant's current condition is caused by her diagnosed herniated disc; that this condition is separate from her original low back sprain/strain injury; and, therefore, that Bauman and Piwowar do not apply.

The denial in question notes that claimant is "seeking treatment for lumbar protruded intervertable disc at L4-5 and low back strain" and states that SAIF is "unable to accept responsibility for any treatment and/or disability in connection with [claimant's] current condition." The denial goes on to state that "SAIF will continue to make medical payments related to [claimant's] original injury." At hearing, the Referee characterized the main issue as a denial of medical treatment having to do with claimant's back care. Claimant's counsel and SAIF's counsel both agreed with this characterization of the issue. In addition, claimant's counsel stated that claimant was not seeking any disability. Moreover, SAIF's counsel subsequently noted that the claim is in own motion status and, therefore, that the issue being litigated is "ongoing treatment."

Therefore, although the denial is somewhat ambiguous, the parties litigated the matter as a medical services issue. As litigated, the basis for SAIF's denial was that the need for treatment was not related to the compensable 1973 injury, but rather was required by an unrelated disc herniation. We address the issue on that basis.

Interpreted as a medical services denial, the denial does not violate Bauman or Piwowar. In this regard, Bauman and Piwowar do not prohibit SAIF from asserting that a current need for medical services is unrelated to a compensable injury. See Barnett v. EBI Cos., 105 Or App 145 (1991); Walter Manchur, 42 Van Natta 2497 (1990). Moreover, we do not agree that the 1981 "Stipulation" precludes SAIF from denying Dr. Gorman's current treatment. In this regard, the "Stipulation" was actually a disputed claim settlement pursuant to ORS 656.289(4); therefore, there was no admission of liability for any condition or treatment by SAIF.

Accordingly, we proceed to address the merits of the medical services issue, i.e., whether the condition for which Dr. Gorman is currently treating is materially related to the compensable injury. Relying upon the opinions of Drs. Hockey, Schroeder and Raaf, the Referee found that claimant's "current pain ... and the disc problems" are not related to the 1973 injury. He, therefore, concluded that Dr. Gorman's current treatment is not compensable. We agree.

Dr. Gorman has opined that claimant's present condition is directly related to her injuries and a resulting ongoing degenerative process caused by trauma to the discs and surrounding soft tissue. However, this is essentially the full extent of his explanation. We conclude that his opinion is largely conclusory and, therefore, not very persuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980). In particular, given the extended period of time between claimant's injuries and the documented onset of her disc pathology, we require more of an explanation than provided by Dr. Gorman. Moreover, like the Referee, we are persuaded by the well-reasoned and thorough opinions of Drs. Hockey, Schroeder and Raaf, who have all opined that claimant's current condition requiring treatment is unrelated to her compensable 1973 injury.

Penalties and Attorney Fees

Because we have concluded that SAIF's denial was not an improper "back-up" denial, no grounds exist upon which to base a penalty and associated attorney fee.

ORDER

The Referee's order dated June 17, 1988 is affirmed.

In the Matter of the Compensation of
MICHAEL L. PURVES, Claimant
WCB Case No. 89-17866
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Jerry Larkin (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Crider.

Claimant requests review of that portion of Referee Peterson's order which declined to assess a penalty and associated attorney fee for the SAIF Corporation's allegedly unreasonable denial of claimant's right knee condition. On review, the issues are penalties and attorney fees. We reverse.

FINDINGS OF FACT

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

Prior to issuing a partial denial of claimant's right knee condition on August 23, 1989, SAIF had received three reports on causation. Dr. Wright, consulting neurosurgeon, noted that he could not connect claimant's current right knee symptoms to claimant's October 1988 injury in a definite way, but noted that the mechanism of injury could have aggravated a preexisting knee condition. Dr. Klump, claimant's treating neurosurgeon for his spinal fracture, deferred to the opinion of Dr. Webb, claimant's treating orthopedic surgeon for his knee condition. Dr. Webb requested time loss and authorization for knee surgery but made no explicit statement regarding work-related causation.

After SAIF issued its partial denial, claimant's attorney forwarded several letters to SAIF to clarify causation. Dr. Webb stated that claimant's current right knee condition was the result of the work injury. Dr. Klump noted that the October 1988 incident probably caused claimant's right knee condition, but again deferred to the opinion of orthopedic surgeon Webb. There were no reports attributing claimant's current knee condition to any cause other than his work injury.

FINDING OF ULTIMATE FACT

The SAIF Corporation's continuing denial of claimant's right knee condition following receipt of Drs. Klump and Webb's letters was not supported by a legitimate doubt as to its legal liability.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside SAIF's denial of claimant's right knee condition. However, he found that SAIF's denial was not unreasonable at the time it was issued. On review, claimant argues only that SAIF's failure to withdraw its denial after it received new medical evidence "destroyed" any reasonable doubt it had regarding causation and, therefore, its conduct was unreasonable. We agree.

After an insurer reasonably denies a claim, "continuation of that denial in the light of new medical evidence becomes unreasonable if, but only if, the new evidence destroys any legitimate doubt about liability." Brown v. Argonaut Insurance Co., 93 Or App 588, 592 (1988). SAIF concedes that it had a continuing duty to consider postdenial medical reports. Moreover, claimant's attorney forwarded the new reports to SAIF for consideration and inquired whether SAIF would change its position on the denial. Nevertheless, SAIF did not respond and the matter went to hearing. Now, SAIF contends Drs. Klump and Webb's reports were not sufficient to counter the predenial reports and, therefore, based on all the evidence, it still had a legitimate doubt as to its liability.

We find that the evidence received by SAIF from Drs. Klump and Webb, and especially Dr. Webb's unequivocal and uncontested statement that the logging accident caused claimant's previously asymptomatic right knee condition to become symptomatic, was sufficient to destroy any legitimate doubt on the part of SAIF that it was responsible for claimant's right knee condition. SAIF should have rescinded its denial of August 23, 1989. It did not, and a hearing was necessary to resolve the compensability issue. Therefore, we conclude that SAIF's continuing denial in the face of such evidence was unreasonable. Brown v. Argonaut, supra. Accordingly, we assess a penalty and associated attorney fee. ORS 656.262(10); 656.382(1).

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 penalty issue is $400, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 16, 1990 is affirmed in part and reversed in part. That portion of the order which declined to assess a penalty and associated attorney fee for unreasonable claim denial is reversed. The SAIF Corporation is ordered to pay a penalty, equal to 25 percent of the amount of temporary disability compensation due at the time of hearing. Additionally, SAIF is ordered to pay a reasonable penalty-related attorney fee, in the amount of $400. The remainder of the order is affirmed.

In the Matter of the Compensation of
THOMAS L. RUNFT, Claimant
Own Motion No. 90-0650M
OWN MOTION ORDER OF DISMISSAL
Saif Legal Division, Defense Attorney

The SAIF Corporation has submitted to the Board claimant's claim for an additional permanent disability award due to his January 22, 1966, occupational disease claim. SAIF opposes his claim on the ground that the Board has no authority to award additional permanent disability benefits on its own motion. SAIF contends that claimant's claim is subject to the Board's own motion authority because his aggravation rights expired January 22, 1971. We disagree and dismiss for lack of own motion jurisdiction.

In January, 1983, claimant filed an occupational disease claim for "asbestos poisoning" allegedly resulting from exposure while working for SAIF's insured from 1959 to 1966. SAIF denied the claim in March, 1983. Claimant

appealed the denial and, in June, 1987, the Supreme Court ordered that SAIF be held responsible for the claim. Runft v. SAIF, 303 Or 493 (1987). On April 27, 1988, SAIF accepted the claim and classified it as nondisabling. Claimant requested review by the Department of Insurance and Finance (the Department) of SAIF's classification and, on July 25, 1988, the Department ordered SAIF to reclassify his claim as disabling. The Department's files show that claimant's claim was closed by Determination Order on October 19, 1988, with no award of temporary or permanent disability benefits.

We have own motion jurisdiction of claimant's claim only if his aggravation rights under ORS 656.273 had expired. Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). ORS 656.273(4) provides:

> "(a) The claim for aggravation must be filed within five years after the first determination order or the first notice of closure made under ORS 656.268.
>
> "(b) If the injury has been in a nondisabling status for one year or more after the date of injury, the claim for aggravation must be filed within five years after the date of injury."

SAIF contends that claimant's aggravation rights expired January 22, 1971, five years after the date of injury. SAIF apparently reasons that claimant's aggravation rights are governed by ORS 656.273(4)(b). We disagree. In our view, ORS 656.273(4)(b) applies only to accepted injuries. That is, an injury is not in a nondisabling status unless and until it is accepted and classified as nondisabling. Here, SAIF did not accept claimant's claim until April 27, 1988. The claim was then classified as nondisabling and remained so until the Department ordered the claim reclassified as disabling on July 25, 1988. Thus, claimant's claim was in nondisabling status for only three months. That is not sufficient for application of ORS 656.273(4)(b).

We conclude, instead, that claimant's aggravation rights are governed by ORS 656.273(4)(a). Under that subsection, claimant's aggravation rights expire five years after the first determination order or notice of closure made under ORS 656.268. Here, the first Determination Order issued under ORS 656.268 on October 19, 1988. Therefore, claimant has until October 19, 1993, to file an aggravation claim.

Inasmuch as claimant's aggravation rights have not yet expired, we conclude that we lack own motion jurisdiction to consider his request for additional permanent disability benefits. Accordingly, claimant's request for own motion relief is dismissed. Instead, SAIF should process claimant's request as a claim for aggravation under ORS 656.273.

IT IS SO ORDERED.

In the Matter of the Compensation of
GREGORY S. SHEWCZYK, Claimant
WCB Case No. 89-21437
ORDER ON REVIEW
Burt, et al., Claimant Attorneys
Lester Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee M. Johnson's order that upheld the SAIF Corporation's denial of a neck injury sustained as a result of a dive into a golf course pond. On review, the issue is compensability.

We affirm and adopt the Referee's order except that we disagree with the Referee's discussion of that aspect of the seven-factor test pertaining to whether or not a worker is paid for the activity at which he was injured. See Mellis v. McEwen, 74 Or App 571, rev den 300 Or 249 (1985). The Referee found that claimant was not paid for the activity of diving into the pond because the employer was not aware of the activity. We find instead that because claimant dove into the pond during worktime and he was in fact paid for that time, the activity was paid for. No more complicated analysis of the point is necessary.

Nevertheless, the fact that claimant was injured while he was on the employer's premises and during paid worktime, does not outweigh the fact that the activity was not for the employer's benefit, was not contemplated by the employer, was not an ordinary risk of employment as a maintenance worker and was not acquiesced in by the employer. On balance, we conclude that claimant was not in the course and scope of employment when injured.

In balancing the factors in this case, we note that, under Clark v. U.S. Plywood, 288 Or 255 (1980), it is particularly important, in assessing the compensability of an injury suffered while engaged in nontask activity incidental to employment, to determine whether or not the employer acquiesced in the activity. Claimant contends that the employer acquiesced in the activity of diving into the pond because the employer acquiesced in other activities necessary to cool off. Claimant notes, in particular, that he and his partner frequently refreshed themselves by stopping to get a drink of water or by driving the maintenance vehicle through an area being sprinkled. However, there is no evidence that the employer was aware that any employee had taken a dip in a pond to refresh himself. The evidence that the employer allowed claimant to cool off in the sprinklers is insufficient to persuade us that cooling off in the pond was also condoned.

On this basis, we affirm.

ORDER

The Referee's order dated April 12, 1990 is affirmed.

In the Matter of the Compensation of
RAYMOND S. VOLLER, Claimant
WCB Case No. 89-16049
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Gruber's order that increased his unscheduled permanent disability award for a low back injury from 27 percent (86.4 degrees), as awarded by Determination Order, to 28 percent (89.6 degrees). On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

Claimant suffered a compensable musculoligamentous low back injury on September 2, 1988 when he was removing a veneer jam from a dryer at the employer's wood products mill. Claimant's work-at-injury required the physical capacity to perform heavy work.

MRI studies revealed a variety of degenerative changes in claimant's thoracic spine, scoliosis, mild central bulging at L4-5, and a probable small central disc herniation at T5-6. Claimant's compensable injury did not cause or worsen claimant's degenerative disc disease or his disc bulges.

Claimant's condition was medically stationary on May 12, 1989. At that time, claimant's treating physician, Dr. Watrous, released claimant to return to modified light duty work with restrictions in lifting, bending and twisting. After working three days, claimant stopped working due to back pain.

A July 25, 1989 Determination Order closed claimant's claim and awarded him 27 percent unscheduled permanent disability. Claimant requested a hearing.

Claimant was examined by Dr. Woolpert, M.D., at the request of the insurer. Later, in August 1989, claimant was examined and treated by Dr. Sawchuk, M.D., who initiated acquatic therapy with no success. Dr. Sawchuk released claimant to return to work with restrictions in repetitive bending, twisting, crouching and stooping.

Claimant, 56 years of age at hearing, has a GED. The job which claimant successfully performed during the ten years preceding the date of determination, with the highest specific vocational preparation (SVP) time, was an electric motor repairer and rewinder, with an SVP of 7. Claimant has demonstrated competence in that specific vocational pursuit.

Claimant returned to modified work. He is capable of occasional lifting up to 40 pounds and is restricted from repetitive lifting, pushing and pulling in excess of 20 pounds.

Claimant sustained permanent loss of lumbar range of motion due to his compensable injury. He also suffers from a chronic condition which resulted in permanent restrictions in performing certain activities with his back.

CONCLUSIONS OF LAW AND OPINION

The Referee increased claimant's unscheduled permanent disability award from 27 percent to 28 percent. We affirm.

Claimant's condition became medically stationary on May 12, 1989. His claim was closed by Determination Order on July 25, 1989. We apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq.

The parties do not dispute the values assigned to age (1) and formal education (0). Therefore, we do not address those issues.

With respect to education values, the insurer contends that the Referee erred in assigning values to the skills category (3) and to the training category (1). We agree.

The insurer specifically argues that claimant's highest SVP during that time frame was a 5, for performing electric repair and rewind work, for a skills value of 2.

Claimant contends, however, that while he once did electric repair and rewinding work, he can no longer do that type of work because of his injury and because of a lack of available work. Claimant contends that his highest SVP during the ten years preceding the date of determination was a 3, for working as an appliance repair person, for a skills value of 3.

Former OAR 436-35-300(4) provides that skills be measured by reviewing the jobs a worker has successfully performed during the ten years preceding the date of determination. The rule further provides that, "[s]uccessful performance is defined as remaining on the job the length of time necessary to meet the specific vocational preparation requirement for that job." There is nothing in the rule that requires the claimant be capable of performing the specific job with the highest SVP value at the time of disability rating. Former OAR 436-35-300(4).

Here, claimant testified that he worked as an electric repairer and rewinder in excess of ten years. The SVP value for that position is a 7. Therefore, the appropriate skills value is 1. Former OAR 436-35-300(4).

The insurer contends that claimant has demonstrated competence in some specific vocational pursuit. Former OAR 436-35-300(5). We agree.

Claimant has worked as an electric repairer and rewinder for years. We find that his employment record establishes that he has demonstrated competence in that specific vocational pursuit. Therefore, the appropriate training value is 0. Former OAR 436-35-300(5).

With respect to the adaptability category, claimant contends that his work-at-injury required the physical capacity to perform heavy work, and his modified job required the physical capacity to perform sedentary to light work, thereby establishing an adaptability value under former OAR 436-35-310(3) of 3.

The insurer, however, argues that claimant's work-at-injury required the physical capacity to perform medium work, and his modified job required the physical capacity to perform light work, thereby establishing an adaptability value of 2 under former OAR 436-35-310(3). We disagree with both the insurer and claimant.

Claimant testified that his work-at-injury required the physical capacity to lift in excess of 50 pounds on an occasional basis. Based on claimant's credible testimony, we find that the lifting requirement establishes that claimant's work-at-injury required the physical capacity to perform heavy work. Former OAR 436-35-310(3); See e.g. Carol Tuggle, 42 Van Natta 2729 (1990).

After the injury, claimant's treating physician, Dr. Watrous, released claimant to return to work with restrictions of never lifting more than 40 pounds, and performing only limited repetitive lifting, pushing and pulling up to 20 pounds. (Ex. 15A). Therefore, we find that claimant's modified job requires the physical capacity to perform light work. See former OAR 436-35-310(3) & (4).

Consequently, we conclude that the appropriate adaptability value is the difference between the physical capacity necessary to perform the usual and customary work (heavy) and the physical capacity to perform the modified job (light), or 2.5. Former OAR 436-35-310(3).

With respect to the impairment value, claimant contends that he sustained a greater loss of range of motion than that calculated by the Referee, that he is entitled to a value for a chronic condition limiting repetitive use, and that he is entitled to a value for each disc bulge. The insurer agrees that a value should be assigned for a chronic condition, but disagrees as to the values assigned for lost range of motion and the disc bulges. Under such circumstances, we award claimant 5 percent for a chronic condition limiting repetitive use of his low back. Former OAR 436-35-320(4).

With respect to the disc bulges, the insurer specifically argues that claimant failed to prove a causal relationship between the disc bulges at L4-5 and T5-6 and his compensable injury. Claimant argues, however, that the insurer has essentially waived the right to contest the compensability of the disc bulges. We disagree.

Any injury-related unoperated rupture bulge or other disc derangement is entitled to a value of 4 percent. Former OAR 436-35-350(2). Further, claimant must establish a causal relationship between his disc bulges and his compensable injury, i.e., he must show that disability resulting from impairment presumed by the "standards" to result from disc bulges is "due to" the compensable injury. ORS 656.214(5); Daniel G. Huff, 42 Van Natta 2805 (1990).

After our de novo review of the record, we find that claimant has failed to establish the causation of his disc bulges. There is no evidence in the record discussing the causation of the "probable" T5-6 disc bulge.

Regarding the L4-5 disc bulge, which is evident, there is only one mention of a causal relationship in the record. Dr. Sawchuk, M.D., reported that he was not certain whether or not the L4-5 disc bulge was related to claimant's compensable injury. Consequently, because we find that Sawchuk's opinion does not rise to the level of a medical probability of a causal connection between claimant's disc bulges and his compensable injury, we conclude that it is not persuasive. Gormley v. SAIF, 52 Or App 1055, 1060 (1981).

Therefore, there is no persuasive evidence to establish that either the T5-6 bulge or the L4-5 disc bulge is causally related to claimant's compensable back injury. Therefore, we conclude that claimant is not entitled to values for the disc bulges. Former OAR 436-35-350(2).

Regarding the category for lost range of motion, claimant contends that the Referee should have relied upon Dr. Sawchuk's findings. The insurer, on the other hand, contends that Sawchuk's findings are inconsistent and should not be relied upon to rate claimant's range of motion impairment. Instead, the insurer argues that the findings of Dr. Watrous, claimant's long-standing treating physician, should be used. We agree with the insurer.

We are persuaded by the inconsistencies in both Dr. Woolpert's and Dr. Sawchuk's medical records that the range of motion findings are not reliable. Therefore, we do not rely on the range of motion findings of Dr. Woolpert or Dr. Sawchuk. See David E. Gates, 40 Van Natta 798 (1988); Edward J. Kelly, 39 Van Natta 1051 (1987). Instead, we find the range of motion findings reported by Dr. Watrous to be more reliable, as Watrous treated claimant at the time of the injury, and continued to so treat until the time of claim closure. David E. Gates, supra; Edward J. Kelly, supra.

Therefore, based on Dr. Watrous' range of motion findings, we conclude that claimant's ratable lost range of motion includes: 20 degrees retained thoracolumbar extension (for a value of 1 percent); 20 degrees retained right lateral flexion (for a value of 1 percent); 20 degrees retained left lateral flexion (for a value of 1 percent); 25 degrees retained right rotation (for a value of 2 percent); and 25 degrees retained left rotation (for a value of 2 percent). Former OAR 436-35-360(6)-(9).

After adding the lost range of motion values, we find that claimant's total lost thoracolumbar range of motion is 7 percent. Finally, after combining claimant's range of motion impairment (7), with his chronic condition impairment (5), we conclude that claimant's total impairment value is 11.65 percent.

Computation of Unscheduled Permanent Disability

When claimant's age value 1 is added to his education value 1, 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 11.65, the result is 16.65 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, 17 percent.

Further, we find no clear and convincing evidence that claimant sustained permanent disability in excess of that calculated under the "standards." Therefore, we do not award disability outside the standards.

The insurer has not sought a reduction in the Referee's award of 28 percent unscheduled permanent disability. Consequently, we affirm the Referee's order.

ORDER

The Referee's order dated April 2, 1990 is affirmed.

January 15, 1991 Cite as 43 Van Natta 75 (1991)

In the Matter of the Compensation of
CINDY J. WOLF, Claimant
WCB Case No. 89-15088
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Brazeau's order that: (1) increased claimant's unscheduled permanent disability award for a cervical spine and right shoulder injury from 14 percent (44.8 degrees), as awarded by a Determination

Order, to 17 percent (54.4 degrees); and (2) affirmed the Determination Order which did not award scheduled permanent disability for loss of use or function of the right arm. On review, the issues are unscheduled and scheduled permanent disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We adopt the conclusions of law as set forth in the "Conclusion" portion of the Referee's order, with the following comments.

Claimant suffers from a chronic condition in her right shoulder which limits her repetitive use of the shoulder. (Ex. 5, 8, 11).

On review, claimant cites a medical text to support her argument that her cervical impairment is greater than that assigned by the Referee. However, this text was not introduced into evidence. Review by the Board is statutorily limited to evidence found in the hearing record. ORS 656.295(5). Furthermore, we may not take official notice of a medical text offered to prove pivotal facts that an opposing party was given no opportunity to contest, cross-examine or refute but which may be subject to dispute. Groshong v. Montgomery Ward Co., 73 Or App 403 (1985); Piedad Zarate, 41 Van Natta 2372 (1989), aff'd mem 104 Or App 446 (1990); Cissie L. St. Clair, 42 Van Natta 958 (1990).

Finally, no grounds are available for remand. The record is adequately developed and there is no evidence as to why the medical text was not obtainable with due diligence at the time of the hearing. ORS 656.295(5); Keinow'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).

ORDER

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

In the Matter of the Compensation of
WAYNE A. WOLFE, Claimant
WCB Case No. 88-15117
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Seifert's order that: (1) found that his right leg claim was not prematurely closed; (2) upheld the self-insured employer's denial of a weight loss program; and (3) affirmed a Determination Order award of 21 percent (31.5 degrees) scheduled permanent disability for the loss of use or function of his right knee (leg). On review, the issues are premature closure, medical services, and extent of scheduled permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

Claimant's right leg claim was properly closed. At the time of claim closure, no further material improvement would reasonably be expected from medical treatment or the passage of time.

Claimant's weight loss program was reasonable and necessary medical services.

Claimant sustained permanent loss of use or function of his right knee (leg) resulting from his 1986 industrial injury.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

We adopt the Referee's "Conclusions" which found and concluded that at the time of claim closure no further material improvement would reasonably be expected from medical treatment or the passage of time.

Weight Loss Program

The Referee found that claimant failed to establish that the weight loss program was reasonable or necessary. We disagree.

Generally, a weight program which will help a claimant alleviate the effect of a compensable injury is compensable under ORS 656.245. Van Blokland v. Oregon Health Sciences University, 87 Or App 694 (1987); See Judy L. Smith, 40 Van Natta 1840 (1988).

Here, the only evidence in the record regarding the reasonableness and necessity of the weight loss program is the July 5, 1989 opinion of claimant's treating physician, Dr. Hermens. In that report, Hermens opined that the weight loss program was not a "medical necessity." He went on to opine, however, that claimant would benefit from weight loss as claimant " . . . does have degenerative changes of the right knee and as such weight loss can be expected to influence progression of these degenerative changes. With such weight loss there is less stress on the knee joint with weight bearing and this can be expected to be beneficial in his symptoms as well as probably delay need for further surgery in the future . . ."

We are persuaded by Dr. Hermens' report that the weight loss program claimant sought was reasonable and necessary. Further, as there is no evidence to the contrary, we find that the evidence establishes that such a weight loss program would be beneficial to claimant, i.e., help alleviate the effect of his compensable injury. See Van Blokland, supra; Judy L. Smith, supra. Consequently, we find that claimant has proven that his weight loss program is reasonable and necessary, and therefore, compensable.

Extent of Scheduled Permanent Disability

We adopt that portion of the Referee's "Conclusions" which found that claimant sustained 21 percent scheduled permanent disability for the loss of use or function of his right knee (leg) resulting from his compensable right leg injury. We make the following supplementation.

The parties do not dispute claimant's entitlement to 21 percent scheduled permanent disability based on an analysis of the applicable standards. Claimant contends, however, that he established that the record, as a whole, establishes by clear and convincing evidence that his disability is in excess of that calculated under the standards. We disagree.

The only evidence cited by claimant in this regard is an October 23, 1989 report authored by Dr. Hermens. In that report, Hermens indicated that claimant's impairment resulting from his compensable injury was in the mildly moderate (20 to 40 percent) category and noted that the standards did not provide for a rating for claimant's surgeries.

While it is true that claimant's surgeries are not ratable under the standards, we find that Dr. Hermens' report, without more, fails to establish that the record, as a whole, constitutes clear and convincing evidence that claimant's loss of right leg use exceeds the 21 percent calculated under the standards. Therefore, we do not award any disability outside the standards.

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 medical services claim for a weight loss program is $1,200, to be paid by the employer. 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 March 2, 1990 is affirmed in part and reversed in part. That portion of the Referee's order that upheld the employer's "de facto" denial of the weight loss program is reversed. The medical services claim for weight loss is remanded to the employer for processing according to law. The remainder of the order is affirmed. For services at hearing and on Board review, concerning the medical services issue, claimant's attorney is awarded a reasonable assessed fee of $1,200, payable by the employer.

In the Matter of the Compensation of
JOSEPH M. ELL, Claimant
WCB Case Nos. 89-09929 & 89-17020
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Schwabe, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

United Employers Insurance requests review of that portion of Referee Leahy's order which set aside its partial denial of claimant's medical services claim for drug dependency treatment. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the Referee's order with the following supplementation.

As a result of claimant's compensable low back injury and subsequent surgeries, his treating surgeon prescribed Vicodin.

Claimant's dependency on Vicodin was a material contributing factor to his hospitalization for drug dependency.

CONCLUSIONS OF LAW AND OPINION

We adopt the conclusions and reasoning as set forth in the Referee's order with the following supplementation.

As a general rule, a carrier is responsible for harmful effects of medical treatment if there is a material causal relationship between the treatment and a compensable condition. Williams v. Gates, McDonald & Co., 300 Or 278, 281-82 (1985), see also 1 A. Larson, The Law of Workmen's Compensation, sec. 13.21 (1985). Treatment may be unreasonable, unnecessary or excessive from a medical standpoint or may be negligently or otherwise tortiously performed and still be causally related to a compensable condition. See 1 A. Larson, supra sec. 13.21 at 3-415 & n. 84 (1985 & Supp 1988); Robert L. Akerson, 41 Van Natta 281, 286 (1989).

Here, claimant was prescribed Vicodin, for relief from the pain effects of his compensable injury and subsequent surgeries. His use of Vicodin continued, prescribed but unsupervised, until he became addicted to it. Ultimately, claimant was hospitalized for drug and alcohol dependency stemming from his use of Vicodin, cocaine and alcohol. Under these circumstances, we conclude that his use of Vicodin was a material consequence of the compensable injury. We further conclude that his addiction to Vicodin was a material contributing factor to his hospitalization for drug dependency. Accordingly, the hospitalization is a compensable medical service.

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 United Employers Insurance. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 24, 1990 is affirmed. For services on review concerning the compensability issue, claimant's counsel is awarded an assessed attorney fee of $750, payable by United Employers Insurance.

January 16, 1991 Cite as 43 Van Natta 79 (1991)

In the Matter of the Compensation of
ANTONIA C. ROMAN, Claimant
WCB Case No. 89-15995
ORDER ON REVIEW
Kirkpatrick & Zeitz, Claimant Attorneys
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Shebley's order that: (1) declined to grant permanent total disability; and (2) affirmed a Determination Order which

awarded 48 percent (153.6 degrees) unscheduled permanent partial disability for a low back injury. On review, the issue is extent of unscheduled permanent disability, including permanent total disability. We modify.

FINDINGS OF FACT

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

Claimant does not suffer from a disabling mental disorder as a result of her compensable injury.

Claimant retains the following ranges of motion in her thoracolumbar spine: 50 degrees flexion, 20 degrees extension, 10 degrees left lateral flexion, 15 degrees right lateral flexion, 5 degrees left rotation and 10 degrees right rotation. (Ex. 88-5).

Claimant's job at injury, as housekeeper, required medium strength. (Tr. 135). After injury, claimant returned to work in a sedentary position. She was not working at the time of hearing, for reasons unrelated to her injury.

CONCLUSIONS OF LAW AND OPINION

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

We agree with the Referee's conclusion that claimant has not proven entitlement to permanent total disability compensation. However, we do not agree that claimant suffers injury-related emotional impairment. In this regard we are persuaded, by the opinion of Dr. Belleville, that any psychological condition which claimant may have does not interfere with her ability to work. (Ex. 30-3).

For purposes of determining injury-related permanent partial disability, former ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the Director pursuant to former 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.

Because claimant's condition became medically stationary on July 6, 1989, and her claim was closed by Determination Order on August 1, 1989, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent disability.

The determination of permanent partial disability under the "standards" is made by determining the appropriate values assigned by the "standards" to 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 and Education

The appropriate value for claimant's age of 56 years is 1. Former OAR 436-35-290.

The appropriate value for claimant's third grade education is 1. Former OAR 436-35-300(3).

The highest specific vocational pursuit (SVP) level demonstrated by a claimant during the ten years preceding the date of determination is used to determined the value for skills. Former OAR 436-35-300(4). For our purposes, permanent disability is determined on the date of hearing. The position which claimant successfully performed during the ten years preceding the date of hearing, which has the highest SVP level, was as a housekeeper (DOT # 321.687-010) which has an SVP of 2. Therefore, the appropriate skills value is 4. Former OAR 436-35-300(4).

Because claimant has acquired no training to perform other than an entry level position, she is entitled to a +1 value for training. Former OAR 436-35-300(5); Larry L. McDougal, 42 Van Natta 1544 (1990).

Adaptability

On review, claimant argues that her adaptability should be evaluated under subsection (4) of former OAR 436-35-310, rather than subsection (3), because she did not successfully perform her modified work. We disagree.

Claimant's job-at-injury was in the medium range, requiring occasional lifting of 25-50 pounds. After injury, claimant returned to sedentary part time work with the same employer. She was expected to work 2 hours per day, three days per week, folding clean underwear and distributing clothing to patients' rooms using a rolling cart. She was allowed to take breaks, sit, stand or walk, as needed. (Exs. 37, 42, 43, 47-1). Claimant was terminated in March, 1987, due to her lack of dependability and bad attitude. In addition, the employer was no longer able to set appropriate work aside for claimant, because it could not count on claimant showing up for work. (Exs. 49-2, 51-1-2, 53-2). The medical evidence establishes that claimant is physically and emotionally capable of performing sedentary work. (Exs. 80, 85, 91). Claimant, on the other hand, asserts that she is unable to work, due to her pain. Inasmuch as the weight of persuasive medical evidence establishes that claimant exaggerates her symptoms (Exs. 24-2, 29-2, 84-2, 91-6), we are not persuaded by claimant's self-proclaimed inability to work. Therefore, we conclude that claimant's unemployed status does not result from reasons related to her injury. (Compare, Donna J. Bartuff, 42 Van Natta 2784 (1990)).

Inasmuch as claimant's failure to continue working at her modified work was not related to her compensable injury, we determine her adaptability under former OAR 436-35-310(3), the matrix designed for injured workers who return to modified work. Because claimant's job-at-injury required medium physical capacity and her modified work was in the sedentary range, she is entitled to an adaptability value of 2.5.

Impairment

Claimant is entitled to the following impairment ratings for her thoracolumbar spine: 4 percent for flexion; 1 percent for extension; 4 percent for left lateral flexion; 3 percent for right lateral flexion; 5 percent for left rotation; and 4 percent for right rotation. Former OAR 436-35-360(6)-(9). These values are added, for a total of 21 percent. Former OAR 436-35-360(10).

Claimant is entitled to 4 percent values for each of her two unoperated bulging discs. These values are added, for a total of 8 percent. She is also entitled to a 5 percent value for her chronic condition. The impairment values, 21, 8 and 5, are combined, for a total impairment of 31 percent. Larry L. McDougal, supra.

Computation of Unscheduled Permanent 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, 6, the sum is 7. Former OAR 436-35-280(4). When that value is multiplied by claimant's adaptability value, 2.5, the product is 17.5. Former OAR 436-35-280(6). When that value is added to claimant's impairment value, 31, the result is 48.5. 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, 49 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 claimant is more or less than the entitlement indicated by the "standards". Former ORS 656.283(7) and 656.295(5). On this record, we do not find clear and convincing evidence that claimant suffers greater disability than provided by application of the standards. See Riley Hill General Contractor Inc. v. Tandy Corp., 303 Or 390, 407 (1987).

ORDER

The Referee's order dated January 5, 1990 is modified. In addition to the Determination Order award of 48 percent (153.6 degrees) unscheduled permanent disability, claimant is awarded 1 percent (3.2 degrees), giving her a total award to date of 49 percent (156.8 degrees) unscheduled permanent disability for her low back. 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.

January 16, 1991 Cite as 43 Van Natta 82 (1991)

In the Matter of the Compensation of
YVETTE SEMAAN, Claimant
WCB Case No. 89-18317
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Daniel J. DeNorch (Saif), Defense Attorney

Reviewed by Board Members Crider and Myers.

The SAIF Corporation requests review of Referee Mills' order which set aside it denial of claimant's claim for a neck and back injury. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the Referee's order with the following supplementation.

Following the July 28, 1989 incident, claimant sought treatment in the emergency room for neck and left shoulder pain. As a result of the incident, claimant sustained a contusion to her left forearm and a neck strain.

ULTIMATE FINDINGS OF FACT

We adopt the "Ultimate Findings of Fact" as set forth in the Referee's order.

CONCLUSIONS OF LAW AND OPINION

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

Although claimant has a preexisting left shoulder condition, the compensability of the July 28, 1989 incident does not present a complex medical question. See Uris v. Compensation Department, 247 Or 420, 426 (1967).

Claimant credibly testified that the incident occurred and that she felt immediate left arm, shoulder and neck pain. She sought treatment for these symptoms from the emergency room and was ultimately diagnosed as having sustained a left arm contusion and neck strain. Under these circumstances, claimant has established that the June 28, 1989 incident was a material contributing cause of her disability and need for medical treatment. See Hutcheson v. Weyerhaeuser, 288 Or 51 (1979).

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 SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated March 6, 1990 is affirmed. For services on review concerning the compensability issue, claimant's counsel is awarded an assessed attorney fee of $750, payable by the SAIF Corporation.

January 16, 1991 Cite as 43 Van Natta 83 (1991)

In the Matter of the Compensation of
MITCHELL D. WELLS, Claimant
WCB Case No. 89-13349
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Gail M. Gage (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Myzak's order that: (1) upheld the SAIF Corporation's denial of claimant's neck injury claim; and (2) declined to assess a penalty and associated attorney fees for SAIF's allegedly unreasonable denial. The issues on review are compensability and penalties and attorney fees. We reverse.

FINDINGS OF FACT

Claimant is a water truck driver for SAIF's insured. One of his duties is to climb on top of a thirteen-feet high, rounded, water tank and insert and remove a water hose to fill the tank. On June 26, 1989, claimant began work at 6 a.m., approximately 30 minutes before anyone else arrived. While filling the water tank, claimant lost his hold on the slick surface of the tank and fell, injuring his neck. At 8:20 p.m. that same evening, claimant sought medical care for pain he was experiencing at the base of his neck. X-rays revealed widening at the C6-7 interspace which is consistent with recent trauma.

Although nobody saw claimant fall, several people learned of the incident that day and one witness noticed claimant's neck was swollen and that he wasn't turning his head normally. Claimant fell on open, compact ground and sustained no scrapes, cuts or bruises. The lack of scrapes and bruises is not medically inconsistent with a fall from 13 feet. Claimant did not notify his employer that day because he was ashamed and feared he would be fired for being clumsy. After the injury was reported on June 27, 1989, claimant's employer changed the method of filling the trucks so that workers no longer had to climb onto the tank.

If the water tank spilled-over the morning of the accident, the ground immediately around the water tank truck may have been muddy. None of the witnesses could recall if claimant's clothes appeared muddy. Claimant had on several layers of clothing when the accident occurred and, as the day got warmer, he removed the layers.

CONCLUSIONS OF LAW AND OPINION

The issue here is whether the alleged injury to claimant's neck actually occurred at work. The Referee concluded that the medical and photographic evidence fully supported claimant's position and that all witnesses, including claimant, were credible based on demeanor and manner. However, the Referee also found claimant's testimony internally inconsistent and, because of substantive contradictions, she found claimant not credible. Since the industrial accident was unwitnessed and claimant's credibility was doubtful, the Referee concluded that claimant failed to meet his burden of proving the injury actually happened at work. We disagree.

Since the Referee doubted claimant's truthfulness based on perceived substantive inconsistency in his testimony, and did not ground her finding on "demeanor," the Board is equally competent to evaluate the substance of claimant's testimony and does not have to defer to the Referee. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987); Tarna D. Palmer, 42 Van Natta 2088 (1990).

We are persuaded by claimant's overall evidence that the injury occurred as he claims. Furthermore, we do not concur with the Referee's finding that claimant's testimony at pages 22-24 of the hearing transcript substantively contradicts later testimony he gave at pages 130-131.

Claimant did not testify in his case-in-chief that the water tank spilled-over on the first fill on June 26, 1989. Rather, on cross-examination, claimant answered "yes" to SAIF's leading question: "[A]s soon as the water started overflowing out of the truck you knew it was full. Is that right?" (Tr. 23). Moreover, in the context of the surrounding testimony, claimant never directly testified that the tank overflowed on the first fill that day. He merely explained how generally one knows when the water tank is full: "When the water runs over." (Tr. 22, line 7). Later, claimant clarified that on the day of injury the water did not actually spill-over the first time and he explained the reasons why he made sure of that. (Tr. 130-131).

Even if we were to agree with the Referee that this is inconsistent testimony, it is not sufficiently suspect to make claimant a noncredible witness, particularly in light of significantly more persuasive evidence in support of claimant's version of events.

SAIF's chief defense was that claimant had actually injured his neck in a demolition derby race on June 24, 1989. However, our review of the record fails

to find support for this position. All witnesses testified that claimant sustained no injuries in the race of June 24.

Claimant has shown by a preponderance of the evidence that it is more probable than not that his neck injury occurred at work.

Penalty and Attorney Fees for Unreasonable Denial

The Referee concluded that there was no basis for an award of a penalty or an attorney fee because SAIF's denial was not unreasonable. We disagree. Former ORS 656.262(10) provides in pertinent part that:

> "(10) If the insurer or self-insured employer 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."

We conclude that SAIF's denial of compensation was unreasonable because the information available to SAIF at the time of denial did not raise a legitimate doubt as to the compensability of the industrial accident. See Brown v. Argonaut Ins. Co., 93 Or App 588, 591 (1988); Norgard v. Rawlinsons & New Systems Laundry, 30 Or App 999, 1003 (1977); Paul W. Luhrs, 42 Van Natta 1312 (1990). Furthermore, SAIF makes no argument regarding what information, if any, caused it to reasonably doubt compensability. The record does not reflect a debate on this point until the time of hearing.

Although we conclude that SAIF's denial was unreasonable, nevertheless, we do not award penalties because there is no evidence of "amounts then due" upon which to assess a penalty. However, even if penalties are not awardable, we assess related attorney fees for SAIF's "unreasonable resistance to the payment of compensation." See ORS 656.382(1); Ellis v. McCall Insulation, 308 Or 74, 78 (1989); Lloyd L. Cripe, 41 Van Natta 1774, 1779 (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's services at hearing and on review concerning the compensability issue is $3,000, and concerning the unreasonable denial is $400, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated November 22, 1989 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,000, to be paid by SAIF. Claimant's attorney is also awarded $400 for an unreasonable denial, to be paid by SAIF.

In the Matter of the Compensation of
JAMES H. WILEY, Claimant
WCB Case No. 89-02531
ORDER ON RECONSIDERATION
Emmons, Kropp, et al., Claimant Attorneys
Karen M. Werner, Attorney
Gary Wallmark (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of that portion of our December 20, 1990 Order on Review that affirmed a Referee's order which increased claimant's unscheduled permanent disability award for a back injury from 36 percent (115.2 degrees), as awarded by Determination Order, to 45 percent (144 degrees). SAIF asserts that we improperly declined to give legally-binding effect to an unsigned letter directed to SAIF from the manager of the Evaluation Section of the Department of Insurance and Finance. Citing Forelaws on Board v. Energy Fac. Siting Council, 306 Or 205 (1988), SAIF argues that the Board should find the letter in question to be a legally-binding agency interpretation of former OAR 436-35-320(4). We do not agree.

The relevant issue in Forelaws on Board, supra, was whether the Energy Facility Siting Council could issue legally-binding interpretive rules in the context of a contested case or, instead, whether such interpretive rules required formal rulemaking procedures. To answer this question, the court looked to the agency's statutory authority. Where the agency has been given broad authority to set policy, a strong inference of legislative intent arose "that the agency exercise its policymaking in rulemaking proceedings rather than in the course of deciding contested cases." Id. at 214.

Here, we note, it is not apparent that the letter in question arose in the context of a contested case. Rather, the letter was apparently issued merely in response to a general inquiry from SAIF. Second, we are not persuaded that the agency employee who sent the letter is authorized to issue a legally-binding interpretation of agency rules. More fundamentally, the statutory authority for the underlying rule, which SAIF asserts has been the subject of a legally-binding interpretive rule, expressly requires that the rule be adopted in accordance with the rulemaking procedures of ORS 656.310 to 183.550. See former ORS 656.726(3)(f). Moreover, the statute requires active public participation in the promulgation of the underlying rule. We, therefore, conclude that the legislature intended that an interpretive rule of the sort alleged here by SAIF be the subject of the rulemaking proceedings established by the APA. We decline to find the letter in question to be a legally-binding interpretive rule. We further note that for the purposes SAIF asserts, it is unlikely that the Evaluations Section of the Department of Insurance and Finance and the Workers' Compensation Board are the same agency. See e.g. ORS 656.283(1); 656.704; 656.712 and 656.726. Each has independent rule making authority. ORS 656.726.

Accordingly, SAIF's request for reconsideration is granted and our prior order withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our December 20, 1990 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRET N. JACOBSON, Claimant
WCB Case Nos. 89-12149, 89-12148 & 89-07668
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Bonnie V. Laux (Saif), Defense Attorney
Stafford Hazelett, Defense Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

K-Mart Corporation, a self-insured employer, requests review of Referee Michael Johnson'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 and Liberty Northwest Insurance Corporation's denial of claimant's "new injury/new occupational disease" claim for the same condition. On review, the issues are compensability and responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant sustained a compensable low back injury on December 29, 1986, and K-Mart accepted the claim. Claimant treated three times with Dr. Buell, osteopath. Following the last treatment, on January 12, 1987, claimant sought no treatment for his back for 23 months.

K-Mart fired claimant on July 8, 1987. Soon thereafter, claimant began working at Cascade Tire. The SAIF Corporation insured Cascade through December 1987; Liberty Northwest Insurance Corporation was on the risk thereafter.

Claimant's work at Cascade is similar to that which he performed at K-Mart, except that he is required to work faster at Cascade. (Tr. 26). Claimant's duties at work involve strenuous repetitive back movement. In January 1988, claimant's back pain became "more relevant." (Tr. 18). During the next year, claimant worked and suffered pain which varied with his level of work activity. (Tr. 20).

In late January 1989, claimant spent many hours installing tire chains. On or about February 7, 1989, while lying on the couch at home, he felt a "pop" in his back, an immediate burning sensation and intense back pain. Following this incident, claimant also had leg pain which he had not felt previously. (Tr. 30). Claimant treated with Dr. Campbell, chiropractor, who took claimant off work for about 30 days.

K-Mart denied claimant's aggravation claim on April 13, 1989. SAIF denied claimant's "new injury" claim on September 5, 1989. Liberty Northwest denied responsibility (only) for claimant's "new injury/new occupational disease" claim on June 7, 1989. (Ex. 22, Tr. 3). No order designating a paying agent issued pursuant to ORS 656.307.

FINDINGS OF ULTIMATE FACT

Claimant's compensable 1986 injury with K-Mart had resolved before February 7, 1989.

Claimant's low back condition on and after February 7, 1989 was materially related to his employment at Cascade.

Claimant's work at Cascade after December 1987 could have contributed to his low back condition on and after February 7, 1989.

CONCLUSIONS OF LAW AND OPINION

In a compensability/responsibility case such as this, the threshold issue is compensability. Joseph L. Woodward, 39 Van Natta 1163, 1164 (1987). If the claim is compensable, then the trier of fact must address the issue of responsibility. See Runft v. SAIF, 303 Or 493, 499 (1987).

Compensability

Claimant's current condition may be compensable as an aggravation, as an industrial injury, or as an occupational disease. No evidence suggests that, since the 1986 compensable injury, claimant suffered any nonwork-related injury or disease.

Claimant's condition is compensable as an aggravation, if the 1986 injury remains a material contributing cause of claimant's existing disability or need for medical treatment. Harris v. Albertson's, 65 Or 254 (1983). In order to establish compensability under a new injury or an occupational disease theory, claimant must prove that an employment-related injury or employment activities constituting a "series of traumatic events or occurrences" materially contributed to his condition. Former ORS 656.005(7)(a); 656.802(1)(c); Donna E. Aschbacher, 41 Van Natta 1242 (1989).

Several medical experts have offered opinions as to causation. Each relates claimant's condition since February 7, 1989 in material part to her employment with K-Mart or Cascade. There is no medical opinion which supports a conclusion that the condition is not compensable as either an aggravation, a new injury, or an occupational disease.

Accordingly, regardless of which medical opinion(s) we accept as persuasive, claimant has established the compensability of his claim. We turn now to the issue of responsibility.

Responsibility

This case involves an accepted compensable injury followed by an increase in disability during employment with a later employer/insurer. In such a case, responsibility is fixed with the employer/insurer which accepted the claim. In order to shift responsibility, the original employer/insurer must prove that a later employment independently contributed to a pathological worsening of the accepted condition. Spurlock v. International Paper Co., 89 Or App 461 (1988; Crowe v. Jeld-Wen, 77 Or App 81 (1985); see Hensel Phelps v. Mirich, 81 Or App 290 (1986).

The Referee concluded that responsibility remained with K-Mart, because "no intervening, overwhelmingly superceding incident has occurred in relation to [claimant's accepted condition]." We disagree. No incident or occurrence is required to shift responsibility. See Home Ins. Co. v. EBI Companies, 76 Or App 112, 118-119 (1985). If the later work contributed, however slightly, to the causation of the disabling condition, the later employer is responsible. Runft v. SAIF, 303 Or 493 (1987); See UAC/KPTV Oregon TV v. Hacke, 101 Or App 598 (1990); Hensel Phelps v. Mirich, supra at 294.

The Referee also found that the 1986 injury remains a material cause of claimant's current condition, based on claimant's testimony regarding continuous symptoms and on his treating chiropractor's opinion. We disagree.

Because several years have passed since the first injury, the issue of whether claimant's current condition and need for medical services is causally related to the 1986 injury is a complex medical question. Thus, although claimant's testimony is probative, resolution of the issue turns largely on an analysis of the medical evidence. Uris v. Compensation Dept., 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). In resolving this issue, we rely on medical evidence which is both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 279 (1986).

When Dr. Campbell, treating chiropractor, took claimant off work in 1989, claimant had been working at Cascade for almost 18 months and had not sought treatment for his back for almost two years. Campbell initially stated that claimant was off work "due to the nature of employment," and that the "incident of injury" was "constant repetative [sic] lifting, bending and twisting." (Ex. 7). Several months later, Campbell opined that the 1986 injury had never resolved. (Ex. 15-3). Campbell did not examine claimant before 1989. Nevertheless, without explanation, he relates claimant's current condition to an injury which occurred years before he saw claimant. His later opinion is apparently based entirely on claimant's belated reporting of continuous symptoms following the 1986 injury. Because we find Campbell's opinion on this issue to be conclusory, we are not persuaded by it.

No other medical evidence relates claimant's current condition to the 1986 injury. Based on his review of claimant's history and X-rays as well as his examination, Dr. Sirounian concluded that claimant's current symptoms are not related to his 1986 injury. (Exs. 12A-3, 21-1). After an August 1989 examination and review of claimant's history, Dr. Duncan reached the same conclusion. (Ex. 23-3-4). There is no suggestion that either Duncan or Sirounian failed to consider claimant's complete history. We are persuaded by the well-reasoned opinions of Sirounian and Duncan. See Somers v. SAIF, supra. Moreover, we note that Campbell's initial impression is consistent with the above-mentioned opinions which we have found to be well-reasoned and based on complete information.

The preponderance of the medical evidence is corroborated by the sequence of events since 1986. Claimant lost no work time following the 1986 injury. Moreover, after he was fired at K-Mart, he sought and successfully performed work which was more physically demanding than his pre-injury job. Based on the medical evidence and claimant's activities since 1986, we conclude that the 1986 K-Mart injury is no longer a material contributing cause of claimant's current condition.

As we have noted, the medical evidence relating claimant's current condition to his work at Cascade is unrebutted. Consequently, the claim is compensable as to Cascade. Moreover, inasmuch as the 1986 injury-related condition resolved and claimant did not seek treatment for his back for over a year and a half after he stopped working at K-Mart, we conclude that claimant's work at Cascade necessarily independently contributed to his current compensable condition. Consequently, responsibility for claimant's back condition has shifted to Cascade, the later employer. As to responsibility between Cascade's insurers, claimant's last work exposure which could have contributed to his current condition occurred after SAIF was off the risk. Therefore, Liberty Northwest is responsible for claimant's current condition unless it can establish that claimant's employment activities and exposures while it was on the risk did not contribute to claimant's disabling condition. Runft v. SAIF, supra. There is no evidence in the record to sustain Liberty's burden. We, therefore, conclude that responsibility for claimant's current condition rests with Liberty Northwest.

Because claimant prevailed on the compensability issue, he is statutorily entitled to a reasonable assessed fee for his counsel's services on Board review in that regard. 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 $300. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. As the party requesting Board review, K-Mart kept compensability at risk. Because claimant's compensation was not reduced or disallowed on review, claimant's fee under ORS 656.382(2) is payable by K-Mart. Cigna Insurance Companies v. Crawford, 104 Or App 329 (1990); Joel D. Turpin, 41 Van Natta 1736 (1989).

ORDER

The Referee's order dated October 30, 1989 is reversed in part and affirmed in part. That portion which upheld Liberty Northwest Insurance Corporation's denial is reversed. Liberty Northwest's denial is set aside and the claim is remanded to it for processing according to law. K-Mart's denial is reinstated and upheld. Liberty Northwest, rather than K-Mart, is responsible for payment of the attorney fee awarded by the Referee. The remainder of the Referee's order is affirmed. For services on Board review regarding the compensability issue, claimant is awarded a reasonable assessed attorney fee of $300, payable by K-Mart Corporation.

In the Matter of the Compensation of
GEORGE K. O'KELLEY, Claimant
WCB Case No. 88-08920
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Miller's order which: (1) increased claimant's unscheduled permanent disability award for a low back injury from 20 percent (64 degrees), as awarded by two Determination Orders, dated May 2, 1988 and September 1, 1989, to 33 percent (105.6 degrees); (2) authorized the SAIF Corporation to offset an overpayment of temporary disability benefits; and (3) declined to award an assessed attorney fee. As an alternative to the extent of unscheduled disability awarded by the two Determination Orders, claimant argues that he should be allowed to appeal the Determination Order dated May 2, 1988 pursuant to the laws applicable at that time. On review, the issues are extent of unscheduled permanent disability, offset, 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.

Claimant was 58 years of age at the time of hearing.

He has completed the ninth grade. After his authorized training program, claimant has documented training showing competence in a vocational pursuit, specifically small engine repair. Claimant's job-at-injury was that of a truck driver, which has an SVP level of 3.

Claimant has returned to modified employment. At the time of his injury, he was performing heavy work. He presently is able to perform medium work.

Claimant last became medically stationary on March 7, 1989.

CONCLUSIONS OF LAW AND OPINION

Applicable Rating Standards

Claimant's claim was closed by Determination Order on May 24, 1988. His claim was reopened for an authorized training program, and reclosed by a Determination Order on September 1, 1989. Claimant argues that he did not waive his right to appeal the May 24, 1988 Determination Order and, thus, should not be rated under the standards in effect at the time of the September 1, 1989 Determination Order. We disagree. Regardless of whether we evaluate claimant's permanent disability based upon his request for hearing from one or both Determination Orders, permanent disability is rated at the time of hearing. Emmons v. SAIF, 34 Or App 603 (1978). Former ORS 656.283(7) required the Referee, and former ORS 656.295(5) requires us, to determine claimant's disability by application of the "standards" adopted pursuant to ORS 656.726(3)(f)(A). Where claimant became medically stationary on or after January 1, 1988, we must apply the "standards" in effect at the time of the most recent claim closure. See former OAR 436-35-002; 436-35-003; 438-10-005; 438-35-010; William J. Thomas, 42 Van Natta 841 (1990); Wade A. Webster, 42 Van Natta 1707 (1990). Accordingly, the Referee correctly applied the "standards" in effect on September 1, 1989.

Extent of Permanent Disability

The Board adopts the Referee's "Opinion and Reasoning" with respect to the issue of extent of permanent disability.

Moreover, on this record, we do not find clear and convincing evidence that claimant suffers more than 33 percent unscheduled permanent disability.

Offset

The Board adopts the Referee's "Opinion and Reasoning" with respect to the issue of offset with the following comment.

Relying on ORS 656.268(10), claimant challenges the Referee's and the Board's authority to authorize the offset which was allowed for compensation paid after the Determination Order issued. He does not dispute, however, the Referee's finding that claimant was overpaid temporary disability compensation to which he was not entitled. Referee and Board authority to authorize an offset of an overpayment arises from ORS 656.268(6) and ORS 656.283(1), which entitles any party to a hearing on any matter concerning a claim. ORS 656.708(3); 656.704(3); SAIF v. Zorich, 94 Or App 661 (1989); Weyerhaeuser Co. v. Sheldon, 86 Or App 46 (1987); Forney v. Western States Plywood, 66 Or App 155 (1983); Petshow v. Portland Bottling Co., 62 Or App 614 (1983). We find that the Referee properly authorized the offset. See Travis v. Liberty Mutual, 79 Or App 126 (1986).

Attorney Fees

The Referee declined to award an assessed fee at hearing for claimant's prevailing on the issue of overpayment. We find that, because claimant prevailed against SAIF's cross-request for hearing on the overpayment issue to the extent of $25.59, a nominal assessed attorney fee, payable by SAIF, is appropriate. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4), we find that $50 is a reasonable fee. In reaching this conclusion, we have particularly considered the time devoted to the issue, the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 1, 1990 is reversed in part and affirmed in part. That portion which declined to award an assessed attorney fee is reversed. For services at hearing relating to the issue of overpayment, claimant's attorney is awarded a reasonable assessed fee of $50, payable by the SAIF Corporation. The remainder of the order is affirmed.

In the Matter of the Compensation of
BILL G. REED, Claimant
WCB Case No. 89-23088
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Larry Schucht (Saif), Defense Attorney

Reviewed by Board Members Myers and Cushing.

The SAIF Corporation requests review of Referee Fink's order which set aside its denial of compensability of an industrial injury to claimant's ankle. On review, the sole issue is compensability. We reverse.

FINDINGS OF FACT

Claimant worked as a hod carrier for this employer. The employer had specifically warned claimant not to fight on the job when he hired claimant.

Claimant and his employer were working on a construction project along with other sub-contractors in October 1989. Claimant had been teasing and taunting Norm Bredall, a siding contractor, for three days.

On October 17, 1989, Bredall asked claimant to move some scaffolding out of Bredall's way. Claimant did so reluctantly and then went by Bredall and gave him a poke saying something like "there does that suit you." Bredall reacted by chasing claimant into the basement of the construction project. Shortly thereafter, claimant emerged from the building and stood with his arms open and said to Bredall "here I am Norm, come and get me." Bredall came up to claimant and claimant did not back down. The two men grappled and Bredall threw claimant to the ground. Claimant's ankle was broken in the fall to the ground. Bredall slapped claimant several times after claimant went to the ground.

Claimant left his regular duties as a hod carrier while he actively participated in this combat with Bredall. Combats are not a part of his job assignment.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was not a credible witness based on his assessment that "[h]e is extremely glib and articulate." We consider that to be a credibility finding based on demeanor. We defer to that finding. Consequently, we have based our findings of fact on the testimony of other witnesses.

ORS 656.005(7)(a)(A) excludes from the definition of compensable injury:

> "Injury to any active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties."

In Kessen v. Boise Cascade Corp., 71 Or App 545 (1984) the Court of Appeals construed this statute to require satisfaction of a four part test:

> "In order to be barred from receiving compensation, (1) the claimant must be an active participant, (2) in assaults or combats, (3) which must not be connected to the job assignment and (4) which must amount to a deviation from customary duties." Id at 548.

The Referee concluded that claimant was not an active participant in an assault or combat. We disagree.

Claimant had actively taunted Bredall for three days. He poked Bredall; but, when Bredall chased him he fled. However, almost immediately claimant invited Bredall to "come and get me" and then stood his ground and grappled with Bredall when Bredall came up to him. We consider this to be active participation in an assault or combat.

We also find that claimant satisfied the other two requirements of the Kessen test. Claimant's employer had specifically forbidden him from fighting on the job. Thus, fighting was certainly not part of his job duties. Furthermore, claimant left his job duties when he poked Bredall and fled. He apparently never returned to his job duties before injuring his ankle.

We conclude that claimant's injury is not compensable under ORS 656.005(7)(a)(A).

ORDER

The Referee's order dated March 30, 1990 is reversed. The SAIF Corporation's denial is reinstated and upheld in its entirety. The Referee's $1,250 attorney fee is reversed.

In the Matter of the Compensation of
DEBBIE L. STADTFELD, Claimant
WCB Case No. 89-14110
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

The insurer requests review of those portions of Referee Peterson's order which: (1) found that claimant had established good cause for an untimely filing of a hearing request; (2) found that claimant's July 21, 1989 request for hearing, regarding the June 1989 Determination Order, was also sufficient to meet the jurisdictional requirement of filing a hearing request within 180 days of the March 6, 1989 denial; (3) set aside the insurer's denial of claimant's thoracic and cervical spine condition; and (4) found that the June 1989 Determination Order, which awarded 22 percent (70.4 degrees) unscheduled permanent disability for a low back condition, had prematurely closed claimants claim. On review, the issues are timeliness of the hearing request, compensability, premature closure, and the extent of unscheduled permanent disability of the low back condition. We reverse in part and affirm in part.

FINDINGS OF FACT

On November 29, 1988, claimant, a 32-year-old courier driver, slipped on a curb and allegedly sustained a lumbar, thoracic, and cervical sprain/strain. She filed an "801" form the same day. On March 6, 1989, the insurer accepted only the lumbosacral strain/sprain and issued a denial of the thoracic and cervical spine claims. Upon receipt of the denial letter, claimant's attorney instructed his secretary to file a request for a hearing; however, the secretary failed to file the request and mistakenly told claimant's attorney that it had been filed.

A Determination Order issued on June 26, 1989, and awarded an unscheduled permanent partial disability award for the accepted low back condition. On June 28, 1989, the insurer denied medical treatment in excess of the Medical Director's guidelines. On July 21, 1989, claimant's attorney filed a request for hearing specifying the issues as the extent of disability from the June Determination Order as well as the denial of medical treatments. There was no mention of the March 1989 denial of compensability for thoracic and cervical spine conditions.

Claimant does not have a high school degree or a GED certificate. During the ten years preceding the date of hearing, in addition to the courier driver position at injury, claimant also successfully worked as both a cashier-checker and as a nursing home aide. At the time of her compensable injury, claimant was performing job duties characteristic of medium/heavy occupations.

Claimant's medical status was stationary on March 7, 1989 and her residual physical capacity is limited to light work. However, she also has limitations on such activities as sitting, standing, carrying, stooping, and twisting.

The retained degrees of motion of claimant's low back are limited to 69 percent on flexion; 24 percent extension; 24 percent left lateral flexion; 26 percent right lateral flexion; and, 45 percent rotation, bilaterally. (Ex. 10).

CONCLUSIONS OF LAW AND OPINION

The threshold question on review is whether claimant's July 21, 1989 hearing request, pertaining to the extent of disability awarded in the June 1989 Determination Order, also put the March 6, 1989 denial at issue, even though the March denial was not specified in the appeal. The Referee concluded that claimant established "good cause" for the untimely filing of the hearing request following the March 1989 denial of cervical and thoracic spine conditions. In addition, the Referee found claimant's July 21, 1989 request for hearing, regarding the June 1989 Determination Order, was sufficient to meet the jurisdictional requirement of filing a request for hearing within 180 days of the March 1989 denial. We disagree.

The time for requesting a hearing is specified in ORS 656.262(8) and ORS 656.319(1). In essence, the request for hearing must be filed within 60 days after the mailing of the notice of denial or within 180 days, if claimant shows good cause for not filing the request before the 60th day. Failure to request a hearing with respect to a denied claim within 180 days, must result in dismissal of the request for hearing. See Lucy (Froyer) Anderson, 34 Van Natta 1249, 1250 (1982), aff'd without opinion 63 Or App 675 (1983). (Emphasis in original).

Here, claimant filed a hearing request on July 21, 1989, pertaining solely to the June 1989 Determination Order without stating issues even impliedly relevant to the March 1989 partial denial. For example, the Determination Order award was for impairment of the lumbar spine, whereas the insurer's compensability denial three months earlier pertained to alleged injury to the cervical and thoracic spine.

Citing Shaw v. SAIF, 63 Or App 239 (1983), the Referee decided that every issue that claimant specified between the time the July 21, 1989 request for hearing was filed and the time of hearing (November 1, 1989), including the issue relating to the March 6, 1989 denial, related back to the date of the the July 1989 request for hearing. Thus, the Referee concluded that the issue of the denial of thoracic and cervical spine injuries was filed within 180 days of the insurer's denial. We do not agree.

The holdings in Anderson, supra and Shaw, supra are explained and distinguished in Tom E. Dobbs, 35 Van Natta 1332, 1334-1336 (1983). The court in Shaw concluded that the Referee had jurisdiction to hear arguments on a third Determination Order, even though claimant did not specifically request a hearing in relationship to that particular order. The court reasoned:

> "The third determination order provided the same permanent partial disability as the first one. There is no claim of surprise, which would have provided a basis for continuance. OAR 436-83-200. The issues are clearly raised by claimant's June, 1981, request for a hearing * * * . Claimant's objections to the third determination order are the same as those to the first and second." 63 Or App at 243.

On the other hand, the claimant in Anderson, supra, filed an appeal pertaining to an extent issue arising from a determination order but failed to request a hearing with respect to a partial denial. Like claimant in this matter, the worker in Anderson also argued that even though the request for hearing only raised the extent of disability in relationship to the determination order, it was also adequate as a request for hearing on the partial denial. We concluded in that instance that claimant had received both the determination order and the denial and that she was under no obligation to appeal either or

both. Since claimant in Anderson chose only to request a hearing on the determination order, it was an "inconsistency" to allow the claimant to later protest the denial, long after the time limitation had expired. Anderson, supra at 1251. Compare, Thomas R. Gregg, 35 Van Natta 1687, 1689 (1983).

This claim is more analogous to Anderson because here the request for hearing does not mention either compensability or the partial denial of cervical and thoracic back injuries. Disability claims for "extent" versus "compensability" are entirely different issues and give rise to distinct facts and objections. In contrast, the court in Shaw based its determination on the observation that the third determination order provided for the same permanent partial disability and claimant's objections to the third determination order were the same as the previous orders. 63 Or App at 243.

Based on the above analysis, we conclude that claimant failed to file a request for hearing, within 180 days, which was intended to or did put at issue the March 6, 1989 denial. Anderson, supra. Therefore, that portion of the Referee's order pertaining to the denial of cervical and thoracic injuries is vacated and claimant's untimely request for hearing from the insurer's March 6, 1989 denial is dismissed.

"Good Cause" for Untimely Hearing Request

We do not reach the "good cause" question because there is no statutory or other legal basis for excusing an untimely hearing request after 180 days from the date of mailing of the denial. See ORS 656.319; Wright v. Bekins Moving & Storage Co., 97 Or App 45, 49 (1989).

Premature Closure

In regard to the accepted low back condition, we adopt the Referee's findings and conclusion regarding claimant's medically stationary date. Only the treating chiropractor, Dr. Pettigrew, did not consider claimant medically stationary as of March 7, 1989. The Orthopaedic Consultants, neurological consultant, Dr. Brett, and independent chiropractic examiner, Dr. Burke, all opined that claimant was medically stationary in March 1989. Claimant has not met her burden of proof.

Extent of Unscheduled Permanent Disability

Inasmuch as the Referee concluded that the denial of claimant's cervical and thoracic conditions was timely appealed and that these conditions were in fact caused by her industrial injury on November 29, 1988, he set aside the June 26, 1989 Determination Order and did not decide the extent of claimant's disability relating to the low back condition.

We reinstate the June 26, 1989 Determination Order and proceed with a de novo review of the extent of permanent partial disability, based on the hearing record. In so doing, we find the record sufficiently developed to make such a determination. David L. Fleming, 38 Van Natta 1321 (1986).

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.

Because claimant's condition became medically stationary on March 7, 1989, and her claim was closed by Determination Order on June 26, 1989, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled 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 claimant is more or less than the entitlement indicated by the "standards." Former 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).

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 and Education

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

Claimant does not have a high school diploma or a GED certificate, thus, the appropriate value for formal education is 1. Former OAR 436-35-300(3).

The highest specific vocational pursuit (SVP) level demonstrated by a claimant during the ten years preceding the date of determination is used to determine a value for skills. Former OAR 436-35-300(4). For our purposes, permanent disability is determined on the date of hearing. The position which claimant successfully performed during the ten years preceding the date of hearing, which has the highest specific vocational pursuit (SVP) level, was a cashier-checker (DOT # 211.462-014). Therefore, the appropriate value for skills is 3. Former OAR 436-35-300(4).

Whether claimant is entitled to a value for training under former OAR 436-35-300(5) is dependent upon whether or not claimant has demonstrated competence in some specific vocational pursuit. Competence in some "specific vocational pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off the job to perform other than an entry level position. Larry L. McDougal, 42 Van Natta 1544 (1990).

Here, claimant has demonstrated competence in several specific vocational pursuits. Therefore, the appropriate training value is a 0. Former OAR 436-35-300(5).

Adaptability

The adaptability value for a claimant who is not working as a result of her compensable injury is determined by the residual physical capacity, without regard to the claimant's physical capacity prior to the injury. Former OAR 436-35-310(4). When a worker's physical capacity falls within one of the four categories but she has limitations in the ability to sit, stand, walk, carry, stoop, crouch, kneel, or twist, the adaptability value shall be the average of the

value for the category for which they qualify and the value for the next lower category.

Claimant has the physical capacity to perform light work. However, she has limitations in her ability to sit, stand, carry, stoop and twist. The average of the light category, with a value of 4, and the next lower category, sedentary, with a value of 8, is 6. Therefore, the appropriate adaptability value is 6. Former OAR 436-35-310(4).

Impairment

Pursuant to former OAR 436-35-320(4) claimant has a chronic condition limiting repetitive use of the lumbar spine and she is accordingly given a rating of 5 percent impairment of that part.

Claimant's impairment due to loss of range of motion in the lumbar spine includes 2 percent for loss of flexion; 0.5 percent for loss of extension; 1 percent for left lateral flexion; and 1 percent for right lateral flexion for a total range of motion rating of 4.5 percent. Former OAR 436-35-360(6)-(10).

The combined impairment rating is 9.3. Former OAR 436-35-360(11).

Computation of Unscheduled Permanent 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, 4, the sum is 4. When that value is multiplied by claimant's adaptability value, 6, the product is 24. When that value is added to claimant's impairment value 9.3, the result is 33.3 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, 34 percent. We do not find clear and convincing evidence of greater or lesser disability.

ORDER

The Referee's order dated January 23, 1990, as supplemented February 12, 1990, is vacated in part, reversed in part and affirmed in part. That portion of the Referee's order pertaining to the denial of cervical and thoracic injuries is vacated, the insurer's March 6, 1989 denial is reinstated and claimant's request for hearing insofar as it allegedly pertained to the March 1989 denial is dismissed. The Referee's assessed attorney fee award of $2,000 is reversed.

The June 26, 1989 Determination Order is reinstated and modified. In addition to the 22 percent (70.4 degrees) unscheduled permanent disability awarded by the Determination Order, claimant is awarded 12 percent (38.4 degrees) unscheduled permanent disability, giving her a total award to date of 34 percent (108.8 degrees) unscheduled permanent disability for a low back condition. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
RUTH V. JOHNSTON, Claimant
WCB Case No. C0-00410
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Callahan & Gardner, Claimant Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board Members Nichols, Brittingham and Crider.

On December 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 $4,500 by Norpac Foods, Incorporated, claimant fully releases her right to future workers' compensation benefits, except medical services, for her 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.

IT IS SO ORDERED.

Board Member Brittingham, concurring.

A proposed disposition must be set aside if we find that it is unreasonable as a matter of law. ORS 656.236 (1) (a). A disposition is unreasonable as a matter of law if a reasonable factfinder could only conclude that the agreement is unreasonable as a matter of fact. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990) (emphasis supplied). Here, the facts may well support both a reasonable or an unreasonable deal. The dissent makes inferences and assumptions that would support an unreasonable finding.

As a reasonable factfinder, not only am I able to envision the dissent's scenario, I am also able to envision others that would be reasonable. If I am not able to only conclude that the agreement is unreasonable, then I must approve the agreement.

Therefore, I concur with the majority opinion.

Board Member Crider, dissenting.

Claimant has entered into a bargain in which she gives up far, far more than the tiny sum she gains. If the Legislature, which made it impossible for a claimant to release future rights in an accepted claim without Board approval, intended the Board to function as anything other than a rubber stamp, it must have intended that we disapprove bargains such as this one. The Board, however, has approved the agreement. I must dissent.

Claimant was compensably injured in a fall. As a result, claimant has undergone surgical replacement of the right hip. The claim has never been closed, so we must infer that her compensable condition is not yet medically stationary. The parties stipulate that claimant has not been able to return to work since the injury. Since claimant is neither medically stationary nor able to return to work, she was presumably continuing to receive temporary total disability compensation as required by law at the time she entered into this agreement. ORS 656.268(3).

In view of the fact that claimant is not yet medically stationary, we cannot determine how great will be her permanent disability due to the injury. However, claimant will be entitled to a rating of that disability at the time of claim closure. In view of her hip surgery, it would appear that even if the surgery is marvelously successful, she will be entitled to an impairment value of no less than 13 percent under the Director's standards for rating permanent disability. See OAR 436-35-340(13). Thus, we know that she will be entitled to at least $4,160 in permanent disability compensation. See ORS 656.214(5). Given her age (55), her education (high school) and her lack of vocational training, she will receive well in excess of $4,160 under the standards unless she is able to and does actually return to her usual and customary work. OAR 436-35-310.

In addition to continued temporary disability compensation and permanent disability compensation when this claim is first closed, claimant also retains rights to additional compensation should her condition worsen and to vocational services. We do not know whether claimant will actually worsen and thus become entitled to additional compensation under ORS 656.273 or 656.278 and we do not know whether she will be eligible for vocational services. Nevertheless, we do know, given our expertise in this field, that a person who has undergone a hip replacement surgery is likely to experience some need for additional medical services and related disability compensation during her lifetime.

Claimant has agreed to forego all of these rights for only $4,500. Her attorney will receive 25 percent of that amount, leaving her only $3,375--considerably less than she will receive in permanent partial disability compensation when her claim is closed.

A proposed disposition must be set aside if we find that it is unreasonable as a matter of law. ORS 656.236(1)(a). A disposition is unreasonable as a matter of law if a reasonable factfinder could only conclude that the agreement is unreasonable as a matter of fact. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990). Because it is clear to me that absent this agreement claimant will certainly become entitled in the near future to more than she will be receive under this agreement, the agreement is unreasonable as a matter of law.

In the Matter of the Compensation of
DIANA L. CODY-MILLER, Claimant
WCB Case No. C0-00591
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Francesconi & Associates, Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

On January 2, 1991, 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 United Foam Corporation, claimant fully releases her right to future workers' compensation benefits, except medical services, for her compensable injury. In addition, claimant agrees not to seek chiropractic treatment in excess of two times per month for six months and further agrees not to seek treatment from Dr. Bercovic or his associates. 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 the

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).

Here, the proposed agreement purports to release claimant's further rights to workers' compensation benefits of any type, except medical services payable under her workers' compensation claim. The disposition then provides that claimant will be limited to chiropractic treatment two times per month for six months and will not seek treatment from Dr. Bercovic or his associates. This language directly limits claimant's right to medical services. See ORS 656.245(1); 656.245(3). Any limitation on that right exceeds the bounds of ORS 656.236 and OAR 436-60-145(1). Accordingly, the agreement is unreasonable as a matter of law and is set aside. See ORS 656.236(2).

Following our standard procedure, we would be willing to consider a revised agreement which does not contain provisions exceeding the bounds of the statutes and rules.

IT IS SO ORDERED.

January 22, 1991 Cite as 43 Van Natta 101 (1991)

In the Matter of the Compensation of
BOBBY S. COMER, Claimant
WCB Case Nos. 89-23654 & 89-18400
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Karen M. Werner, Attorney
Cummins, et al., Defense Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Speer and Howell.

CNA Insurance Companies (CNA) requests review of those portions of Referee Davis' order that: (1) assessed penalties and related attorney fees for an allegedly unreasonable denial; and (2) directed it to pay claimant's assessed attorney fees at hearing, although Farmers Insurance Group (Farmers) was found responsible for claimant's condition. Alternatively, CNA contends that the assessed fee of $1,600 is excessive. Farmers cross-requests review of those portions of the Referee's order that: (1) set aside its responsibility denial of claimant's aggravation claim for a worsened low back condition; and (2) upheld CNA's denial of claimant's new occupational disease claim for the same condition. On review, the issues are responsibility and penalties and attorney fees.

The Board affirms and adopts the order of the Referee.

Compensability was litigated and decided at hearing. Therefore, claimant's right to compensation remained at risk on review by virtue of the Board's de novo review authority. Because claimant's compensation was not disallowed or reduced, claimant is entitled to an assessed fee under ORS 656.382(2). Tanya L. Baker, 42 Van Natta 2818 (1990). Because CNA sought Board review and Farmers cross-requested review, the two insurers jointly placed claimant's compensation at risk and, therefore, are jointly responsible for the assessed attorney fee for claimant's counsel's services on Board review. See Cigna Insurance Companies v. Crawford & Co., 104 Or App 329 (1990).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $200, payment to be made equally between CNA and Farmers. In reaching this conclusion, we have particularly considered the complexity of the issue, the time devoted to the issue as represented by claimant's respondent's brief, and the value of the interest involved.

ORDER

The Referee's order dated February 7, 1990 is affirmed. For services on Board review, claimant's counsel is awarded a reasonable assessed fee of $200, to be paid in equal shares of $100 by CNA Insurance Companies and Farmers Insurance.

January 22, 1991 Cite as 43 Van Natta 102 (1991)

In the Matter of the Compensation of
WILLIE MAE DEROSS, Claimant
WCB Case Nos. C0-00536 & C0-00532
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Coons & Cole, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

On December 19, 1990, the Board acknowledged receipt of the parties' claim disposition agreement and addendum in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $26,000 (claim no. 10840100) and $1,000 (claim no. 01531680) by Roseburg Forest Products, claimant fully releases her right to future workers' compensation benefits, except medical services, for her compensable injury. In addition, claimant agrees to return this consideration to the self-insured employer in the event that a subsequent "violation" of the agreement causes the assessment of any increased claims costs to the self-insured employer under these claims other than for medical benefits." We set aside the proposed disposition.

We consider the following portion of the proposed disposition contrary to statutory and administrative prerequisites. Specifically, the agreement provides that in the event of "any violation of this stipulation which causes the assessment of any increased claims costs to [the self-insured employer] under these claims other than for medical benefits, [the violation] shall vest with [the self-insured employer] certain contractual rights and civil remedies for the return of their money, the sum of $27,000 which is payable hereunder." Page 4, Lines 9-15. Once approved, a claim disposition is final. ORS 656.236(1), (2). Furthermore, it is impermissable to make approval of a claim disposition agreement contingent on a subsequent event. See James J. Treml, 42 Van Natta 2594 (1990) (ORS 656.236 does not permit approval of a claim disposition agreement to be contingent on the approval of a disputed claim settlement). We consider this rationale to be equally applicable to a provision purporting to effectively make disapproval of a disposition contingent on a subsequent event.

Inasmuch as the offensive portions of the parties' agreement cannot be excised without substantially altering the bargain underlying the exchange of consideration, we are without authority to approve any portion of the proposed disposition. Karen A. Vearrier, 42 Van Natta 2071 (1990). Consequently, the disposition is set aside. 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 438-09-001 et seq.

We note parenthetically that there is a discrepancy in the amount of the attorney fees payable to claimant's attorney according to the terms of the agreement and the amounts that appear in the summary sheets, although the amount stated in the agreement is within the amount allowed under OAR 438-15-052 and thus would not be subject to disapproval under that rule.

IT IS SO ORDERED.

In the Matter of the Compensation of
NANCY C. EVENHUS, Claimant
WCB Case No. 90-0625M
OWN MOTION ORDER ON RECONSIDERATION
Brian Whitehead, Claimant Attorney
John E. Snarskis, Defense Attorney

Industrial Indemnity requests reconsideration of the Board's December 27, 1990, Own Motion Order which reopened claimant's claim for the payment of additional temporary disability benefits and authorized reimbursement of those benefits from the Reopened Claims Reserve. Industrial Indemnity now requests additional authorization of reimbursement from the Reserve for claim costs it may voluntarily reimburse to another insurer. We deny the request.

The relevant facts follow. Claimant compensably injured her left knee on August 25, 1980. Industrial Indemnity accepted the claim and processed it to closure. In September 1986, claimant fell and tore the medial meniscus in the left knee while working for another employer. She underwent surgery for the worsened knee condition on December 1, 1986, and filed a claim for the worsening with Industrial Indemnity. Industrial Indemnity denied responsibility for the claim. Because claimant's aggravation rights on the 1980 claim had expired, the claim for worsening was subject to the Board's own motion authority under former ORS 656.278. Yet, Industrial Indemnity did not submit the claim to the Board.

Meanwhile, Liberty Northwest accepted claimant's "new injury" for the left knee condition. Liberty Northwest later rescinded its acceptance, but a Referee and the Board found that Liberty Northwest remained responsible for the knee condition. Nancy C. Evenhus, 41 Van Natta 1023 (1989). Liberty Northwest processed the "new injury" claim to closure. The claim was closed by Determination Order on November 11, 1988, with awards of temporary total disability benefits from December 1, 1986, through February 1, 1987, and 5 percent scheduled permanent partial disability.

The Court of Appeals subsequently reversed the Board order and remanded for further consideration. Camlu Retirement Center v. Evenhus, 102 Or App 603 (1990). On remand, we upheld Liberty Northwest's denial and, instead, found Industrial Indemnity responsible for claimant's knee condition and resulting surgery. Nancy C. Evenhus, 42 Van Natta 2615 (1990). Thereafter, Industrial Indemnity submitted the claim to the Board for own motion relief under ORS 656.278 and recommended claim reopening for the payment of temporary disability benefits commencing December 1, 1986, the date of surgery. Industrial Indemnity also requested Board authorization of reimbursement from the Reopened Claims Reserve for any benefits paid under the Board's own motion authority. See ORS 656.625.

By Own Motion Order dated December 27, 1990, the Board concluded that claimant was entitled to reopening of the 1980 injury claim with temporary disability benefits to commence December 1, 1986. However, because claimant had

already received temporary disability benefits from Liberty Northwest for the period of disability following surgery, the Board ordered the payment of additional temporary disability benefits only insofar as benefits owed by Industrial Indemnity exceeded what claimant received from Liberty Northwest. The Board also authorized reimbursement for any temporary disability benefits paid by Industrial Indemnity pursuant to the order. Thereafter, Industrial Indemnity issued a Notice of Closure on January 4, 1991, which declares that temporary disability benefits were paid for the period from December 1, 1986, through February 1, 1987.

On reconsideration, it now appears that Liberty Northwest is seeking reimbursement from Industrial Indemnity for temporary disability benefits paid by Liberty Northwest. Industrial Indemnity contends, therefore, that it should be reimbursed from the Reopened Claims Reserve for any amounts it voluntarily reimburses to Liberty Northwest. We disagree based on the following reasoning.

ORS 656.625(1) provides that the Director "shall establish a Reopened Claims Reserve within the Insurance and Finance Fund for the purpose of reimbursing the additional amounts of compensation payable to injured workers that results from any award made by the board pursuant to ORS 656.278 after January 1, 1988." Notwithstanding any other provision of law, any reimbursement from the Reserve shall be in such amounts as the Board prescribes. ORS 656.625(1). These provisions became operative January 1, 1988. Oregon Laws 1987, ch 884, 63; Andy Webb, 40 Van Natta 586 (1988). Consequently, effective January 1, 1988, reimbursement from the Reserve is permitted for only those awards made by the Board pursuant to ORS 656.278.

Therefore, the dispositive issue in this case is whether Industrial Indemnity's voluntary reimbursement to Liberty Northwest would qualify as an award made by the Board pursuant to ORS 656.278. Reimbursement between carriers is a matter within the exclusive jurisdiction of the Director of the Department of Insurance and Finance. ORS 656.307(3); Liberty Northwest Ins. Corp. v. SAIF, 99 Or App 729 (1989); Kathryn D. Wagner, 42 Van Natta 1981, 1985 (1990). Absent the issuance of a Director's order pursuant to ORS 656.307, there is no authority which permits the Board to order reimbursement between carriers. See id.

Here, an order did not issue pursuant to ORS 656.307. Thus, the Board has no authority to order reimbursement between Liberty Northwest and Industrial Indemnity. Absent such authority, any voluntary reimbursement between the carriers cannot qualify as an award made by the Board pursuant to ORS 656.278. Accordingly, the Board is unable to authorize reimbursement from the Reopened Claims Reserve for any claims costs that Industrial Indemnity voluntarily reimburses to Liberty Northwest.

Our December 27, 1990, order is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our December 27, 1990, order in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT G. SMITH, Claimant
WCB Case Nos. 89-05547 & 89-00232
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Dennis L. Ulsted (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Gruber's order which: (1) declined to assess a penalty and attorney fee for the SAIF Corporation's allegedly unreasonable initial processing of a claim as an aggravation

rather than a new injury; (2) declined to award an attorney fee for securing acceptance of a new injury claim; (3) declined to assess a penalty and attorney fee for SAIF's alleged failure to timely accept or deny the new injury claim; (4) declined to assess a penalty and attorney fee for SAIF's failure to timely provide discovery of claimant's taped statement; and (5) awarded an assessed attorney fee of $250 for services related to SAIF's unreasonable failure to submit a surgical report to the Department of Insurance and Finance (DIF) at the time the claim was submitted for closure. On review, the sole issues are penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" as corrected on reconsideration.

CONCLUSIONS OF LAW AND OPINION

Failure to Initially Process the Claim as a New Injury

Claimant seeks a penalty and associated attorney fee for SAIF's allegedly unreasonable failure to originally process his January 4, 1988 claim as a new injury, rather than an aggravation.

Because of its investigative report of February 23, 1988, SAIF had knowledge of an "incident" which occurred at work on January 4, 1988. However, claimant's treating physician did not clearly, causally link the incident to a worsening of claimant's underlying condition, which would have sufficiently provided SAIF with notice of a new injury claim. We find that SAIF first received notice of a new injury claim when it received the letter from claimant's attorney dated March 17, 1989, requesting a hearing. Accordingly, SAIF's original acceptance of the January 1988 claim as an aggravation, under these circumstances, was reasonable. Consequently, no penalties and/or attorney fees are warranted for unreasonable resistance to the payment of compensation.

However, to the extent that acceptance of a new injury results in increased temporary total disability benefits, an out-of-compensation attorney fee of 25 percent of the increased compensation shall be approved. ORS 656.386(2).

Attorney Fee for Securing Acceptance of a New Injury Claim

Claimant next argues that his attorney is entitled to an assessed fee for securing acceptance of the new injury claim. We disagree.

After SAIF received claimant's attorney's letter of March 17, 1989, informing it that claimant had suffered a new injury in January 1988, SAIF accepted a new injury, before going to hearing. Accordingly, because claimant did not finally prevail against rejected (denied) new injury claim in a hearing before a Referee, his attorney is not entitled to an assessed attorney fee. See Duane L. Jones, 42 Van Natta 875 (1990). Additionally, because we have found that SAIF was not unreasonable in not accepting a new injury from the start, no penalty-related attorney fee is warranted. ORS 656.262(10); ORS 656.382(1). As noted above, claimant's attorney is entitled to a fee out of any additional temporary disability compensation obtained.

Penalty and Attorney Fee for Failure to Timely Accept or Deny a New Injury Claim

Claimant next argues that a penalty and attorney fee are due because of SAIF's failure to timely accept or deny the new injury claim. We disagree.

As noted above, SAIF did not receive notice of a new injury claim until it received the letter from claimant's attorney dated March 17, 1989. SAIF accepted the claim by letter dated May 16, 1989, 59 days later. (Ex. 18). Accordingly, SAIF's acceptance of the claim was not untimely. Former ORS 656.262(6). SAIF did not delay acceptance or denial of claimant's new injury claim. Claimant is not entitled to a penalty or attorney fee. ORS 656.262(10); ORS 656.382(1).

Penalty and Attorney Fee for Failure to Timely Provide Discovery

Claimant next argues that he is entitled to a penalty and attorney fee for SAIF's failure to timely provide discovery of claimant's taped statement. The Referee found that a taped statement was not a claims document and, thus, stated that SAIF was not obligated to provide it until specifically requested. We agree that no penalty or attorney fee is warranted, but disagree with the Referee's reasoning.

We have previously held that videotapes are "documents" within the meaning of OAR 438-07-017, pertaining to impeachment evidence, and must be disclosed prior to the close of hearing. Jon A. Hissner, 42 Van Natta 2731 (1990). In this case, we also find that video and audio tapes are "documents" within the meaning of OAR 438-07-015. Because SAIF is not contending that it withheld claimant's tape recorded statement as impeachment evidence, it should have provided the taped statement along with all other documents pertaining to this claim. SAIF offers no reason why it did not provide the taped statement.

Accordingly, we find that SAIF's failure to provide the document was unreasonable. However, there has been no showing that the failure to provide the tape resulted in delayed payment of compensation or constituted unreasonable resistance to the payment of compensation. Nor has is been shown that any compensation was "then due" during the delay. Consequently, claimant is not entitled to a penalty or attorney fee. Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (1989).

Attorney Fee for Prevailing on the Issue of SAIF's Failure to Provide a Medical Report to DIF

Claimant prevailed, at hearing, on the issue of a penalty and attorney fee for SAIF's failure to provide a medical report to the Evaluation Section of DIF. The Referee found that SAIF's failure to provide the report was unreasonable. He found that he was unable, however, to determine the amount of any increase in permanent disability and thus, was unable to determine whether there were any amounts "then due" on which to base a penalty. He did award claimant's attorney an assessed fee of $250 for unreasonable resistance to the payment of compensation.

Here, claimant does not request Board review of the Referee's refusal to award a penalty. Rather, we are requested to determine the appropriateness of the $250 attorney fee. We find that claimant received 4 percent impairment for an unoperated disc (Ex. 18), and note that if the Evaluation Section had had the operative report, claimant probably would have been entitled to an additional 1 percent impairment value for a laminectomy with single discectomy. Former OAR 436-35-350(2). Considering the factors at OAR 438-15-010(6), particularly the value of the compensation which was the subject of unreasonable resistance, the benefit obtained and the uncomplicated nature of the issue, we conclude that $250 was an appropriate attorney fee.

ORDER

The Referee's order dated September 15, 1989, as reconsidered January 10, 1990, is reversed in part and affirmed in part. That portion of the Referee's order which declined to award an out-of-compensation attorney fee for failure to initially process claimant's claim as a new injury is reversed. Claimant's attorney is awarded an approved fee, not to exceed $3,800, of 25 percent of the additional temporary disability compensation to which claimant is entitled as a result of his claim being reclassified as a new injury rather than an aggravation. The attorney fee shall be paid directly to claimant's attorney. The remainder of the order is affirmed.

In the Matter of the Compensation of
EDWIN L. CARSON, Claimant
WCB Case No. 89-08904
ORDER ON REVIEW (REMANDING)
David Schieber (Saif), Defense Attorney

Claimant, pro se, requests review of Referee Brown's order which approved a stipulation, on the record, in which claimant withdrew his request for hearing upon the terms and conditions set forth in the Referee's order. Claimant contends that the order should be set aside and the request for hearing reinstated. On review, the issue is reinstatement of the request for hearing. We remand.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant agreed to withdraw his request for hearing on the compensability of his occupational disease claim for stress and diabetes in exchange for the SAIF Corporation paying a penalty and associated attorney fee for late denial.

On review, claimant asserts two bases for setting aside the Order on Stipulation: (1) the stipulation is "flawed" in that it incorrectly identifies Southern Oregon State College (SOSC) as his at-injury employer; and (2) he received inadequate legal advice. Although the order contains the scrivener's error alleged by claimant, we do not find that error dispositive on the validity of the order. Turning to claimant's second contention, we find that although claimant was present at the hearing and represented by counsel, the record is silent on whether claimant understood the terms of the stipulation and assented to those terms. In this regard, we especially note the absence of either claimant's signature on the stipulation or his verbal assent in the transcribed record.

Since our review is restricted to the record created by the Referee, and since that record is not sufficient for the Board to determine whether claimant understood and freely entered into the stipulation, we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(3) and (5). Therefore, we vacate the Referee's order and remand the case to Referee Brown, with instructions to hold a hearing concerning the issues raised by claimant.

Should the Referee determine that claimant understood the terms of the stipulation and agreed to those terms, the Referee shall reinstate the stipulated order by means of a final, appealable order. In the event that the Referee finds that claimant did not understand the stipulation's terms or did not agree to those terms, the Referee shall issue an interim order declaring

that the stipulated order shall remain vacated and shall schedule a hearing regarding the merits of claimant's hearing request. Following the hearing on the merits, the Referee shall issue a final, appealable order incorporating his interim order.

IT IS SO ORDERED.

In the Matter of the Compensation of
PRIMROSE T. MORGAN, Claimant
WCB Case No. 89-21433
ORDER ON REVIEW (REMANDING)
Bischoff & Strooband, Claimant Attorneys
Ron Pomeroy (Saif), Defense Attorney

Claimant, pro se, requests review of Referee Brown's order which: (1) found that claimant had withdrawn her hearing request; and (2) dismissed her request for hearing. On review, the issue is the propriety of the Referee's dismissal. We remand.

FINDINGS OF FACT

On October 25, 1989, claimant timely filed a Request for Hearing. The Hearings Division issued a Notice of Hearing on November 1, 1989, setting a hearing date of February 27, 1990. On February 22, 1990, claimant's former attorney notified the Referee that claimant was withdrawing her request for hearing. The attorney sent a copy of this notification to the SAIF Corporation's counsel, but not to claimant. No hearing was held. On March 2, 1990, the Referee issued an Order of Dismissal.

Claimant timely requested Board review, stating, that she was advised by her attorney not to be present at the November 27, 1989 Informal Dispute Resolution Conference, that she heard nothing about what was said or decided at this conference, and that she could not understand how or why the Referee dismissed a case as serious as her head injury.

CONCLUSIONS OF LAW AND OPINION

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(3) and (5). Other than claimant's request for Board review, the record does not contain any correspondence or exhibits concerning the circumstances surrounding the dismissal of her request for hearing. Likewise, the Order of Dismissal recites only that claimant's request for hearing had been withdrawn. Furthermore, because the case was dismissed without a hearing, no transcript exists.

Claimant asserts on review that she did not withdraw her request for hearing. Since our review is restricted to the record created at the hearing, the record is inadequate to determine whether claimant withdrew her hearing request. Consequently, we find that the record has been "improperly, incompletely or otherwise insufficiently developed." Id.

Therefore, we vacate the Referee's order and remand the case to Referee Brown with instructions to determine whether claimant withdreww her hearing request and whether the dismissal was justified. The processing to make such a determination shall be held in any manner that achieves substantial justice.

Should the Referee determine that dismissal was justified, he shall issue a final appealable dismissal order. Should the Referee find that claimant's hearing request should not have been dismissed, the Referee shall issue an interim order declaring that his March 2, 1990 order shall remain vacated, and the Referee shall proceed to a hearing on the merits of the issues raised in claimant's hearing request.

Following the hearing on the merits, the Referee shall issue a final, appealable order incorporating his Interim order. The proceedings concerning the dismissal issue and the hearing on the merits may be held in one proceeding, if the Referee determines that such a procedure will achieve substantial justice to all parties.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD E. SYLER, Claimant
WCB Case No. C0-00541
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Callahan & Gardner, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

On December 20, 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 $40,000 by Beachcraft Marine Corporation, through its claims administrator, Alexis Risk Management Service, claimant fully releases his right to future workers' compensation benefits for his compensable injury. We set aside the proposed disposition.

We will 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 the 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 of under ORS 656.236 and the rules promulgated thereunder. See OAR 436-60-145(1); 438-09-001(1).

Here, the proposed disposition purports to release all workers' compensation benefits, except medical services, in regard to claimant's compensable injury. The disposition then provides that a portion of the $40,000 consideration "represents a compromised valuation" of, among other things, "future medical expenses." This language could reasonably be interpreted to limit claimant's right to medical services under ORS 656.245 for his compensable injury. Any limitation on that right exceeds the bounds of ORS 656.236 and OAR 436-60-145(1) and 438-09-001(1). Accordingly, the proposed disposition is unreasonable as a matter of law and is set aside on this basis. See ORS 656.236(2).

Therefore, we are unable to approve the parties' proposed disposition. Following our standard acknowledgment procedures, we would be willing to consider a revised agreement which does not contain provisions exceeding the bounds of the statutes and rules.

IT IS SO ORDERED.

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
SECOND ORDER ON RECONSIDERATION
Allen, Stortz, et al., Claimant Attorneys
Winslow & Alway, Attorneys
Saif Legal Department, Defense Attorney

On November 14, 1990, we abated our October 24, 1990 Order on Reconsideration, which had adhered to our September 13, 1990 order that dismissed the Department of Insurance and Finance's request for Board review on the ground that we lacked jurisdiction to consider the request. We took this action in response to the Department's request to submit further argument on the issue of whether we have jurisdiction to review the Referee's order. Having received additional argument from the Department and claimant, we proceed with our reconsideration.

The relevant facts are as follows. A Director's proposed order found Patrick M. Arnold, the alleged employer, to be noncomplying. The Department referred claimant's injury claim to the SAIF Corporation for processing pursuant to ORS 656.054. Arnold requested a hearing, contesting the noncompliance order. Meanwhile, SAIF accepted the claim and began providing benefits.

Before the hearing, both SAIF and the Department waived appearance. At hearing, the sole issue was the Director's proposed order of noncompliance. Finding that claimant's employment was casual, the Referee concluded that claimant was not a subject worker. Reasoning that the alleged employer was not a subject employer, the Referee set aside the Director's noncompliance order. Despite the aforementioned conclusions, the Referee directed SAIF to continue processing the claim as a compensable claim and to pay an attorney fee. The Referee's December 16, 1988 order notified the parties that any appeal should be directed to the Board.

On February 14, 1989, the Department moved for reconsideration of the Referee's order. Noting that the only issue at hearing was the noncompliance order, the Department contended that the Referee lacked authority to direct SAIF to continue to process the claim and to award an attorney fee. Furthermore, the Department asserted that the appropriate appellate forum was the Court of Appeals pursuant to ORS 656.740(4) and ORS 183.482.

On March 16, 1989, the Referee issued an Order on Reconsideration republishing his December 16, 1988 order. However, the Referee's reconsideration order stated that any appeal of his order should be directed to the Court of Appeals.

On March 27, 1989, the Department requested Board review. We dismissed the request, concluding that since a matter concerning a claim was not contested at hearing, proper review of the Referee's order was before the Court of Appeals. We relied on ORS 656.740(4)(c), which provides as follows:

> "When an order declaring a person to be a noncomplying employer is contested at the same hearing as a matter concerning a claim pursuant to ORS 656.283 and 656.704, the review thereof shall be as provided for a matter concerning a claim." (Emphasis supplied).

In dismissing the request for review, we further noted that the Referee exceeded the scope of his authority in addressing a compensability issue. Thus, we reasoned that the Referee's direction to continue providing compensation and to pay an attorney fee was gratuitous.

On reconsideration, the Department contends that we have jurisdiction over this case because the Referee's order addressed a "matter concerning a claim pursuant to ORS 656.283 and 656.704." See ORS 656.740(4)(c). We acknowledge that the Referee's order purported to direct SAIF to continue providing benefits and to pay an attorney fee. Furthermore, had the issue of compensability, or any other matter concerning the amount of or entitlement to compensation, also been contested at the hearing regarding the noncompliance order, we would agree that jurisdiction to consider the Referee's order rests with this forum. ORS 656.704(3); 656.740(4)(c).

Yet, as we have previously explained, neither compensability nor any other issue concerning a worker's right to receive compensation, or the amount thereof, was directly in issue or contested at the hearing. Under such circumstances, the appropriate appellate forum is the Court of Appeals as provided in ORS 183.310 to 183.550. ORS 656.740(4).

In adhering to our prior conclusion that we are without authority to review the Referee's order, we note that the Department reached a similar assessment in its February 14, 1989 motion for reconsideration to the Referee. Thus, although we continue to regret the inaccurate statement of appeal rights on the Referee's December 16, 1988 order, it would appear that the Department was aware of where its appeal should be directed. In any event, the Referee corrected this inaccuracy in his March 16, 1989 reconsideration order, which advised the parties to seek judicial review of his order. However, rather than avail itself of the opportunity to seek judicial review, the Department requested Board review.

We also reiterate that the Referee exceeded the scope of his authority in addressing issues other than the noncompliance issue. We further note that not only were the Referee's directions gratuitous, but contrary to current law. See Juan A Garcia, 42 Van Natta 2632, 2797 (1990) (Where noncompliance order finding an individual to be an employer on claimant's date of injury was finally set aside, SAIF was not precluded from denying claimant's previously accepted claim because it no longer was providing coverage under ORS 656.017 and 656.054).

Finally, assuming for the sake of argument that the Board is the proper forum to consider an appeal from the Referee's order, we would still lack jurisdiction. We reach this conclusion based on the following reasoning.

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

The time within which to appeal an order continues to run, unless the order had been "stayed," withdrawn or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986). In order to abate and allow reconsideration of an order issued under ORS 656.289(1), at the very least, the language of the second order must be specific. Farmers Insurance Group v. SAIF, 301 Or 612, 619 (1986).

Here, the Referee's order issued December 16, 1988. No response to that order was submitted until the Department's February 14, 1989 motion for reconsideration. On March 16, 1989, the Referee issued an Order on Reconsideration

adhering to his prior order and notifying the parties that any appeal should be directed to the Court of Appeals. On March 27, 1989, the Department requested Board review.

Thus, the Department requested Board review within 30 days of the Referee's reconsideration order. Yet, the Referee's reconsideration order issued more than 30 days after the Referee's December 16, 1988 order. Moreover, the December 16, 1988 order was neither abated, withdrawn, stayed, modified, nor republished prior to the issuance of the March 16, 1989 reconsideration order.

A Referee cannot by letter or order extend the appeal period beyond the time permitted by statute. Farmers Insurance Group v. SAIF, supra. Consequently, even assuming that the Referee's December 16, 1988 order was subject to the appeal rights of ORS 656.289(3), the 30-day statutory appeal period from that order elapsed unabated without a timely request for Board review. Under such circumstances, neither we nor the Referee would have authority to further consider the matter.

Accordingly, we withdraw all our prior orders. On reconsideration, as supplemented herein, we adhere to and republish our August 15, 1990 and October 24, 1990 orders. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID B. ALLEN, Claimant
WCB Case No. 89-24372
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Spangler's order which: (1) upheld the insurer's denial of claimant's current low back condition; and (2) declined to assess a penalty and attorney fee for an allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees.

We affirm and adopt the Referee's order with the following exception. The Referee sua sponte raised the issue of the procedural validity of the denial as a preclosure denial. Because neither party raised that issue it was not properly before the Referee. Boise Cascade Corporation v. Katzenbach, 307 Or 391 (1989). Accordingly, we do not adopt that portion of the Referee's order which discusses the procedural validity of the denial.

ORDER

The Referee's order dated April 25, 1990 is affirmed.

In the Matter of the Compensation of
DAVID W. BELSHEE, Claimant
WCB Case Nos. 87-01107, 86-06951, 86-04811, 85-12805 & 85-12804
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Brian L. Pocock, Defense Attorney
Lester R. Huntsinger (Saif), Defense Attorney
Schwabe, et al., Defense Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Speer and Howell.

Aetna Casualty Company requests review of Referee Gruber's order that: (1) set aside its denial of claimant's "new injury" claim for his current low back condition; (2) upheld the SAIF Corporation's denials of claimant's medical services claims for the same condition under 1970 and 1975 compensable injury claims; (3) upheld Pacific Insurance's denial of claimant's aggravation claim for the same condition; and (4) upheld Wausau Insurance Company's denial of claimant's aggravation claim for the same condition. On review, the issue is responsibility. We affirm in part and reverse in part.

FINDINGS OF FACT

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

The first sentence of the next-to-last paragraph on page three is replaced with: "The August 28, 1975 injury was accepted as a new injury by SAIF Corporation."

The last sentence of the next-to-last paragraph on page four is replaced with: "A July, 1981 Stipulation between claimant and Pacific Insurance allowed claimant 10 percent unscheduled permanent disability related to the April 1980 back strain."

CONCLUSIONS OF LAW AND OPINION

The Referee correctly noted that the Court of Appeals' decision in Industrial Indemnity Company v. Kearns, 74 Or App 583 (1984), imposes a presumption in this case. However, the Referee then found that Aetna Casualty Company (Aetna) failed to prove that claimant's work with its insured did not contribute independently to claimant's disability and concluded therefore that Aetna is responsible for claimant's current condition. We disagree.

Aetna never accepted claimant's 1985 injury claim. Inasmuch as Kearns allocates the burden of proof among carriers with accepted injuries only, that case does not establish Aetna's burden. Accordingly, we proceed to analyze the responsibility issue as among carriers with accepted injuries first.

Responsibility between carriers with accepted claims

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. Kearns, supra; Linda L. Wise, 42 Van Natta 115 (1990); Fransisca Garcia, 42 Van Natta 2050 (1990).

However, the insurer with the most recent accepted claim, as well as all prior accepting insurers, may escape liability by establishing that a subsequent

injury or exposure independently contributed to claimant's current problems or that a previously accepted injury or injuries are entirely responsible for the condition giving rise to the current claim.

Here, SAIF accepted low back claims for 1970 and 1975 injuries; Pacific Insurance (Pacific) accepted a claim for a 1980 low back condition; and Wausau Insurance Company (Wausau) accepted a claim for a 1984 low back injury.

Claimant variously testified that his symptoms remained the same since 1970 and that they worsened over the years. (Tr. 45-48).

The only medical opinions addressing the potential contribution of claimant's various injuries and exposures to his current problems are those of Drs. Sargent and Martens. Sargent, family physician, treated claimant from January 1, 1986 until March 24, 1987. On September 23, 1987, after reviewing claimant's medical records since 1970, Sargent concluded that there had been no overall change in claimant's disability over the years. (Ex. 194-20).

Dr. Martens, who treated claimant intermittently since 1970, consistently diagnosed recurrent lumbosacral strains, following claimant's repeated back injuries. Martens examined claimant on July 1, 1987, interpreted current x-rays and described claimant's "recurrences of low back pain 1-6 times per year." (Ex. 193A). Martens noted: "By [claimant's] own admission his symptoms today are no different than they have been since he had recurrent low back pain since 1970." (Ex. 193A-4). We interpret Martens' opinion to be that each recurrence of increased low back symptoms represented a temporary worsening of the original, underlying injury. Martens' opinion is thorough, well-reasoned and based on a complete history. For these reasons, as well as his advantage of having treated claimant since 1970, we are persuaded by Martens' opinion and conclude that claimant's condition has not changed, except temporarily and periodically, since the first compensable injury in 1970. In this regard, we also note that there is no medical evidence addressing claimant's current condition which indicates otherwise. That is, there is no indication that the temporary recurrent problems in 1975, 1980 and 1984 presently contribute to claimant's low back condition.

In reaching this conclusion, we acknowledge that claimant received a 20 percent permanent disability award under his 1975 injury claim with SAIF and a 10 percent permanent disability award by stipulation under his 1980 low back claim with SAIF. (Exs. 68, 142). We nonetheless remain persuaded, by Dr. Martens' opinion, that claimant's condition has not changed, except temporarily, since his 1970 injury. See City of Portland v. Duckett, 104 Or App 318 (1990). (A claimant may completely recover from an injury for which permanent partial disability compensation was awarded.) Accordingly, SAIF, under the 1970 claim is responsible for claimant's current condition, unless it shifts responsibility to the remaining, subsequent insurer, Aetna.

Responsibility between SAIF and Aetna

The Referee found that Aetna has the burden of proving that the work activities which claimant performed, while employed at Aetna's insured, did not contribute independently to claimant's current condition. As we have explained, that burden does not rest with Aetna, because the claim against Aetna has never been accepted or ordered accepted.

Moreover, in assigning responsibility to Aetna, the Referee relied on the opinion of Dr. Sargent. We do not find Sargent's opinion persuasive in this regard, for the following reasons. Because Sargent did not examine claimant until January 1986, he did not have first-hand knowledge of claimant's back condition

prior to his job with Aetna's insured. (Exs. 184-5, 190-3). Moreover, even if Sargent's opinion was otherwise persuasive, he did not express sufficient certainty to establish that the work in question did contribute to claimant's underlying condition. In this regard, we note that Sargent opined that the "kind of employment which [claimant] had with [Aetna's insured] was the kind of thing which could cause back injuries. . . ." (Ex. 193, emphasis added).

In this case, to shift responsibility to a subsequent employer/insurer, SAIF 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. Hensel Phelps Const. v. Mirich, 81 Or App 290 (1986).

As we have explained, we are persuaded by the opinion of Dr. Martens that, although claimant suffered numerous symptomatic recurrences, his underlying back condition has not worsened. Inasmuch as there is no persuasive medical evidence that claimant's work accidents or exposures since 1970 -- including those during his employment at Aetna's insured -- caused a worsening of his low back condition, we conclude that SAIF has failed to shift responsibility to Aetna. Accordingly, SAIF remains responsible for claimant's medical services related to his compensable condition.

Finally, since claimant unsuccessfully sought on review the affirmation of the Referee's order, we conclude that his participation has not been meaningful and that he should receive no attorney fee for his services on review.

ORDER

The Referee's order dated February 2, 1988 is reversed in part and affirmed in part. That portion of the order that set aside Aetna Causalty Company's denial is reversed and the denial is reinstated and upheld. That portion of the order that upheld the SAIF Corporation's denial of claimant's medical service claim under the 1970 injury is reversed. The denial is set aside and the claim is remanded to SAIF for further processing according to law. SAIF is responsible for the Referee's $1,400 attorney fee award. The remainder of the Referee's order is affirmed.

January 24, 1991 Cite as 43 Van Natta 115 (1991)

In the Matter of the Compensation of
SUSAN L. BULLOCK, Claimant
WCB Case No. 89-21786
ORDER ON REVIEW
Garlock, Smith & Associates, Claimant Attorneys
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Peterson's order that: (1) upheld the insurer's denial of claimant's neck condition and resulting treatment; and (2) declined to assess penalties and related attorney fees for an allegedly unreasonable denial. On review, the issues are procedural propriety of the insurer's denial, compensability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant, who worked many years as a fruit packer, experienced left arm and shoulder pain on March 7, 1988, that prevented her from working. The employer filled out a Form 801 on which it identified claimant's injury as a "left

shoulder strain." The employer initially denied the claim, but subsequently accepted it by stipulation on May 27, 1988. (Ex. 12).

On March 10, 1988, claimant complained of pain in the shoulders, neck and back, and numbness in both hands to Dr. Phillips, chiropractor, who diagnosed left shoulder strain and acute cervicothoracic strain. (Ex. 2).

Claimant improved with conservative care, but continued to have numbness and loss of grip in both hands. Phillips referred claimant to Dr. Durkan, orthopedist, who examined claimant on May 23, 1988. (Ex. 3). Claimant was independently examined on the same date by the Orthopaedic Consultants. (ex. 4). Claimant complained to both of pain in the left upper arm and shoulder, and tingling in the left fingers.

Claimant's condition continued to deteriorate. On September 7, 1988, she was examined by Dr. Johnson, neurosurgeon. Claimant complained of right shoulder and arm pain with tingling and paresthesia in both hands. As a result, she was operated on for bilateral carpal tunnel syndrome in December 1988.

After the carpal tunnel surgery, claimant continued to have neck, bilateral shoulder and interscapular pain, chronic cervical muscle spasm, headache, radicular left arm pain and numbness radiating into the left thumb.

Claimant was examined by the Orthopaedic Consultants and Dr. Wilson in February 1989. She complained of bilateral shoulder pain, right and left elbow pain, and weakness and numbness in both hands.

Dr. Phillips referred claimant to Dr. Brett, neurosurgeon, who, in June 1989, diagnosed a disc protrusion at C5-6 with compression of the nerve root on the left. Brett recommended a discectomy and fusion at C5-6. (Ex. 13).

Claimant had another independent medical examination by the Orthopaedic Consultants on July 10, 1989. She continued to complain of bilateral shoulder pain, right worse than left, bilateral numbness in her hands, and neck pain when she lay down. (Ex. 14).

The Emanuel Pain Center performed physical and psychological evaluations on August 21, 1989. Claimant's primary complaints were of bilateral shoulder pain, weakness in the right arm and pain in the left forearm. (Ex. 17).

Dr. Brett performed a cervical discectomy and fusion on September 9, 1989. (Ex. 19).

On October 20, 1989, the insurer denied claimant's claim for her neck condition and the ensuing cervical discectomy and fusion as well as continuing chiropractic care.

FINDINGS OF ULTIMATE FACT

The insurer's denial is limited to claimant's neck condition and ensuing medical treatment for that condition.

Claimant's neck condition is materially related to her March 7, 1988 industrial injury.

CONCLUSIONS OF LAW AND OPINION

The Referee upheld the insurer's October 20, 1989 denial in its entirety and dismissed claimant's Request for Hearing with prejudice. There was no basis

for dismissing claimant's hearing request. Dismissal was not an issue raised at hearing, nor did the Referee address this issue elsewhere in his order. A hearing was held on the matter, and we review on the merits.

Scope of the Denial

The insurer denied claimant's neck condition, ensuing surgery and "continuing chiropractic treatment." Claimant contends that the denial of continuing chiropractic treatment is an impermissible denial of all future chiropractic care. A general denial of continuing chiropractic treatment for an accepted condition should be construed as an impermissible prospective denial, particularly when there are no unpaid billings for past services. Nevertheless, in this case,when read as a whole, the denial in this case denies care only for the neck condition and does not deny future care for the accepted left shoulder condition. The denial reads:

> "... Recent medical evidence shows that your were admitted to the hospital to under go an arterior cervical discectomy and fusion at C5-6 on September 6, 1989."
>
> "In reviewing your claim, we find that there is insufficient evidence to support that this condition is a direct result of your industrial injury of 3/7/88 or that your industrial injury contributed to this condition. We also find that there is insufficient documentation to warrant continuing chiropractic care. We find that the time loss that you are currently experiencing is as a result of the 9/6/89 unauthorized cervical surgery and not due to your 3/7/88 injury. We also find that all current medical treatment as well as the treatment with relationship to the aforementioned surgery is not as a result or directly related to your industrial injury of 3/7/88. Therefore, we must respectfully deny continuing time loss benefits, medical benefits as it relates to the aforementioned surgery and continuing chiropractic care.
>
> Medical benefits which are found to be directly related to your industrial injury of March 7, 1988 will be continued to paid (sic) in accordance with the Oregon Workers' Compensation Law- ORS 656.245."

We further note that the insurer stated at hearing that it had accepted the left shoulder claim and related medical services, including chiropractic care for that condition. Accordingly, the denial is not an impermissible denial of future treatment for an accepted condition. We thus proceed to the merits of claimant's claim.

Compensability

The Referee upheld the insurer's denial of the neck condition on the basis that there was no evidence in the record of any trauma involving claimant's neck on March 7, 1988, and that her original symptoms involved only her left shoulder and arm. He also found that there was no explanation as to why claimant's symptoms shifted from her left shoulder and arm to her right shoulder and arm many months after March 1988. We disagree with the Referee's findings and his conclusion based on those findings, for the following reasons.

In order to prove a compensable injury, claimant must prove by a preponderance of the evidence that an industrial injury materially contributed to her disability or need for treatment. Milburn v. Weyerhaeuser Co., 88 Or App 375, 378 (1987); Hutcheson v. Weyerhaeuser Co., 288 Or 51, 56 (1979). An accidental injury is generally the unexpected result of either an identifiable incident or an onset traceable to a discrete time period. Valtinson v. SAIF, 56 Or App 184 (1982).

According to Dr. Phillips, claimant had complained of neck pain in addition to shoulder pain since March 10, 1988. (Ex. 2, 2A, 2C-1). Phillips' initial diagnosis was shoulder strain and acute cervicothoracic strain. (Ex. 2). Phillips further noted symptoms of numbness extending into the fingers. Although claimant's neck pain improved with conservative care, she continued to experience tingling in the left thumb, index and middle fingers and some radiating symptoms in the forearm and left shoulder region. Phillips continued to diagnose chronic cervicothoracic strain. (Ex. 8A, 10A, 10B, 10C). Thus, we find that the onset of claimant's neck condition is traceable to the same discrete time period as her accepted left shoulder condition.

In May 1988, Dr. Durkan, neurosurgeon, and the Orthopaedic Consultants each diagnosed overuse syndrome and recommended conservative treatment. (Ex. 3, 4). By September 1988, Dr. Johnson, neurosurgeon, noted nocturnal acroparesthesia (abnormal sensation of the tips of the extremities due to nerve compression at any of several levels) to right and left hands, which, he stated, could have been caused by either cervical radiculopathy or carpal tunnel syndrome. (Ex. 5). After claimant completed bilateral carpal tunnel surgery in December 1988, her shoulder pain, radicular left arm pain and left arm numbness continued.

Claimant was again examined in February 1989 by the Orthopaedic Consultants and by Dr. Wilson, who each noted residual impairment and "multiple vague complaints," which they attributed to psychological factors. X-rays and an MRI revealed degenerative disc changes at C3-4, C4-5 and C5-6, but did not reveal a herniated disc. (Ex. 9, 10).

In February 1989, Phillips recommended getting a second opinion by a neurosurgeon concerning the discs in the lower cervical area. (Ex. 10B). Dr. Brett, neurosurgeon, noted the same findings from the x-rays and MRI as the Consultants and Dr. Wilson, but requested a cervical Isovue myelography in addition. The myelograms revealed a C5-6 disc protrusion. (Ex. 13C). Brett stated that the disc protrusion explained claimant's continuing neck, referred shoulder and interscapular pain, as well as her chronic cervical muscle spasm, headache, radicular left arm pain and residual dysesthesia into the left thumb. (Ex. 13). Dr. Brett also stated that claimant's disc protrusion was clearly related to her industrial injury. (Ex. 15). Upon evaluation and comparison of their earlier MRI with the myelogram, the Orthopaedic Consultants noted that at times in difficult cases, one study will show a problem quite well where the other will not, although the problem could have been present all the time. (Ex. 26-2).

Furthermore, although Durkan originally diagnosed overuse syndrome, he later opined that claimant's symptoms could be explained as a result of a cervical nerve root syndrome. He also opined that it was likely that her disc pathology occurred at the time of her March 7, 1988 injury. (Ex. 24A).

We are persuaded by the history of claimant's continuing neck and referred shoulder pain and radicular left arm pain and hand numbness, and by Dr. Brett's expert opinion, that claimant's neck condition is materially related to her industrial injury of March 7, 1988. Consequently, we find her neck condition to be compensable.

Penalties and Attorney Fees

Claimant contends that the denial of "continuing chiropractic care" was unreasonable because the insurer denied all chiropractic care. We have already addressed this issue under the above section entitled Scope of Denial. Because the scope of the denial is limited to medical services, including chiropractic care, related to claimant's denied neck condition, we do not find it to be unreasonable on that basis.

Claimant also contends that the denial of the neck condition was unreasonable because the neck was a compensable part of this claim from the time of onset. However, at the time of the denial, the insurer had medical reports from the Orthopaedic Consultants and the Emanuel Pain Center attributing her complaints to overuse syndrome and carpal tunnel syndrome, rather than a cervical disc. In light of these medical records available to the insurer, we do not find the denial to be unreasonable. Thus, no penalty or attorney fee is appropriate on this issue.

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 $2,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue, as distinct from the procedural propriety, penalty and attorney fee issues on which claimant did not prevail, and the complexity of the compensability issue.

ORDER

The Referee's order dated March 2, 1990 is reversed in part and affirmed in part. Claimant's hearing request is reinstated. The insurer's denial of claimant's neck condition is set aside and the claim is remanded to the insurer for processing according to law. The remainder of the order is affirmed. For services at hearing and on review regarding the compensability issue, claimant's attorney is awarded an assessed fee of $2,000, payable by the insurer.

January 24, 1991 Cite as 43 Van Natta 119 (1991)

In the Matter of the Compensation of
VIVIAN F. FOLTZ, Claimant
WCB Case No. 87-11312
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Arthur Stevens (Saif), Defense Attorney

Reviewed by Board Members Nichols, Brittingham, and Crider.

The SAIF Corporation requests review of Referee Livesley's order which granted permanent total disability, whereas a Determination Order awarded 35 percent (112 degrees) unscheduled permanent partial disability for a low back injury. On review, the issue is extent of permanent disability, including permanent total disability. We reverse the award of permanent total disability and reinstate the Determination Order award.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," with the following supplementation. Claimant's previous work experience includes salesperson. Claimant must use a cane to walk.

FINDINGS OF ULTIMATE FACT

Claimant is not permanently and totally disabled for medical reasons alone. Nor is she permanently and totally disabled as a result of a combination of medical and nonmedical factors. Claimant has established that she is willing to work and has made reasonable efforts to find work. Work search efforts are not futile for claimant.

As a result of her compensable low back injury, claimant has sustained a 35 percent loss of earning capacity.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

The Referee concluded that claimant is permanently and totally disabled as a result of her compensable injury. We disagree.

To establish permanent total disability, claimant must prove that she is presently unable to perform any work at a gainful and suitable occupation. ORS 656.206(1). Claimant must prove this by a preponderance of the evidence. Harris v. SAIF, 292 Or 683 (1982).

There are two types of permanent total disability: (1) that arising entirely from physical incapacity; and (2) that arising under the "odd-lot" doctrine, resulting from less than total physical incapacity plus nonmedical factors, which together may result in permanent total disability. Shaw v. SAIF, 78 Or App 588 (1986); Welch v. Bannister Pipeline, 70 Or App 699, 701 (1984).

In addition, claimant has the burden to establish that she has made reasonable efforts to obtain work at a gainful and suitable occupation, unless it is shown that efforts would be futile. ORS 656.206(3); Butcher v. SAIF, 45 Or App 318 (1983). However, even if a work search would be futile, such a claimant must establish that she, but for the compensable injury, would have been willing to seek regular gainful employment. SAIF v. Stephen, 303 Or 41 (1989). Moreover, "[a] finding of futility is reserved for the extreme situation where, for example, the record shows that the individual is physically totally disabled or is not capable of retraining." Georgia-Pacific Corp. v. Perry, 92 Or App 56 (1988).

Extent of Impairment

The first step in determining whether claimant is permanently and totally disabled requires an evaluation of her physical condition.

Dr. Dunn, claimant's treating neurologist for more than ten years, determined that claimant could "perform only the most sedentary type of work with absolutely no lifting, bending, twisting, pushing or pulling, and this work can be performed only for a period of four hours a day, five days a week." (Ex. 39-63). In addition, Dr. Dunn stated that claimant must be able to change positions at will. (Ex. 37A-3).

Dr. Holmes, M.D., examining physician, opined that Dr. Dunn's restrictions seemed overly restrictive. Holmes stated that with well received rehabilitation efforts, claimant could function in the light sedentary category for a full eight hour day. (Ex. 49-7).

Thus, both Drs. Dunn and Holmes support a finding that claimant is not permanently and totally disabled on the basis of her physical incapacity alone. Accordingly, on this record we are not persuaded that claimant is physically incapacitated from performing any work at a gainful and suitable occupation. Instead, we find that she is able to perform sedentary work part-time. In reaching this conclusion, we particularly rely on the opinion of Dr. Dunn, claimant's long-time treating physician. Weiland v. SAIF, 64 Or App 810, 814 (1983).

Odd-Lot Doctrine

Since claimant is not totally precluded from all employment on the basis of her physical condition, the next question is whether she qualifies under the "odd lot" doctrine. Under the "odd lot" doctrine a disabled person may remain capable of performing some kind of work but still be permanently disabled due to a combination of medical and nonmedical disabilities which foreclose her from gainful employment. Such nonmedical factors include age, education, adaptability to nonphysical labor, mental capacity, emotional condition and conditions of the labor market. Welch v. Bannister Pipeline, supra, 70 Or App at 701.

Claimant was 44 years old at the time of the hearing. She had a GED and one quarter of course work at a business school. Vocational tests indicated good reading skills, adequate math skills and poor spelling skills. (Ex. 39-55). The tests also showed a good capacity for nonverbal reasoning. Her mental capacity is also demonstrated by the fact that she was on the Dean's honor roll for her work at the business college. (Tr. 49).

Claimant has transferable skills from her previous jobs as a receptionist/reservation clerk, grocery clerk, and salesperson. Her vocational counselor found that, even considering her limitations to part-time work and restrictions on lifting, all of her skills were transferable to light or sedentary positions. (Ex. 39-7).

Claimant's primary argument is that 20 hours at the minimum wages she could command does not qualify as "gainful" employment. However, the ability to do regular part-time work precludes a status of permanent total disability. Georgia-Pacific Corp. v. Perry, 92 Or App 56, 58 (1988) (emphasis supplied). In Perry, the court found that, although claimant was not working, his ability to perform regular part-time work precluded a status of permanently and totally disabled; especially since he had refused to participate in a rehabilitation program and therefore it was impossible to know whether it would be futile for him to seek work. Id. at 58-9. Cf. Harris v. SAIF, 292 Or 683 (1982) (Claimant was able to generate income through infrequent investment activity; ability to work, not income generated, was determinative); and Hill v. SAIF, 25 Or App 697 (1976) (A finding that claimant can perform regular part-time work may defeat a claim for permanent total disability benefits).

Claimant attempts to distinguish Hill by pointing out that the claimant there was actually working part-time whereas she was not working. However, Perry covers this situation. Georgia-Pacific Corp. v. Perry, supra, 92 Or App at 58. The claimant in Perry was not actually working and the court held that if he was able to do regular part-time work, he was not permanently and totally disabled. Id.

Claimant has not sustained her burden of proof that she is permanently totally disabled on the basis of the "odd lot" doctrine. She has the necessary mental capacity, education and transferable skills to perform such part-time sedentary work as receptionist, clerk and cashier. She has not found work because of the competitiveness of the labor market and the more limited labor market in the area where she lives, not because she is unable to perform work.

Unscheduled Permanent Disability

The last Determination Order issued on July 14, 1987. (Ex. 46). Claimant was medically stationary on February 27, 1987. (Exs. 39-63 & 45). Therefore, the "guidelines" rather than the "standards" apply in rating any increase in permanent partial disability.

The criteria for rating extent of unscheduled disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5); Barrett v. D & H Drywall, 300 Or 553, 555 (1986). Earning capacity is the ability to obtain and hold gainful employment taking into consideration age, education, training, skills and work experience. ORS 656.214(5); see also former OAR 436-30-380 et seq. We apply these rules as guidelines, not as mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984).

Furthermore, should a further accident occur to a worker who is receiving compensation for a permanent disability, the award of compensation for such further accident shall be made with regard to the combined effect of the injuries of the worker and past receipt of money for such disabilities. Former ORS 656.214(5); Mary A. Vogelaar, 42 Van Natta 2846 (1990). ORS 656.222. The statute prescribes that compensation for permanent disability awarded shall be counted in an award for a later accident. Norby v. SAIF, 303 Or 536, 540 (1987). However, a mechanical offset is not required. Thomason v. SAIF, 73 Or App 319, 322-23 (1985).

In October 1969 claimant injured her lower back while working for a different employer. This injury resulted in a laminectomy and discectomy. (Ex. 42). Claimant returned to the same type of work after her 1969 injury, but with some discomfort and limitations.

In June 1975 claimant again injured her lumbar spine while working for yet another employer. This injury resulted in a lumbosacral fusion. (Ex. 42). A stipulation awarded a total of 35 percent (112 degrees) for this injury. (Ex. 28-2).

Claimant was able to return to work in 1982 when she began working for her current at injury employer. She worked full-time for two years until she again injured her lower back in May 1984 while attempting to move wood in a fireplace at work. She was treated conservatively and was able to return to work for 32 hours per week. However, she injured her back again in November 1984 while opening a window at work. At that time she was taken off work. She was released to return to work in October 1985 with her current limitations of sedentary work for only four hours a day, five days a week with no lifting, bending, twisting, pushing or pulling. Her 1984 injuries did not require surgery. A Determination Order issued awarding her 35 percent (112 degrees) for her May 1984 injury. (Ex. 46).

Following our de novo review of the medical and lay testimony, and after considering the combined effect of claimant's prior low back injuries and awards, we are persuaded that the Determination Order award of 35 percent (112 degrees) unscheduled disability appropriately compensates claimant for the permanent loss of earning capacity resulting from this compensable injury. See former ORS 656.222; Vogelaar, supra.

ORDER

The Referee's order dated March 10, 1988 is reversed. Claimant's permanent total disability award is reversed. The Determination Order is reinstated and affirmed.

Board Member Crider, dissenting.

Claimant, at best, can perform only subsedentary work at minimum wage on a 20 hours per week basis. She contends that, assuming she could do such work, it is not "gainful employment" within the meaning of ORS 656.206 and, therefore, that she is permanently and totally disabled. The Board answers by stating that the ability to do regular part-time work precludes an award of permanent total disability. Although the Board correctly paraphrases the court's opinion in Georgia-Pacific Corp. v. Perry, 92 Or App 56 (1988), the court's comment was not addressed to a similar argument. Rather, it was addressed to the claimant's reliance on evidence that he could not do full-time work to establish permanent total disability. I am not persuaded that the court intended its comment to mean that no injured worker is permanently and totally disabled who is capable of holding a job with regularly scheduled hours, regardless of the number of hours he or she is capable of working and regardless of the rate of pay he or she is capable of earning.

Indeed, the Board has recognized that there is some point at which a worker can regularly work so few hours per week, at so low a wage, that he cannot be deemed able to perform "gainful" work. See Peggy S. Charpilloz, 42 Van Natta 125 (1990) (Part-time work one or two hours per week is not "regular, gainful" employment.) See also, John K. Huffman, 42 Van Natta 319 (1990) (Part-time work 25-30 hours per week at $5.00 per hour is "gainful" employment.) In this case, we should determine whether or not claimant falls on the Huffman or on the Charpilloz side of the line between gainful and nongainful employment. Because we fail to do so, I dissent.

January 24, 1991 Cite as 43 Van Natta 123 (1991)

In the Matter of the Compensation of
KATHLEEN K. HAWKINS-ROBELLO, Claimant
WCB Case No. 89-15487
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The self-insured employer requests review of that portion of Referee Galton's order which set aside its denial of claimant's medical services claim for a swim therapy program. Claimant cross-requests review contending that OAR 436-10-040(8) is invalid because it exceeds the Director's rulemaking authority. On review, the issues are medical services and the Director's rulemaking authority. We affirm.

FINDINGS OF FACT

Claimant suffered a compensable upper back, shoulder, and neck injury on March 7, 1988.

Initially, claimant was treated by Dr. Takacs, osteopath. Claimant's treatment included indirect and direct osteopathic manipulation, various medication, and a TENS units. He also injected claimant's trigger points for pain relief.

On June 3, 1988, Dr. Hard became claimant's treating chiropractor. He treated claimant with manipulation, range of motion stretches, ultrasound and adjustments.

Claimant was medically stationary on March 17, 1989.

On August 2, 1989, Dr. Hard recommended claimant add a swimming therapy program to her physical maintenance program because it would decrease claimant's need for palliative care by "incorporating the best in range of motion and muscle toning activity for the upper body with the least stress."

On August 8, 1989, the employer sought additional information about the swimming program. Dr. Hard did not respond to this request.

On September 11, 1989, the employer reiterated its written request to Dr. Hard for additional information regarding the swim therapy program. Dr. Hard stated in response that swimming four times per week would be beneficial to claimant because it would reduce her pain and her need for palliative care.

On September 25, 1989, the employer denied claimant's swim therapy treatment, reasoning it had not received any information indicating this treatment was necessary to claimant's recovery.

The employer again denied claimant's swim therapy treatment on September 26, 1989, reasoning there was no information indicating that the swim therapy program was necessary to claimant's recovery.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had established special medical circumstances which required her to have swim therapy treatment. We agree.

Rules promulgated by the Workers' Compensation Director set forth certain prerequisites for demonstrating that specific types of treatment are compensable. The rules in effect at the time of claimant's proposed swim therapy provided that "trips to spas, to rest areas or retreats ... are not reimbursable unless special medical circumstances are shown to exist." See OAR 436-10-040(8). This rule also applies to swim therapy. Kelly B. Worden, 41 Van Natta 1758 (1989).

Here, Dr. Hard, claimant's treating chiropractor, opined that a swim therapy program would reduce claimant's pain and need for palliative treatment because it would improve ranges of motion and muscle tone with low stress. On the other hand, Dr. Simpson, a chiropractor and independent medical examiner, concluded that a swim therapy program would be of no assistance. We generally assign greater weight to the opinion of a worker's treating physician, in the absence of persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). We find Dr. Hard's opinion, as claimant's treating physician, to be thorough and well reasoned. Consequently, we find it persuasive. Weiland v. SAIF, supra; Somers v. SAIF, 77 Or App 259 (1986).

On the other hand, Dr. Simpson examined claimant once, in February 1989. Simpson opined in January 1990 that claimant's condition did not require her to undergo a swim therapy program. (Ex. 57). Simpson based this opinion on the February 1989 examination and a subsequent review of claimant's medical records. In light of the approximately one year interval between his examination of claimant, and his opinion regarding the appropriateness of a swim therapy program, we do not find Dr. Simpson's opinion persuasive. See Thelma A. Daly, 41 Van Natta 1494 (1989).

We conclude that Dr. Hard's opinion that swim therapy will reduce claimant's pain and need for palliative treatment by providing improved ranges of motion and muscle toning with low stress is sufficient to establish special medical circumstances that required claimant to participate in a swim therapy program.

Because we have determined that special medical circumstances existed that required claimant's participation in a swim therapy program, we need not address whether OAR 436-10-040(8) exceeded the Director's rule making authority.

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 medical services issue is $500, to be paid by the employer. 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 February 16, 1990 is affirmed. For services on review, claiment's counsel is awarded $500, to be paid by the employer.

In the Matter of the Compensation of
PATRICIA A. ITEL, Claimant
WCB Case No. 89-20088
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Davis' order that increased claimant's unscheduled permanent disability award for a psychological condition from 19 percent (60.8 degrees), as awarded by a Determination Order, to 20 percent (64 degrees). On review, the issue is unscheduled permanent partial disability. We affirm.

FINDINGS OF FACT

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

ULTIMATE FINDING OF FACT

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

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.

Here, because claimant's claim was closed by an August 21, 1989 Determination Order, the "standards" adopted effective January 1, 1989, former OAR 436-35-010 et seq, apply to the rating of claimant's permanent disability. Former

OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent disability.

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

Claimant does not dispute the values assigned by the Referee for claimant's age and education. We therefore adopt the Referee's opinion and conclusion regarding those values and address only the issues of adaptability and impairment.

Adaptability

The adaptability value for a claimant who is not working as a result of the compensable condition 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).

Here, claimant was not working as a result of her compensable injury and no offer of employment had been made. The Referee found that claimant had no physical impairments that limited her ability to perform physical activities identified in the standards and, accordingly, assigned an adaptability value of 1. Former OAR 436-35-310(4).

Claimant contends that the Referee erred in rating her adaptability, because he considered only physical factors. She argues that, under the circumstances, the Referee should have considered her psychological residuals which limit her adaptability for future employment. We disagree.

The adaptability value under the standards is based on a claimant's physical capacity. Former OAR 436-35-310(3), (4). Although the Referee and the Board are required to apply the "standards" in his rating of permanent partial disability, nothing in the rules prevents either party from establishing 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). Thus, claimant's contention concerning her psychological residuals will be considered in determining whether it was highly probable that her impairment was in excess of that indicated by application of the rules.

Impairment

The criteria to be used in rating the impairment resulting from a permanent mental disorder is found in former OAR 436-35-400. The medical evidence establishes that the mental impairment from which claimant suffers is a form of psychoneurosis. Psychoneuroses are subdivided into three "classes" depending on the severity and duration of the symptoms. Former OAR 436-35-400(4).

Dr. Colbach, a psychiatrist, placed claimant's psychoneurotic condition in Class 2 of the standards and believed that claimant had an impairment of 15 percent. Claimant's treating physician, Dr. Gross, concurred. There was no contrary medical evidence. Relying on those opinions, the Referee concluded that claimant was entitled to an impairment value of 15 percent. Claimant contends that her impairment corresponds to a Class 3 rating. We disagree.

Claimant testified that she experiences some residual depression and paranoid thinking. Her psychiatric problem limits her handwriting capacity to only a few lines. However, she also testified that depression, over all, was not a problem. Claimant is functional in her personal life and her anxiety condition appears to be under control. Moreover, there is no medical evidence to support a Class 3 rating.

Comparing those symptoms to the various classes of psychoneurosis defined in the standards, we are persuaded that claimant's impairment is properly placed in the Class 2 rating. Former OAR 436-35-400(4)(b). Furthermore, noting that claimant does not suffer from the more extreme symptoms associated with the reactions described in Class 2, we conclude that claimant's impairment is within the lower range of the Class 2 rating. Consequently, we agree with the Referee's impairment rating of 15 percent.

Computation of Unscheduled Permanent 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 1, the product is 5. When that value is added to claimant's impairment value 15, the result is 20 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 20 percent.

As indicated earlier, 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 that claimant has failed to establish entitlement to permanent disability in excess of that indicated by the standards. After our de novo review of the record, including claimant's contentions concerning her psychological residuals, we agree. Consequently, we decline to increase claimant's award beyond that awarded by the Referee.

ORDER

The Referee's order dated March 19, 1990 is affirmed.

January 24, 1991 Cite as 43 Van Natta 127 (1991)

In the Matter of the Compensation of
ARTHUR M. JENSEN, Claimant
WCB Case Nos. 88-19148, 88-17696, 88-05343 & 88-17697
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Beers, et al., Defense Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of that portion of Arbitrator/Referee Myzak's order that affirmed two Determination Orders which awarded no permanent disability for his low back condition. On review, the issue is extent of unscheduled permanent partial disability. We affirm.

FINDINGS OF FACT

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

Claimant has treated with Dr. Hebert, D.C., since his 1981 injury.

Claimant retired on December 31, 1981.

On July 22, 1987, a hearing was held before Referee Mccullough on EBI's April 6, 1987 denial of claimant's aggravation claim for his January 6, 1981 low back injury, and the SAIF Corporation's August 25, 1986 denial of claimant's aggravation claim for a low back injury on December 28, 1981. In his August 3, 1987 Opinion and Order, Referee McCullough held that, under Davison v. SAIF, 80 Or App 541 (1986), SAIF was required to close the claim even though it was accepted as nondisabling. Because SAIF had never closed the claim, Referee McCullough found that its denial of responsibility for medical services was invalid; Referee McCullough declined to address the issue of permanent disability until SAIF closed the claim. There is no evidence that any party requested review of Referee McCullough's order. Two Determination Orders for the December 28, 1981 injury then issued, awarding no permanent disability. The present case arose pursuant to claimant's request for hearing on these two Determination Orders.

FINDINGS OF ULTIMATE FACT

Claimant's December 28, 1981 back injury did not materially contribute to his disability or current need for treatment.

CONCLUSIONS OF LAW AND OPINION

Because this issue involves claimant's right to receive compensation or the amount thereof, we review de novo. ORS 656.307 (2) and 656.704(3). See John L. Riggs III, 42 Van Natta 2816 (1990).

The Referee affirmed the two Determination Orders that awarded no permanent disability. She reasoned that because claimant's December 1981 injury was classified nondisabling, any claim for permanent disability must be made as a claim for aggravation, pursuant to ORS 656.262(12) and ORS 656.273. Since claimant had made no aggravation claim, the Referee concluded that claimant is not entitled to an award for that injury. On review, claimant argues that the fact that SAIF defined claimant's injury as nondisabling does not prevent the Board from making its own determination of whether an award of permanent disability is appropriate where claimant has established that his condition has worsened. Claimant also argues that Referee McCullough's August 3, 1987 order, which declined to address the issue of permanent disability for claimant's December 28, 1981 injury until SAIF closed the claim, constitutes the law of this case. In its brief, SAIF concedes that defining the claim as nondisabling does not preclude an award of permanent disability and that Referee Myzak erred in not addressing the extent issue. Therefore, we must determine whether or not claimant suffers permanent disability due to the compensable injury. ORS 656.214.

Claimant is not entitled to an award for permanent disability resulting from his compensable back injury in 1981. It is undisputed that claimant suffers from preexisting degenerative osteoarthritis, and also suffered several back injuries prior to his December 28, 1981 injury. Therefore, we find the causation of claimant's permanent impairment to be a complex medical question. Thus, while his testimony is probative, the resolution of this case turns on

medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 259, 263 (1986). That evidence is in conflict.

Treating chiropractor Hebert opined on July 28, 1982 that claimant was permanently impaired. In support of this conclusion, he reported positive findings on application of several tests, but did not relate claimant's disability to his December 1981 injury.

Dr. Smith, independent orthopedist, examined claimant on December 16, 1982. He opined that claimant's disability was caused by the degenerative changes in his low back. Dr. Smith stated that he was unable to determine how much of claimant's disability was present before his December 1981 injury and how much had occurred since that time. On January 11, 1983, Dr. Hebert concurred with Dr. Smith's findings. However, on September 16, 1985, Dr. Hebert reported that "We are treating L-5 which was this specific subluxation of the December 28, 1981 incident."

Dr. Bolin, D.C., examined claimant on August 8, 1988, at EBI's request. He did not review claimant's medical records at that time. Bolin opined that any treatment was related to claimant's degenerative arthritis and not his December 1981 injury. However, after reviewing the medical records, Dr. Bolin changed his mind and opined on October 15, 1988 that claimant's December 1981 injury independently contributed to his current low back condition. We do not give Dr. Bolin's opinion great weight, as he failed to explain the basis for his opinion that claimant's December 1981 injury independently contributed to his current condition. Further, he did not explain why he changed his opinion.

On April 14, 1988, claimant's records were reviewed at SAIF's request by Dr. Woolpert, orthopedic surgeon. Dr. Woolpert then examined claimant 7 days prior to the hearing. He opined that claimant's December 1981 accident caused a temporary symptomatic worsening, but that there was not enough evidence to substantiate any permanent impairment. Woolpert based this conclusion on the fact that claimant was treating with Dr. Hebert prior to the incident, then increased the frequency of treatment after the incident, then subsequently decreased the frequency to the same amount as before the incident.

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).

We do not rely on treating chiropractor Hebert's opinion because we do not find it well-reasoned. While he opined that claimant suffered from permanent impairment, he agreed with Dr. Smith, who could not say that it was medically probable that claimant's condition was due to his December 1981 injury. Two years later, Hebert changed his mind and opined that claimant's condition was due to his December 1981 injury. He did not explain the reason for the change in his opinion.

We find Dr. Woolpert's opinion that claimant's condition is due to his osteoarthritis to be well-reasoned. It is based on a review of claimant's medical record and an examination of claimant, and it is consistent with claimant's treatment history. Therefore, we rely on Dr. Woolpert's opinion and find that claimant did not suffer a permanent loss of earning capacity due to his December 28, 1981 injury. Accordingly, the Referee's order is affirmed.

ORDER

The Referee's order dated March 31, 1989, as amended and republished April 10, 1989 and October 11, 1989, is affirmed.

In the Matter of the Compensation of
ALICE C. LANE, Claimant
WCB Case No. 88-18253
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Robert J. Jackson (Saif), Defense Attorney

Reviewed by Board Members Cushing and Myers.

The insurer requests review of Referee Danner's order that: (1) set aside its partial denial of claimant's neck, upper back, left shoulder and left arm condition; and (2) awarded an attorney fee for claimant overturning the denial. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

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

ULTIMATE FINDING OF FACT

Claimant's neck, upper back, left shoulder and left arm complaints are not causally related to her October 1984 compensable injury.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant's neck, upper back, left shoulder and left arm complaints were related to her compensable injury. We disagree.

At the outset, we do not agree with claimant's suggestion that the insurer has accepted her claim by virtue of having paid medical bills for her current condition. The payment of medical expenses and other benefits, without more, does not constitute acceptance of a claim. ORS 656.262(9); Jonny D. Lane, 41 Van Natta 718 (1989). In order to establish compensability of her claim, claimant must prove by a preponderance of the evidence that her compensable injury was a material contributing cause of her existing disability or need for medical treatment. Harris v. Albertson's, Inc., 65 Or App 254 (1983).

Claimant compensably injured her low back in October 1984. She did not report upper extremity pain, however, until she was examined by the Orthopaedic Consultants in December 1985. During that examination, she reported "numbness and tingling in the left hand and arm" and indicated that she first experienced the symptoms about one month earlier. Given the 13 month period of not reporting any upper extremity problems following the October 1984 injury, the resolution of the compensability question primarily turns on an analysis of medical evidence. Uris v. Compensation Department, 247 Or 420 (1967); Vernon R. Tosh, 41 Van Natta 2159 (1989).

Two expert medical opinions on causation were introduced. Dr. Barth, a neurologist who was part of a panel of medical experts who examined claimant on

February 22, 1988, expressed the opinion that claimant's current condition was not related to her compensable injury:

> "Based on the information obtained from the worker, a review of the extensive medical records and x-ray films provided, the patient's neck, upper back, and left arm complaints are in no way related to the industrial injury of October 12, 1984." (Ex. 8).

On the other hand, Dr. Helms, a chiropractor who began treating claimant on March 22, 1988, believed that her symptoms were related:

> "Although her present left sided upper back, shoulder and arm numbness did not occur at the time of injury she suffered in 1984, they are definitely caused by the effects of this injury and associated problems since that time. When the effects of mechanical compensation in the spinal column and the bridging relationships of the associated muscles, sleep disturbances for over the last three plus years are considered, the complaints [are] nearly self-explanatory." (Ex. 9-1).

When there is a dispute between medical experts, the Board tends to give greater weight to the conclusion of the treating physician. Taylor v. SAIF, 75 Or App 583 (1985). However, claimant's treating chiropractor, Dr. Helms, did not examine claimant until well after the onset of symptoms in late 1985. Moreover, the record establishes that he rendered his opinion after less than a month of treatment. Because Dr. Barth had similar opportunities to evaluate claimant's condition, we consider the medical experts to be on equal footing in this regard.

After considering both opinions, we do not find Dr. Helms' report persuasive. His explanation lacks little analysis and is summarized by his opinion that claimant's complaints were "nearly self-explanatory." By comparison, Dr. Barth is a neurologist who has special expertise in diagnosing and treating spinal conditions. After a complete physical exam, a detailed review of claimant's medical records, and a review of x-ray films, Dr. Barth concluded that claimant's neck, upper back, and left arm symptoms were not related to her compensable injury. We consider his opinion well-reasoned and, consequently, find it persuasive. Somers v. SAIF, 77 Or App 259 (1986).

After our de novo review of the record, we conclude that claimant has failed to prove by a preponderance of evidence that her compensable injury was a material contributing cause of her neck, upper back, left shoulder and left arm condition.

Attorney Fees

The Referee assessed an attorney fee for claimant's overturning the insurer's partial denial. Given the fact that we have determined that claimant has failed to establish the compensability of her claim, the Referee's assessed fee is reversed.

ORDER

The Referee's order dated April 17, 1990 is reversed. The insurer's partial denial is reinstated and upheld. The Referee's assessed attorney fee of $1,225 awarded to claimant for overturning the insurer's partial denial is reversed.

In the Matter of the Compensation of
DONALD P. LANGENFELD, Claimant
WCB Case Nos. 90-11966 & 90-11963
ORDER ON REVIEW (REMANDING)
Bennett & Durham, Claimant Attorneys
Pamela Schultz, Defense Attorney
Darrell E. Bewley, Defense Attorney

Reviewed by Board Members Myers and Cushing.

The insurer, on behalf of Industrial Maintenance, requests review of Referee Menashe's order that set aside its denial of claimant's occupational disease claim for hearing loss. On review, the insurer contends that claimant is precluded from receiving compensation in this claim because he has already received compensation for his current condition under the Longshoremen's and Harbor Workers' Compensation Act. We remand.

FINDINGS OF FACT

Claimant periodically worked as a boilermaker for the FMC Corporation from 1968 to 1980. His job involved prolonged exposure to noisy machinery. In October 1981, he consulted Dr. Wilson, M.D., for hearing problems. Dr. Wilson found evidence of high frequency hearing loss and diagnosed acoustic trauma.

In December 1982, claimant and FMC agreed that claimant had sustained a binaural hearing loss that fell within the jurisdiction of the Longshoremen's and Harbor Workers' Compensation Act (LHWCA), 33 U.S.C. 901 et seq. The agreement provided that FMC would assume responsibility for all future medical and other expenses related to the binaural hearing loss, as provided by 33 U.S.C. 907. (Ex. 9-2). Claimant's hearing loss at that time would have been 30.75 percent binaurally had it been rated under Oregon law.

Thereafter, claimant worked as a boilermaker for several Oregon employers not subject to the LHWCA. He again was exposed to noisy machinery at each employment. On December 22, 1989, he consulted Dr. Lipman, M.D., who tested claimant's hearing and found that his hearing loss had increased to 33.31 percent binaurally, as rated under Oregon law.

Claimant subsequently filed hearing loss claims against several Oregon employers, including one against the insurer's insured, his most recent employer. He had worked for the insured for about four days, from December 7, 1989 to December 11, 1989. The insurer denied responsibility on May 16, 1990.

In June 1990, claimant obtained new hearing aids at the expense of FMC. The hearing aids were provided in accordance to the terms of the 1982 settlement agreement.

At the hearing, claimant and the carriers for his other Oregon employers were negotiating a settlement. Therefore, the parties agreed that the other carriers need not appear at the hearing.

CONCLUSIONS OF LAW AND OPINION

The question is whether claimant is a subject worker under Oregon law. The Referee concluded that he was and set aside the insurer's denial. We remand.

ORS 656.027 provides that all workers are subject to the Oregon Workers' Compensation Act except those specifically excluded under the law. Among those

excluded is "a person for whom a rule of liability for injury or death arising out of and in the course of employment is provided by the laws of the United States." ORS 656.027(4).

The insurer argues that ORS 656.027(4) applies here, because claimant received benefits under the LHWCA. It relies on Mann v. SAIF, 91 Or App 715 (1988), in which the court held that a claimant's receipt of benefits under the LHWCA excluded him from coverage under Oregon law. The court reasoned:

> "Because LHWCA, a 'law[] of the United States,' provides coverage for claimant's work-related disability, he is not a subject worker under ORS chapter 656." 91 Or App at 716. (Footnote omitted.)

We agree that claimant has received benefits under the LHWCA. It is undisputed that he received hearing aids at the expense of FMC in accordance with the 1982 settlement agreement. That agreement, entered into pursuant to 33 U.S.C. 908(i)(A), required FMC to assume responsibility for all future medical services and supplies related to claimant's hearing loss "for such period as the nature of the injury or the process of recovery may require." 33 U.S.C. 907(a).

It is unclear from the record, however, whether claimant has made a claim against FMC for his current condition and whether the claim, if made, has been finally determined to be compensable under the LHWCA. If so, then, as in Mann v. SAIF, supra, claimant is, by definition, not a subject worker for whom compensation is available under Oregon law. See also Thomas A. Wuellett, 42 Van Natta 1927 (1990). On the other hand, if claimant has filed no such claim and the benefits received were awarded without regard to his current condition, ORS 656.027(4) would not apply and claimant would be entitled to pursue a claim under Oregon law.

Consequently, we find that the record has been insufficiently, incompletely or otherwise inadequately developed. ORS 656.295(5). We therefore remand this case to the Referee to determine whether claimant has filed a claim for his current condition under the LHWCA and, if so, whether the claim for his current condition has been finally determined to be compensable under federal law.

ORDER

The Referee's order dated July 18, 1990 is vacated. This matter is remanded to Referee Menashe for further proceedings consistent with this order.

January 24, 1991 Cite as 43 Van Natta 133 (1991)

In the Matter of the Compensation of
JAMES McCORMAC, Claimant
WCB Case No. 89-17548
ORDER OF DISMISSAL
Charles G. Duncan, Claimant Attorney
Robert Jackson (Saif), Defense Attorney

Claimant has requested review of Referee Miller's order which denied claimant's motion to set aside her Order of Dismissal. We have reviewed the request to determine whether we have jurisdiction to consider the matter. We conclude that we lack jurisdiction.

FINDINGS OF FACT

On December 20, 1989, the Referee issued an Order of Dismissal based on claimant's failure to appear at hearing. That order notified the parties that any appeal should be directed to the Board within 30 days.

On January 10, 1990, claimant filed a Motion to Set Aside Order of Dismissal for good cause. Thereafter, on February 1, 1990, the Referee issued a second order denying the motion, and again notifying the parties that any appeal of the order should be directed to the Board. Claimant requested Board review of the second order on February 2, 1990.

FINDINGS OF ULTIMATE FACT

The Referee's December 20, 1989 dismissal order was neither abated, withdrawn, stayed, republished, modified, nor appealed within 30 days of its issuance.

CONCLUSIONS OF LAW AND OPINION

A Referee's order becomes final within 30 days after the date on which a copy of the order is mailed to the parties, unless one of the parties requests Board review under ORS 656.295. ORS 656.289(3). The time within which to appeal an order continues to run, unless the order had been "stayed," withdrawn or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986).

Here, claimant requested review of the Referee's February 1, 1990 order denying the Motion to Set Aside Order of Dismissal within 30 days of its issuance. However, the February 1, 1990 order issued more than 30 days after the December 20, 1989 dismissal order. Moreover, the December 20, 1989 order was neither abated, withdrawn, stayed, modified, nor republished prior to the issuance of the February 1, 1990 order.

The Referee's February 1, 1990 order contained a statement of appeal rights. However, a Referee cannot extend the appeal period beyond the time permitted by statute. Farmers Insurance Group v. SAIF, 301 Or 612, 619 (1986). Since the 30-day statutory appeal period from The Referee's December 20, 1989 order elapsed unabated without a timely request for Board review, it has become final by operation of law. See ORS 656.289(3); International Paper Co., supra; Farmers Insurance Group, supra. Moreover, because the December 20, 1989 dismissal order had become final, we find that Referee Miller lacked jurisdiction to issue her February 1, 1990 order. See ORS 656.289(3); International Paper Co., supra; Farmers Insurance Group, supra. Consequently, the February 1, 1990 order is a nullity.

Based on the foregoing reasoning, we conclude that we lack jurisdiction to consider claimant's request for Board review of either the December 20, 1989 Order of Dismissal or the February 1, 1990 order denying the Motion to Set Aside Order of Dismissal. Accordingly, the request for review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
SUSANNAH RATEAU, Claimant
WCB Case No. 88-07541
ORDER ON REVIEW
Bernt A. Hansen, Claimant Attorney
John Motley (Saif), Defense Attorney

Reviewed by Board Members Cushing and Myers.

Claimant requests review of that portion of Referee Bethlahmy's order that affirmed a Determination Order award of 5 percent (7.5 degrees) scheduled permanent disability for each forearm. On review, the issue is extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant does suffer from a chronic condition that limits repetitive use of a scheduled body part and affirmed a Determination Order award of 5 percent scheduled permanent disability for each forearm. On review, claimant contends that she is entitled to an increased award of scheduled permanent disability.

Claimant first argues that the Board should consider her timely appeal from the earlier December 28, 1987 Determination Order and evaluate her disability under the then applicable guidelines set forth in former OAR 436-30-380 et seq. Under those guidelines, claimant contends that she is entitled to a separate award of scheduled permanent disability for her disabling pain. We disagree.

Where there are requests for hearing dated both before and after July 1, 1988, and the Determination Orders are consolidated for the purposes of hearing, the "standards" in effect on the date claimant last became medically stationary apply to the rating of permanent partial disability. Wade A. Webster, 42 Van Natta 1707 (1990).

Here, claimant last became medically stationary on August 31, 1989. Her claim was closed by Determination Order dated October 3, 1989. Therefore, the "standards" adopted effective January 1, 1989, former OAR 436-35-001, et seq., apply to the rating of her permanent partial disability. Under those standards, pain is considered only to the extent that it results in "measurable impairment." Former OAR 436-35-320(1). Therefore, claimant is not entitled to a separate award for disabling pain. Sheila A. Davison, 42 Van Natta 2350 (1990).

Claimant next contends that the October 3, 1989 Determination Order should have awarded additional permanent disability, because her condition had permanently worsened since the last arrangement of compensation, which claimant believes is the December 28, 1987 Determination Order.

Claimant is correct that, in order to receive an increased award of permanent disability after the reopening of a claim, an injured worker must demonstrate that her condition has permanently worsened since the last award or arrangement of compensation. Stepp v. SAIF, 304 Or 375 (1987). However, in this case, the December 28, 1987 Determination Order is not a final award or arrangement of compensation. To the contrary, it is presently before this Board, following a timely request for hearing, the reopening of the claim prior

to hearing, the reclosure of the claim by the October 3, 1989 Determination Order, another timely request for hearing and the subsequent consolidation of the Determination Orders for hearing. The finality required has not yet attached. Consequently, claimant's argument that her condition has permanently worsened after a first award of compensation is premature.

Claimant next contends that the occasional numbness in her thumb, index and middle finger entitles her to an award under the loss of sensation standards. However, former OAR 436-35-110(b) provides that there is no ratable loss of sensation if enough sensitivity remains to distinguish two pin pricks six millimeters apart applied at the same time. Because there is no evidence that the pin prick test had been performed on claimant and that her numbness met that criteria, claimant has failed to prove entitlement to an award under those standards.

Claimant finally contends that her weakness in her right hand entitles her to an award for decreased grip strength. She acknowledges that there were few positive findings of diminished grip strength. Nonetheless, she argues that the lack of such findings is irrelevant because, although she is able to perform well on strength tests when her wrist is rested, such findings do not mean that she did not have disabling pain when she used her wrist at work.

The Referee is required to apply the standards in her rating of permanent partial disability. Those standards provide that, if there is no measurable impairment, no award of scheduled permanent partial disability is allowed. Former OAR 436-35-010(2)(b). Because there was no measurable impairment of diminished grip strength, the Referee properly declined to grant such an award.

We note, however, that nothing in the rules prevents claimant from establishing 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). After our de novo review of the record, we find that claimant has failed to establish entitlement to permanent disability in excess of that indicated by the standards. Consequently, we decline to increase claimant's award beyond that awarded by the Determination Order.

ORDER

The Referee's order dated March 30, 1990 is affirmed.

January 24, 1991 Cite as 43 Van Natta 136 (1991)

In the Matter of the Compensation of
JOHN T. SEIBER, Claimant
WCB Case No. 89-14515
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Brazeau's order that: (1) denied claimant's request for additional temporary partial disability; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial. On review, the issues are entitlement to temporary disability and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Temporary Disability

The issue is whether claimant, who became disabled during a work layoff, is entitled to temporary partial disability for an aggravation of his original compensable injury. The Referee concluded that he was not, because at the time he became disabled, he was not a "worker" within the meaning of the Worker's Compensation Act. We disagree.

A claimant is entitled to temporary partial disability upon aggravation of a work-related injury, provided that the claimant is a member of the work force at the time of the aggravation. Cutright v. Weyerhaeuser, 299 Or 290 (1985). A claimant is deemed 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 (1989).

In this case, although claimant was not employed at the time he became disabled, he was receiving unemployment benefits. Because a person must establish that he is able, available, actively seeking and unable to obtain employment to qualify for unemployment compensation, ORS 657.155(1)(c), claimant's receipt of such benefits prima facie demonstrates that he is willing to work and is making reasonable efforts to obtain employment. The insurer offers no evidence in rebuttal to this evidence.

Accordingly, we conclude that claimant was a member of the work force at the time of the aggravation of his prior work-related injury. He is therefore entitled to receive temporary partial disability from the date his doctor informed claimant that he was unable to return to his regular work, May 26, 1988, until the date he was declared medically stationary, November 23, 1988. However, we add that unemployment benefits received during that period may be treated as receipt of post-injury earnings and may be offset against payment of temporary disability benefits. See Wells v. Pete Walker's Auto Body Shop, 86 Or App 739 (1987).

Penalty and Related Attorney Fee

Claimant argues that the Referee erred in failing to assess a penalty and related attorney fee for the insurer's allegedly unreasonable denial. We disagree.

A penalty and related attorney fee may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10) and 656.382(1). The standard for an unreasonable denial is whether the carrier had a legitimate doubt as to its liability for the payments. "Unreasonableness" and "legitimate doubt" are to be considered in light of all the information available to the carrier at the time of its denial. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n.3 (1985).

Although we have determined that the insurer's denial of claimant's request for additional temporary disability was improper, we do not find that its conduct was unreasonable. Given the facts that claimant had left work for reasons unrelated to his disability and was receiving unemployment compensation at the time of his subsequent aggravation, we believe that the insurer could have had a legitimate doubt as to its liability. Accordingly, an award of a penalty and related attorney fee is not warranted.

ORDER

The Referee's order dated April 19, 1990 is affirmed in part and reversed in part. That portion which denied claimant's request for additional temporary disability is reversed. The insurer is ordered to pay claimant temporary disability benefits for the period between May 26, 1988 and November 23, 1988, less unemployment compensation received during that period. Claimant's attorney is granted 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
DUANE G. TAYLOR, Claimant
WCB Case No. 89-07216
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The insurer requests review of those portions of Referee Quillinan's order which: (1) granted claimant permanent total disability, whereas a Determination Order had awarded 77 percent (246.4 degrees) unscheduled permanent disability for a low back injury and related psychological condition; and (2) ordered it to pay claimant's counsel's out-of-compensation attorney fee in a lump sum. On review, the issues are extent of unscheduled permanent disability, including permanent total disability, and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the Referee's order with the following supplementation.

On May 30, 1990, the Board issued its Order on Review which affirmed Referee Fink with regard to setting aside the insurer's partial denial of claimant's psychological condition. This order was not appealed and has become final by operation of law.

ULTIMATE FINDINGS OF FACT

We adopt the "Ultimate Findings of Fact" as set forth in the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

We adopt the conclusions and reasoning concerning the permanent total disability issue as set forth in the Referee's order.

Attorney Fees

The Referee ordered that claimant's counsel's attorney fee, payable out of the increased compensation, be paid in a lump sum. We disagree.

OAR 438-15-085(1) allows a Referee or the Board discretion to "order the payment of approved attorney fees directly to claimant's attorney in a lump sum

when the fee is to be paid out of an award of compensation for permanent disability," provided that claimant consents in the attorney retainer agreement.

This provision uses the term "permanent disability" and does not make a distinction between an award of permanent partial disability and an award of permanent total disability. The difference between the two forms of permanent disability, particularly with regard to certainty of amount, does create a distinction with regard to the payment of an approved attorney fee.

The amount of an award of permanent partial disability is fixed by the number of degrees of permanent partial disability awarded. Therefore, an attorney fee equal to 25 percent of the award, up to the prescribed limit, can be readily determined.

By contrast the actual amount of an award of permanent total disability is not a static amount as it is paid periodically during the time in which a worker is permanently and totally disabled. Further, an award of permanent total disability is subject to review and possible reduction at any time. See ORS 656.206(5); OAR 436-30-065(1). Therefore, a lump sum attorney fee award, equal to the maximum fee allowed for obtaining an award of permanent total disability, may exceed 25 percent of claimant's increased compensation. Such an attorney fee would be in violation of OAR 438-15-040(2).

We conclude therefore that claimant's counsel cannot be awarded a lump sum approved attorney fee for obtaining a permanent total disability award. Rather, claimant's counsel is entitled to 25 percent of each payment of permanent total disability, up to the maximum attorney fee allowed. See OAR 438-15-040(2)

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 permanent total disability issue is $2,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated October 27, 1989, as supplemented November 15, 1989, and as reconsidered November 20, 1989, is modified in part and affirmed in part. That portion which awarded claimant's counsel a lump sum approved attorney fee of $4,600 is modified. Claimant's counsel is awarded 25 percent of the increased compensation created by the Referee's order, not to exceed $4,600, payable in the monthly installments as prescribed by ORS 656.216(1). The remainder of the order is affirmed. For services on review concerning the permanent total disability issue, claimant's counsel is awarded an assessed attorney fee of $2,500, payable by the insurer.

In the Matter of the Compensation of
SHARON K. VANBUREN, Claimant
WCB Case No. 89-22405
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Bethlahmy's order which: (1) found that claimant was not entitled to have her claim closed by Determination Order; and (2) declined to assess a penalty and associated attorney fee for the self-insured employer's allegedly unreasonable failure to submit the claim for closure. On review, the issues are whether claimant is entitled to claim closure, penalties and attorney fees. We reverse.

FINDINGS OF FACT

Claimant filed a claim for left wrist, hand and elbow pain in February 1984. EBI, a self-insured employer, accepted the claim. Medical reports from that period indicate that claimant had tendonitis of both arms. EBI closed the claim as nondisabling on March 13, 1985.

Claimant later began working for a different employer. On October 12, 1987, she filed a claim with that employer alleging weakness and pain in both arms and both hands. EBI and the insurer for the later employer both denied responsibility.

The responsibility case went to hearing before Referee Leahy on February 19, 1988. Referee Leahy concluded:

> "I find the October 1987 episode to be an aggravation of the 1984 claim, and not a new injury, relying on testimony of continuous symptoms if the wrists were overused. I find the underlying condition has not been worsened, relying on Dr. Button's medical evidence that claimant is better after being off work for several months."

Referee Leahy also found that EBI had accepted bilateral arm conditions.

On March 1, 1989, claimant's attorney requested that EBI process the claim to a Determination Order. Claimant's attorney repeatedly requested a Determination Order through October 1989. On November 2, 1989, EBI wrote the attorney stating:

> "Your client's claim has never been reopened. Referee Leahy indicated in his Opinion and Order that there was no point (sic) .307 order because the claimant 'lost no time from work.' Referee Leahy found EBI to be responsible for ongoing .245 care.
>
> "Your client's claim was closed by Notice of Closure dated March 13, 1985. She did not appeal the Notice of Closure and there has not been a reopening of the claim."

Claimant then requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee held and the employer contends that claimant is precluded from obtaining a Determination Order by Referee Leahy's order under the doctrine of res judicata. The Referee understood Referee Leahy to have found no worsening. Therefore, she concluded that, under Stepp v. SAIF, 304 Or 375 (1987), claimant could not be entitled to an award for permanent disability.

What Referee Leahy actually found was that claimant had sustained a compensable aggravation, but that her underlying condition had not worsened. While a worsening of the underlying condition is necessary to shift responsibility, a symptomatic worsening is sufficient to establish a compensable aggravation. The law of the case is that claimant has a compensable aggravation claim. Under former ORS 656.273 she is entitled to claim closure and rating of permanent disability.

The Stepp case is inapposite because it deals with whether claimant is entitled to an award for permanent disability. It does not deal with the question of whether claimant is entitled to have permanent disability determined.

We conclude that EBI's failure to submit the claim to closure was unreasonable. Referee Leahy had specifically found a compensable aggravation claim. A compensable aggravation claim must be closed when claimant becomes medically stationary. EBI did not submit this claim for closure. Accordingly, we assess a penalty equal to 25 percent of any permanent disability awarded by Determination Order, and a related attorney fee. ORS 656.262(10), 656.382(1); Brenda Hinkle, 40 Van Natta 1655 (1988).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee concerning EBI's unreasonable conduct is $850, to be paid by EBI. 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 April 9, 1990 is reversed. The claim is remanded to EBI for processing consistent with this order. Claimant is awarded a penalty equal to 25 percent of any permanent disability awarded upon claim closure. Claimant's attorney is awarded a reasonable attorney fee of $850 for prevailing on the penalty issue. In addition, claimant's attorney is awarded 25 percent of any increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney.

January 24, 1991 Cite as 43 Van Natta 141 (1991)

In the Matter of the Compensation of
ALLEN L. WIEDRICH, Claimant
WCB Case No. 89-23815
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The insurer requests review of those portions of Referee Bethlahmy's order which set aside its denial of compensability of an alleged industrial injury. On review, the sole issue is compensability. We reverse.

FINDINGS OF FACT

Claimant is a garbage hauler. On October 26, 1989, he noticed that he was stiff and worked more slowly than usual. He had similar problems the next day. He worked his whole scheduled shift both days.

On October 27, 1989, after work, claimant bent over to pet his dog and felt a sudden severe pain in his low back. He sought chiropractic treatment the next day. Claimant's condition is a tear in the annulus of a lumbar disc, with a slight disc protrusion. Claimant's condition has resolved and he has returned to work.

CONCLUSIONS OF LAW AND OPINION

Claimant has the burden of proving by a preponderance of the evidence that his work is a material cause of his need for medical treatment or of a disability. The Referee concluded that claimant has sustained his burden of proof. We disagree.

The history of this incident is not sufficient to establish that claimant's work is a material cause of his severe pain which led to his time loss and medical treatment. The mere fact that claimant is a garbage hauler who lifts heavy weights repetitively and experiences some stiffness, is not sufficient to establish that the work activities caused an incident of severe pain which happened after work. Consequently, we conclude that causation is a complex medical question which requires expert medical evidence.

Dr. Kayser, the orthopedist who diagnosed the torn annulus, voices no opinion on causation. Dr. Plewes, the chiropractor, opines that claimant's work has caused numerous strains and sprains. He opines that claimant suffered a strain on October 27, 1989. He does not explain the connection between the alleged sprain and claimant's severe off-work pain which caused claimant to seek medical attention. We are unpersuaded by Dr. Plewes' opinion.

ORDER

The Referee's order dated May 1, 1990 is affirmed in part and reversed in part. That portion of the Referee's order which set aside the insurer's denial is reversed. The insurer's denial is reinstated and upheld. The Referee's $2,000 attorney fee award is reversed. The balance of the Referee's order is affirmed.

January 24, 1991 Cite as 43 Van Natta 142 (1991)

In the Matter of the Compensation of
ARBRA WILLIAMS, Claimant
WCB Case Nos. 88-13474 & 88-13473
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Norman Cole (Saif), Defense Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Claimant requests review of those portions of Referee Knapp's order which: (1) upheld EBI Companies' denial of his medical services claim for cervical surgery as not reasonable nor necessary; (2) upheld the SAIF Corporation's denial of his medical services claim for the same surgery; (3) upheld the SAIF

Corporation's denial of his medical services claim for lumbar surgery; (4) declined to award an assessed attorney fee, payable by EBI Companies, for services concerning its denial of cervical surgery; (5) declined to assess a penalty or related attorney fee against EBI Companies for an allegedly untimely denial. EBI Companies cross-requests review contending that the Referee erred in finding that claimant's need for cervical surgery was materially related to his September 1981 compensable injury. On review, the issues are medical services, responsibility, and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the Referee's order.

ULTIMATE FINDINGS OF FACT

We adopt the "Ultimate Findings of Fact" as set forth in the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Compensability

Cervical Surgery

We adopt the conclusions and reasoning concerning the compensability of the cervical surgery as set forth in the Referee's order with the following supplementation.

To establish the compensability of his cervical surgery, claimant must prove that the proposed surgery is reasonable and necessary as a result of his compensable injury. See ORS 656.245(1); Van Blokland v. Oregon Health Sciences University, 87 Or App 694 (1987); James v. SAIF, 81 Or App 80 (1987).

Although claimant has established that his need for the proposed surgery is materially related to the compensable injury for which EBI is responsible, he has not established that the proposed surgery is reasonable or necessary. Accordingly, we agree with the Referee that EBI's denial should be upheld.

As we have herein adopted the Referee's conclusions and reasoning which upheld both EBI's and SAIF's denial of the claimant's proposed cervical surgery. We do not reach the responsibility issue.

Lumbar Surgery

We adopt the conclusions and reasoning concerning the compensability of the lumbar surgery as set forth in the Referee's order.

Attorney Fees

Claimant contends that he is entitled to an attorney fee on the basis that he established that his need for cervical surgery was materially related to his September 1981 compensable injury. We disagree.

EBI's denial of claimant's proposed cervical surgery denied both causation and the need for surgery. Consequently, to "set aside" the denial, claimant had to prove both causation and that the proposed surgery was reasonable and necessary. He did not. Rather, he only proved causation. He did not prove that the proposed cervical surgery was reasonable and necessary.

Inasmuch as claimant did not prove that the proposed cervical surgery was reasonable and necessary, he did not finally prevail as to EBI's denial, but rather proved one element of his claim. Accordingly, claimant is not entitled to an assessed attorney fee in this situation. ORS 656.386(1); Lynn M. Elliott, 42 Van Natta 23, 24 (1990).

Penalties and Attorney Fees

We adopt the conclusions and reasoning regarding the penalty and attorney fee issue as set forth in the Referee's order. See Lloyd L. Cripe, 41 Van Natta 1774 (1989).

ORDER

The Referee's order dated March 1, 1990, as reconsidered April 24, 1990, is affirmed.

January 24, 1991 Cite as 43 Van Natta 144 (1991)

In the Matter of the Compensation of
NORMAN L. WINTER, Claimant
WCB Case No. 89-14002
ORDER ON REVIEW
Aspell, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Peterson's order that upheld the insurer's denial of his occupational disease claim for a back condition and heart surgery. The insurer, in its respondent's brief, cross-requests review of that portion of the Referee's order that declined to determine whether claimant's occupational disease claim was timely filed. On review, the issues are timeliness, compensability and medical services. We reverse.

FINDINGS OF FACTS

Claimant has a history of hypertension, chest pain, and heart problems, in addition to a long-standing overweight problem and gout. Claimant first sought medical treatment for his back in 1964 when he suffered a back strain. That condition resolved.

In 1973, claimant started working for the employer as a backhoe driver. He worked approximately 8 to 10 months out of the year in that capacity. The remainder of each year, claimant did other work for the employer, or was laid off.

Claimant did not seek treatment for his back from 1964 until 1974, when x-rays revealed degenerative arthritis in claimant's spine. Claimant started treating with Dr. Balme, M.D., in 1982.

In January 1987, claimant experienced an onset of back pain and Dr. Balme released him from work. Claimant was off work until February 1987. Claimant did not seek treatment for back problems from February 1987 until April 1989.

Claimant was off work in the winters of 1988 and 1989. He worked part-time for the employer in March and April 1989, and then in May 1989, he returned

to regular full-time work as a backhoe driver. By May 1989, claimant returned to Balme for increased back symptoms. Balme again released claimant from work.

Claimant's back problems were first associated with claimant's work activities in April 1989. In May 1989, while a myelogram was being performed, the immediate need for a pacemaker was determined. Claimant underwent surgical insertion of a pacemaker the same day as the myelogram. Five days later, back surgery was performed. Claimant filed his occupational disease claim on May 12, 1989.

On July 12, 1989, the insurer denied claimant's current back condition and the medical services associated with the pacemaker surgery. Claimant requested a hearing.

Claimant's occupational disease claim for his back condition was timely filed.

Claimant's work activities, which involved a series of traumatic events, were a materially contributing cause of increased back symptoms which required medical services.

Claimant's pacemaker surgery was a necessary prelude to his back surgery.

CONCLUSIONS OF LAW AND OPINION

Timeliness

The Referee did not address the insurer's contention that claimant's occupational disease claim was not timely filed. We proceed to address that issue.

The insurer asserts that it was prejudiced by untimely notice of claimant's occupational disease claim, contending that it was not until May 1989 that claimant first gave notice that he had a back problem which could have been caused by his work activities. The insurer contends that claimant knew of the occupational disease for over two years, asserting that claimant's missing work during 1986 and 1987 established a knowledge that the time off work due to back pain was related to his work activities. We disagree.

While we agree that the insurer first received notice of the possibility that claimant's back condition was related to work in May 1989, we do not find that the claim was untimely filed.

Former 656.807(1)(b) provides, in pertinent part, that:

> "(1) All occupational disease claims shall be void unless a claim is filed with the insurer . . . by whichever is the later of the following dates:
>
> "(a) One year from the date the worker first discovered, or in the exercise of reasonable care should have discovered, the occupational disease; or
>
> "(b) One year from the date the claimant becomes disabled or is informed by a physician that the claimant is suffering from an occupational disease." (Emphasis added).

Claimant's current back condition was first related to claimant's work activities by claimant's treating physician, Dr. Balme, in May 1989. Because former ORS 656.807 provides that an occupational disease claim must be filed by

the "later" of certain dates, because claimant's physician first indicated that claimant's current back condition was related to claimant's work in May 1989, and because claimant filed his occupational disease claim in May 1989, we find that claimant timely filed his occupational disease claim.

Compensability

The Referee found that claimant's current back condition was not compensable. We disagree.

For an occupational disease claim, the date of "injury" is the date upon which claimant was last exposed to employment conditions which allegedly caused the disease. Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986). Claimant's last exposure to the work which he alleges caused increased back symptoms was in May 1989. Accordingly, the occupational disease law, which became effective January 1, 1988, is applicable. See Johnson, supra, at 146-48; Donna E. Aschbacher, 41 Van Natta 1242 (1989).

Here, claimant's work activities as a backhoe driver included repetitive twisting, bending and bouncing motions. Considering such circumstances, we conclude this claim is for a condition resulting from a "series of traumatic events or occurrences" pursuant to former ORS 656.802(1)(c).

To establish that his condition is compensable under former ORS 656.802(1)(c), claimant need not prove a worsening of a preexisting condition. Rather, he must prove that his 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 and that such worsening or increased symptoms resulted from a series of traumatic events or occurrences. Former ORS 656.802(1)(c); Donna E. Aschbacher, supra.

Claimant's current back condition was treated or evaluated by Dr. Balme, Dr. Fuller and Dr. Tennyson. Claimant contends that the opinion of his treating physician, Dr. Balme, should be relied upon in determining the compensability of his claim. We agree.

Generally, the Board 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). Further, when there is a dispute between medical experts, the greater weight will be given to those medical opinions 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).

Dr. Balme was the only physician to treat claimant's back condition. Dr. Fuller, M.D. representing the Western Medical Consultants, examined claimant as part of an independent medical examination. Dr. Tennyson, neurological consultant, neither treated nor examined claimant. Tennyson only reviewed claimant's history and medical reports.

In October 1989, Dr. Balme opined that claimant's work as a heavy equipment operator caused a worsening of his underlying low back condition, reasoning that prolonged sitting and driving a piece of equipment, that is continually bumping, could aggravate an arthritic condition in the spine. (Ex. 48B). Further, after noting that claimant's job involved repetitive trauma, Balme opined that claimant's job was a contributing cause of his increased symptoms. Id. Finally, Balme testified that claimant's performance as a heavy equipment operator significantly contributed to claimant's current condition, foraminal stenosis, for which claimant sought medical treatment and resulted in claimant's May 1989 back surgery.

In June 1989, Dr. Fuller opined that claimant's back condition worsened and progressed during the 16 years he had worked for the employer, but concluded that claimant's work activities were not a "major" contributing cause of his current condition. Fuller attributed claimant's problem to being overweight, the progressive nature of degenerative arthritis, and claimant's ongoing gout. Fuller did not specifically address whether or not claimant's work activities caused claimant's increased symptoms. Fuller merely opined that claimant's preexisting back condition worsened during the time he worked for the employer.

After our review of Dr. Fuller's opinion, we find that it is not helpful to a determination of compensability as it is internally inconsistent and addresses the wrong standard of proof regarding occupational disease claims. Under former ORS 656.802(1)(c), the test centers on "material" contributing cause, rather than "major" contributing cause. See Donna E. Aschbacher, supra.

With respect to Dr. Tennyson's opinion, we find it likewise unpersuasive. Tennyson's initial report was merely a conclusory two paragraph report which concurred with the opinion of Dr. Fuller. Tennyson later testified that a material contributing cause of claimant's current back condition was claimant's weight problem. We do not find Tennyson's opinion persuasive, however, because it is not complete. While Dr. Tennyson did provide an opinion regarding the cause of claimant's back condition, he did not render an opinion as to whether or not claimant's work activities caused, in material part, his increased symptoms.

Therefore, because Dr. Tennyson did not treat or evaluate claimant, because his opinion is incomplete and conclusory regarding causation, we do not find it persuasive. Weiland, supra; Somers, supra; Moe v. Ceiling Systems, 44 Or App 429 (1980).

We find no persuasive reason not to defer to claimant's treating physician, Dr. Balme. Balme treated claimant since 1982 and was well aware of claimant's prior medical history. We also find that his opinion was well-reasoned. Further, his opinion regarding "significant contribution" convinces us that claimant's work activities were at least a material contributing cause of his increased symptoms. Therefore, we find Dr. Balme's opinion persuasive. Weiland, supra; Somers, supra; Hammons, supra.

Finally, we note that claimant's work activities as a heavy equipment operator, and as a backhoe driver specifically, which included repetitive bouncing, twisting and bending, establishes that claimant's work involved a series of traumatic events.

Consequently, we find that claimant has established the compensability of his occupational disease claim.

Medical Services - Pacemaker Surgery

The Referee did not address claimant's contention that the need for pacemaker surgery was a necessary prelude to his back surgery, and was, therefore, compensable. We proceed to address that issue.

Claimant has a preexisting heart condition. The compensability of that condition is not at issue. What is at issue is whether or not the need for pacemaker surgery was a natural consequence of his compensable back condition.

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). Further, 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);

See James v. Kemper Insurance Co., 81 Or App 80, 84 (1986) Lloyd L. Cripe, 41 Van Natta 1774 (1989).

The Supreme Court has held that where a claimant undergoes a surgical procedure which is found to be a necessary prelude to a second, compensable surgical procedure, the first surgical procedure is likewise compensable. See Williams, supra.

Here, the record establishes that claimant's heart physician, Dr. McDowell, opined that it was "medically necessary to insert a cardiac pacemaker prior to performing orthopedic surgery on [claimant's] low back." (Ex. 48A). There is no evidence to the contrary. Therefore, we find that claimant's pacemaker surgery was a necessary prelude to claimant's subsequent back surgery. Consequently, we find that claimant's pacemaker surgery was a natural consequence of claimant's compensable back condition, and is, therefore, compensable under former ORS 656.245.

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 occupational disease and heart surgery issues is $3,000, to be paid by the insurer. 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 January 17, 1990, is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded a reasonable assessed fee of $3,000, payable by the insurer.

January 25, 1991 Cite as 43 Van Natta 148 (1991)

In the Matter of the Compensation of
CHERYL J. GLOS, Claimant
WCB Case No. C0-00647
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Coons & Cole, Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

On December 31, 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 $1,600 by Connecticut Indemnity/EBI Companies, claimant fully releases her right to future worker' compensation benefits, except medical services, for her compensable injury. We set aside the proposed disposition.

We shall not approve a proposed claim disposition agreement 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 it exceeds the bounds of existing statutes or rules. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990). Here, a disputed claim settlement (DCS) was submitted as part of the claim disposition agreement document. The Board rules require that a claim disposition agreement be in a separate document from a disputed claim settlement. OAR 438-009-010(7); OAR 438-09-020(1)(b). The rules further instruct that any document filed for approval by the Board as a claim disposition agreement which does not

comply with this rule shall be disapproved as unreasonable as a matter of law pursuant to ORS 656.236(1)(a). OAR 438-09-020(2). We further note that the paragraph ("order clause") that is required to be located at the conclusion of the document after the signature lines for the parties is missing. See OAR/438-09-020(1)(c). Accordingly, the Board finds that the agreement is unreasonable as a matter law and sets it aside. See ORS 656.236(2); Louis R. Anaya, supra. Following our standard procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
VALARIE J. HENDERSON, Claimant
WCB Case No. 90-00457
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee T. Lavere Johnson's order that declined to assess penalties and attorney fees for an allegedly unreasonable failure to timely pay an approved attorney fee. The issue on review is penalties and attorney fees.

The Board affirms and adopts the Referee's order, with the following supplementation.

Pursuant to OAR 436-60-150(1) compensation is deemed paid when deposited in the U.S. Mail to the correct address or last known address of the recipient. We concur that the insurer's six-day delay in paying claimant's approved attorney fee, due to an unintentional misdirection of the payment check, was not unreasonable. Accordingly, even though there was untimely payment of compensation, penalties and attorney fees are not warranted.

ORDER

The Referee's order dated May 9, 1990 is affirmed.

In the Matter of the Compensation of
VICTOR H. KANE, Claimant
WCB Case No. 89-10978
ORDER ON REVIEW
William Skalak, Claimant Attorney
James L. Edmunson, Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Speer and Howell.

The insurer requests review of Referee Thye's order which granted permanent total disability, whereas a Determination Order had awarded 16 percent (51.2 degrees) unscheduled permanent partial disability for a back condition.

On review, the issue is extent of unscheduled permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT

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

Claimant's preexisting Multiple Sclerosis (MS) interferes with treatment for, and has prevented recovery from, his industrial injury. In addition, claimant's industrial injury is a material cause of a worsening of his MS condition.

ULTIMATE FINDINGS OF FACT

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

Claimant is willing to work and has made reasonable efforts to obtain employment.

CONCLUSIONS OF LAW AND OPINION

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

ORS 656.206(1)(a) provides in relevant part:

> "'Permanent total disability' means the loss, including preexisting disability, of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation."

In evaluating permanent total disability, we consider preexisting disabilities and their impact on performing work at a gainful and suitable occupation, as those conditions existed at the time of claimant's compensable injury or to the extent that claimant's compensable injury worsened the preexisting condition. Searles v. Johnston Cement, 101 Or App 589 (1990). In addition, when a preexisting noncompensable condition prevents recovery from a work injury, that effect on the injury is also taken into consideration in a determination of permanent total disability. Waremart, Inc. v. White, 85 Or App 122 (1987).

In this case, Dr. Wells, long-time family physician, opined that claimant's MS prolonged his recovery from the back strain. (Ex. 24-15). His opinion in this regard is corroborated by the Orthopaedic Consultants and by Dr. Rosenbaum, treating neurologist. The Consultants concluded that claimant would have recovered from his back strain May 1988, if not for his MS. (Ex. 9-6). Rosenbaum noted claimant's loss of function of his lumbar spine was "markedly exacerbated" by his preexisting MS. (Ex. 15-4). There is no medical evidence to the contrary. We, therefore, consider claimant's back condition as it exists, including contributions to the back condition made by the MS.

The Referee found that claimant's back injury contributed to a worsening of his disabling MS condition. We agree. Six months after the injury, Dr. Wells noted that, when claimant decreases activity to make his back more comfortable, "his MS will get worse." (Ex. 2-8). Nine months later, Wells noted that claimant's injury-related back spasms are disabling "in their own right." Moreover, he found that medication for claimant's back worsened claimant's MS symptoms to the extent that he became wheelchair bound. The same medication

made claimant otherwise less able to work, because it interfered with his cognitive abilities. (Ex. 23-1).

Finally, claimant and Dr. Wells agree that claimant would currently be able to perform at a sedentary job, but for his injury-related back condition. (Id.; Tr. 53). Due to his back injury and its sequelae, including the injury-related worsening of his MS, claimant is precluded from even subsedentary work. Accordingly, we conclude that claimant is permanently incapacitated from regularly performing work at gainful employment, due to his compensable injury.

We are further persuaded that claimant is willing to work, despite his disability. We are also persuaded that he has made reasonable efforts to find employment. He attempted to return to work on three occasions, subsequent to his injury. In January 1988, he attempted to fill his pre-injury position as a registered nurse. He was unable to continue, due to back pain, after two days. (Tr. 31). In March 1988, he attempted to fill a sedentary "monitor watch" position at the hospital. He was able to do this for three weeks and three days, at four hours per day. Then pain forced him to quit. (Tr. 38). A year later, he tried to act as a medical records analyst, in a subsedentary position. After about three weeks, he was forced to quit due to pain and the effects of his pain medication. (Tr. 12). He wanted to keep working, but could not. (Tr. 39). Claimant applied for several other jobs, even though he did not believe he would be physically able to perform them. (Tr. 41-42). We conclude that claimant has established that he is willing to work and has made reasonable efforts toward that end.

Claimant is entitled to a reasonable assessed fee for his counsel's successful defense of the Referee's permanent total disability award. 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 is $1,400, 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 January 11, 1990 is affirmed. Claimant's attorney is awarded a reasonable assessed fee of $1,400, to be paid by the insurer.

January 25, 1991 Cite as 43 Van Natta 151 (1991)

In the Matter of the Compensation of
JOSEPH S. MERRITT, Claimant
WCB Case No. 89-15495
ORDER ON REVIEW
Francesconi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Tenenbaum's order which upheld the self-insured employer's denial of an alleged industrial injury. Claimant also challenges the Referee's ruling excluding Exhibit 40 from evidence. On review the issues are compensability and the admissibility of Exhibit 40.

We affirm and adopt the Referee's order with the following comment. We conclude that the Referee did not abuse her discretion in declining to admit

into evidence the testimony of two witnesses who were not available for the employer's attorney to cross-examine. Her ruling served substantial justice.

ORDER

The Referee's order dated April 19, 1990 is affirmed.

January 25, 1991 Cite as 43 Van Natta 152 (1991)

In the Matter of the Compensation of
GARY A. RAMBEAU, Claimant
WCB Case No. C1-00059
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Vick & Gutzler, Claimant Attorneys
Gordon L. Welborn, Defense Attorney

On January 14, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

OAR 436-60-145(4) requires that a claim disposition agreement contain specified information concerning claimant and the history of the claim. A proposed disposition that does not contain the required information will not be approved by the Board. See OAR 436-60-145(5); 438-09-020(1). Such an agreement is deemed unreasonable as a matter of law. ORS 656.236(1)(a); OAR 438-09-020(2).

Here, the proposed disposition does not provide: (1) date of first closure, if any; (2) the amount of permanent disability award(s), if any; (3) whether claimant has returned to the work force; and (4) claimant's age, highest educational level and extent of vocational training. This information is required pursuant to OAR 436-60-145(4)(b)-(e). Under these circumstances, the proposed disposition is unreasonable as a matter of law. See OAR 438-09-020(2). Accordingly, we decline to approve the agreement and return it to the parties.

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES H. WILEY, Claimant
WCB Case No. 89-02531
ORDER ON REVIEW
Emmons, Kropp, et al., Claimant Attorneys
Karen M. Werner, Attorney
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Irving's order that: (1) increased claimant's unscheduled permanent disability award for a back injury from 36 percent (115.2 degrees), as awarded by Determination Order, to 45 percent (144 degrees); and (2) declined to award any scheduled permanent disability. The SAIF Corporation cross-requests review, seeking a reduction in claimant's unscheduled permanent disability award. The issues on review are extent of scheduled and unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Opinions and Conclusions" as supplemented below.

Unscheduled Permanent Disability

On review, SAIF argues that the Referee improperly awarded claimant separate 5 percent impairment values for chronic conditions limiting repetitive use of both his neck and low back.

SAIF first contends that, because claimant is entitled to an impairment value for lost ranges of motion in both the cervical and lumbar areas, he is not entitled to an additional award for chronic conditions limiting repetitive use of those areas. SAIF asserts that former OAR 436-35-320(4) permits an award for "chronic conditions limiting repetitive use" only where there exists no other impairment measurable under the "standards." In support of this assertion, SAIF attaches to its brief an unsigned letter directed to SAIF from the manager of the Evaluation Section of the Department of Insurance and Finance which supports SAIF's assertion.

We first note that our review is limited to the record developed at hearing. ORS 656.295(5). Therefore, we are not authorized to consider the evidence submitted by SAIF on review. However, we may remand to the Referee if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." Id. Therefore, we treat SAIF's submission as a motion to remand; we review the submission only for purposes of ruling on that motion.

To merit remand, it must be shown that material evidence was not obtainable with due diligence before the hearing. Bernard L. Osborn, 37 Van Natta 1054, 1055, aff'd mem 80 Or App 152 (1986). Here, the letter which SAIF submits is dated more than one month prior to the date of hearing in this matter. Therefore, we are not persuaded that the proferred evidence was unobtainable with due diligence prior to the hearing. Moreover, even if the letter was unobtainable prior to the hearing, we are not persuaded that the record is improperly, incompletely or otherwise insufficiently developed in its absence. In this regard, we are not persuaded that the letter, which purports to explain the agency's intent regarding the administrative rule in question, has legal effect as a rule

or as a legally-binding agency interpretation of a rule. Therefore, we decline to remand and do not consider the submission on review.

With regard to the merits of SAIF's argument, we have previously rejected SAIF's interpretation of former OAR 436-35-320(4). Larry L. McDougal, 42 Van Natta 1544 (1990). We continue to conclude in this regard that an award of 5 percent impairment for a chronic condition 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. McDougal, supra.

SAIF alternatively contends that claimant's "spine" is a single body part and, therefore, claimant cannot be awarded more than a single 5 percent "chronic condition" impairment value for his spine. However, in McDougal, supra, we concluded that a "body part" as used in former OAR 436-35-320(4) is one of the areas of the body that is dealt with as a separate unit or system by the standards. In this regard, the thoracolumbar spine (OAR 436-35-360(6)-(9)) and the cervical spine (OAR 436-35-360(2)-(5)) are treated as separate "body parts" for determining ranges of motion and/or other values for impairment under the "standards". Thus, as determined by the Referee, claimant is entitled one 5 percent impairment value for his cervical spine and a separate 5 percent value for his thoracolumbar spine.

Claimant argues on review that he has established that his disability is greater than that indicated under the "standards." In this regard, 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." Former 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).

Claimant argues in this regard that the cumulative effect of his age, limited education, inability to return to his prior employment, lack of transferable skills, and absence of vocational goals supports an unscheduled permanent disability award of 75 to 80 percent. While these factors support a finding that claimant has sustained a material loss of earning capacity, they do not prove that it is "highly probable" that claimant's permanent disability exceeds the 45 percent value indicated by the "standards."

Scheduled Permanent Disability

The Referee did not award claimant any scheduled permanent disability. Claimant contends that he has established entitlement to a permanent disability award for a chronic condition limiting repetitive use of his eyes under former OAR 436-35-010(7) and an award for loss of visual acuity under former OAR 436-35-260. Claimant relies upon the report of Dr. Long, ophthalmologist, in support of his claim for a scheduled award. However, Dr. Long stated in his July 20, 1988 report that he did not anticipate any "permanent visual problem." Accordingly, we conclude that claimant is not entitled to a permanent disability award for loss of use or function of his eyes.

Although claimant was unsuccessful in attempting to obtain an increased permanent disability award, claimant's counsel is, nevertheless, entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review for prevailing on SAIF's cross-request seeking to reduce his permanent disability award. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that $500 is a reasonable assessed fee for claimant's counsel's efforts. In reaching this conclusion, we have particularly considered the time devoted to SAIF's cross-request, the complexity of the issue presented, and the value of the interest involved.

ORDER

The Referee's order dated December 15, 1989, as reconsidered February 23, 1990, is affirmed. For services on review concerning the SAIF Corporation's cross-request, claimant is awarded a reasonable assessed attorney fee of $500, to be paid by SAIF.

December 26, 1990 Cite as 43 Van Natta 155 (1991)

In the Matter of the Compensation of
JESSICA L. RILATOS, Claimant
WCB Case No. 89-20326
ORDER ON REVIEW
David Ray Fowler (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant, pro se, requests review of Referee Garaventa's order that: (1) upheld the SAIF Corporation's denial of her bilateral carpal tunnel syndrome condition; (2) upheld SAIF's "de facto" denial of her current neck condition; (3) found that her claim had not been prematurely closed; and (4) affirmed a Determination Order award of 13 percent (41.6 degrees) unscheduled permanent disability for her low back injury. Claimant has submitted documents not admitted at hearing. We treat such submissions as a request for remand. On review, the issues are remand, compensability, premature closure and 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 "Conclusions and Opinion," with the following supplementation.

Remand

Claimant has submitted documents including a physical therapy authorization form and physical therapy reports. We may remand a case to the Referee when the record is incompletely, improperly, or otherwise insufficiently developed. ORS 656.295(5). To merit remand, it must be established that the evidence is relevant to the issues raised in the remand request and was unobtainable with due diligence before the hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Delfina P. Lopez, 37 Van Natta 164, 170 (1985).

Here, claimant contends that the physical therapy authorization form signed by Dr. Scheinberg, M.D., on January 18, 1988, presents support for the argument that her neck claim is compensable. However, claimant has not shown that, with due diligence, the report was unobtainable at the time of the February 22, 1990 hearing. Moreover, we are unable to find that the record was incompletely, or otherwise insufficiently developed at hearing. Accordingly, claimant's request for remand is denied.

Extent of unscheduled disability

Adaptability

The Referee assigned a value of 0, stating that claimant had refused an offer of work. See former OAR 436-35-310(2)(b). We note, however, that claimant refused an offer of modified work. Claimant's prior work was in the medium category and the offer of modified work was in the light category. Her adaptability value, therefore, would be 2. Former OAR 436-35-310(3).

Impairment

The Referee found that claimant had exaggerated and embellished her physical complaints, both to her physicians and in testimony at hearing. She concluded that claimant was entitled, however, to values for loss of range of motion and chronic condition limiting repetitive use. We disagree.

Because claimant is not credible, we conclude that claimant's demonstrated active ranges of motion and her subjective complaints regarding limited repetitive use are also unreliable. Because we are unable to rely on the range of motion findings and claimant's testimony, we conclude that claimant has not established any physical impairment. Accordingly, she is not entitled to an award of permanent partial disability.

In the present case, SAIF has not cross-requested review of the Referee's order. We therefore affirm the remainder of the Referee's order and the 13 percent unscheduled permanent disability awarded by the June 1989 Determination Order.

ORDER

The Referee's order dated February 28, 1990 is affirmed.

In the Matter of the Compensation of
GINGER L. CHRISTMAS, Claimant
WCB Case Nos. 89-24888 & 89-12677
ORDER ON RECONSIDERATION
Welch, Bruun & Green, Claimant Attorneys
Roy Miller (Saif), Defense Attorney
Roberts, et al., Defense Attorneys

Claimant requests reconsideration of that portion of our January 7, 1991 Order on Review which awarded her counsel an attorney fee of $200 for services on Board review. Claimant contends that, although her appellate brief was not lengthy, her attorney fee should reflect the hours listed on her statement of services, as her counsel's time was required to produce a concise brief. Claimant argues that if the Board awards attorney fees based upon the length of appellate briefs, then briefs emphasizing quantity rather than quality will be rewarded.

At the outset, we note that we do not doubt that claimant's counsel expended the stated number of hours upon the appellate brief in question. However, as noted in our Order on Review, claimant's entitlement to an assessed attorney fee results from the fact that compensability of her claim was potentially at risk of disallowance on Board review. While it was necessary for claimant's counsel to review the insurers' briefs on review, no argument was

actually presented on the compensability issue in those briefs, nor does claimant's brief contain argument on that issue. Moreover, time devoted to the case is only one factor to be considered in determining the amount of attorney fees awarded on review. As regards the issue on compensability for which the assessed fee was awarded, we note that the issue was not complex since it was not argued and the risk to claimant's benefits was small, for the same reason. Upon reconsideration, we continue to conclude that, considering all of the factors set forth in OAR 438-15-010(4), claimant's counsel is entitled to an attorney fee of $200 for services at the Board level.

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

IT IS SO ORDERED.

January 28, 1991 Cite as 43 Van Natta 157 (1991)

In the Matter of the Compensation of
ARTHUR FRANK, Claimant
WCB Case No. C1-00014
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Craine & Love, Claimant Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Cushing and Myers.

On January 7, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $8,000 by the SAIF Corporation, claimant agreed to release his right to future workers' compensation benefits, except medical services, for his compensable injury. We set aside the proposed disposition.

Claimant requests the Board to disapprove the agreement. Claimant made his request within 30 days of submitting the agreement. See OAR 438-09-025(2). Accordingly, the Board disapproves the agreement and sets it aside. ORS 656.236(1)(c).

IT IS SO ORDERED.

January 28, 1991 Cite as 43 Van Natta 157 (1991)

In the Matter of the Compensation of
BOBBI KLEIN, Claimant
WCB Case Nos. C0-00653 & C0-00654
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Hampson, et al., Claimant Attorneys
David Lillig (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

On January 3, 1991, 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 $14,800 by the SAIF Corporation, claimant agrees to release her right to future workers' compensation benefits, except medical services, for her compensable injury. We set aside the proposed disposition.

A claim disposition agreement must be set aside if we find that it is unreasonable as a matter of law. ORS 656.236(1)(a). An agreement is "unreasonable as a matter of law" if it exceeds the bounds of applicable administrative rules, or if a reasonable fact-finder could only conclude that the agreement was unreasonable as a matter of fact. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990). Former OAR 436-60-145(6)(a)(D) & (b) through (h) (Temp.) and former OAR 438-09-020(2)(a) (now OAR 438-09-020(1)(a)), which apply here, required that an agreement provide the date of the compensable injury or disease; the identification of the accepted conditions that are the subject of the disposition; the date of the first claim closure if any; the amount of any permanent disability award; and the amount of the consideration to be paid the claimant for his release of benefits.

Here, the agreement consists of two separate claims dispositions. However, it identifies only one date of injury (January 26, 1990) and one accepted condition (right knee strain). It provides no information about the dates of claim closure or the amounts of permanent disability awarded for either claim. It provides that the amount of consideration for claimant's release is $14,800, but does not indicate to which claims disposition it is to be applied. These statutory requirements are to be provided for each disposition of a claim. See Jerry H. Foss, 43 Van Natta 48 (1991). Because these statutory requirements were not provided for each claim, we find this claims disposition to have exceeded the bounds of former OAR 436-60-145(6) and former OAR 438-09-020(1)(a).

We further find that, if the consideration is to be applied to the 1990 claim, a reasonable fact-finder could only conclude that the disposition of the 1988 claim was unreasonable as a matter of fact. Claimant's 1988 claim was accepted; therefore, she is entitled to workers' compensation benefits for that claim. Those potential benefits are the value of the claim. Yet, if the consideration is to be applied to the 1990 claim, the parties purport to dispose of the claim for no consideration beyond that provided for disposition of the 1990 claim.

For the above resons, we find the claims disposition agreement to be unreasonable as a matter of law. See Louis R. Anaya, supra. Accordingly, we decline to approve the agreement and return it to the parties.

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) & (6)(e).

We also note parenthetically that agreements received after December 31, 1990 and signed by all parties after December 26, 1990 require a bold-face notice, see OAR 436-60-145(4)(g), and a bold-face order clause, see OAR 438-09-020(1)(c).

Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
LINDA WARNER, Claimant
WCB Case No. 89-18566
ORDER ON REVIEW (REMANDING)
Rasmussen & Henry, Claimant Attorneys
Roderick D. Peters (Saif), Defense Attorney

Reviewed by Board Members Howell, Crider & Myers.

Claimant requests review of that portion of Referee Bennett's order which denied claimant's request to have her claim reclassified from nondisabling to disabling. On review, the issue is reclassification, or entitlement to a determination of the correct classification, of her claim. We remand.

FINDINGS OF FACT

Claimant was injured on February 5, 1987. Her claim was accepted as nondisabling. She missed one-half day of work after the injury, and expected to fully recover.

Claimant had continuing symptoms and treated for several months after the injury. Claimant was examined by Dr. Novak, M.D., on about April 13, 1987. On April 21, 1987, SAIF received a first medical report from Dr. Novak indicating that claimant was not released to return to work and was not to be seen again for two weeks. (Ex. 8).

In July 1987, claimant was diagnosed by Dr. Kho, neurologist, as status post head trauma with cervical myofacial pain syndrome and hyperextension of the neck. Dr. Kho stated that claimant had minimal permanent partial impairment. SAIF received Dr. Kho's report indicating that claimant had minimal permanent impairment on July 17, 1987. (Ex. 10).

CONCLUSIONS OF LAW AND OPINION

Claimant argues that her claim was misclassified as nondisabling from the outset.

Former ORS 656.262(6) required the insurer or self-insured employer to accept or deny claims within 60 days. If accepted, the insurer or self-insured employer was required to give claimant notice, including notice of whether the claim was disabling or nondisabling. "A 'disabling compensable injury' is an injury which entitles the worker to compensation for disability or death." Former ORS 656.005(7)(b). "A 'nondisabling compensable injury' is an injury which requires medical services only." Former ORS 656.005(7)(c). If a claimant objected to the classification of his or her injury by the notice of acceptance as nondisabling, he or she must have requested that a determination of that question be made by the Evaluation Section of the Department of Insurance and Finance. Former ORS 656.262(6)(b); 656.268(8).

There is no evidence that claimant made a request of the Evaluation Section for a determination of the disabling status of her initial claim. In any case, the evidence does not establish that, at the time SAIF accepted the present claim as nondisabling, claimant was entitled to any compensation for disability or death. See Darold W. Miller, 42 Van Natta 2296 (1990); Randy Fisher, 42 Van Natta 635 (1990).

Claimant argues, in the alternative, that SAIF should have reclassified her claim as disabling after acceptance but within one year after her injury.

An accepted claim which is properly classified as nondisabling at the outset, may become disabling thereafter. If, within one year after the injury, an insurer or self-insured employer has notice or knowledge that a claimant claims that a nondisabling injury has become disabling, the insurer or self-insured employer must immediately report the claim to the director. Former ORS 656.262(12). That statute does not require the insurer or self-insured employer to reclassify the claim (although it could presumably do so voluntarily if the claim had not yet been closed). The insurer or self-insured employer must, however, report the claim (that a nondisabling injury had become disabling) to the director. At that point the Evaluation Section would, pursuant to former ORS 656.268, determine whether the claim was or was not disabling. Michelle Fleming, 41 Van Natta 887 (1989). See also Jay A. Hagan, 42 Van Natta 2489 (1990). To the extent that our order in Timothy R. Schroeder, 41 Van Natta 568 (1989) suggests that the the insurer or self-insured employer has no obligation in such a circumstance, we disavow its holding.

Whether we interpret the term "claim" as used in ORS 656.262(12) to mean only an assertion by claimant that a nondisabling injury has become disabling, or to mean a more formal "claim," as that term is defined in ORS 656.005(6), the result here is the same. Notice or knowledge of such a claim may be acquired directly from claimant or through another source, such as claimant's attorney, attending physician or vocational counselor, who may assert the "claim" on claimant's behalf. See Berkey v. Fairview Hospital, 94 Or App 28 (1988) (insurer knowledge that claimant was medically unable to work obtained through claimant's vocational counselor); ORS 656.005(6).

In the present case, SAIF accepted claimant's claim as nondisabling on March 9, 1987. On April 21, 1987, SAIF received a first medical report from Dr. Novak indicating that claimant was not released for work. Further, on July 17, 1987, SAIF received a report from Dr. Kho, indicating that claimant was medically stationary with minimal injury-related permanent impairment. Those reports constituted claims, on claimant's behalf, that her accepted nondisabling injury had become disabling. The claims were made within one year of claimant's February 5, 1987 date of injury. Once SAIF received notice and knowledge of claimant's claim, it was obligated, pursuant to former ORS 656.262(12), to immediately report the claim to the director.

The record does not indicate whether SAIF reported the claim that claimant's condition had become disabling to the Evaluations Section. Because we cannot determine the proper disposition of this case without knowing whether SAIF complied with ORS 656.262(12), we find the present record incompletely developed and remand to the Presiding Referee with instructions to assign this case to another Referee. Upon remand, the assigned Referee shall determine, in whatever manner will achieve substantial justice, if SAIF reported the claim of disabling status. If it did not, the Referee shall order that SAIF do so. If SAIF did report the claim as required by law, the Referee shall determine the appropriate disposition of this case. In either case, the Referee shall issue a final order.

ORDER

The Referee's order dated February 2, 1990 is vacated and the case is remanded to the Presiding Referee for further action consistent with this order.

In the Matter of the Compensation of
RANDALL P. ADAMS, Claimant
WCB Case No. 89-10079
ORDER ON REVIEW
Wilbur C. Smith, Jr., Claimant Attorney
Norman B. Cole (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

The SAIF Corporation requests review of Referee Bennett's order which increased claimant's unscheduled permanent disability award for a psychological condition from 28 percent (89.6 degrees), as awarded by a Determination Order, to 36 percent (115.2 degrees). On review, the issue is extent of permanent disability. We modify.

FINDINGS OF FACT

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

Claimant suffers from underlying psychological disorders which prevent him from satisfactorily dealing with authority, in particular, his supervisors at work. He had not sought treatment for his underlying personality disorders before 1986. (Tr. 6).

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent 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. Former OAR 438-10-010.

Because claimant's condition became medically stationary on March 7, 1989, and his claim was closed by Determination Order on March 20, 1989, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq.

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." Former 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).

SAIF argues that claimant has no permanent impairment as a result of his compensable mental stress claim and, thus, is entitled to no award of permanent disability. We disagree. We find that there is impairment, but do not agree with the extent of impairment found by the Referee. Neither party disputes the Referee's findings relating to claimant's age, education and adaptability. We agree with those findings and adopt the Referee's conclusions with reference to those factors.

Impairment

Claimant has a mixed personality disorder which was probably fixed by the time he was a teenager. (Ex. 68-13). Claimant's treating physician stated that

claimant's underlying problem was exacerbated by problems encountered in the work environment, resulting in claimant having trouble dealing with people in life situations, making him sensitive to criticism and having difficulty dealing with authority figures. (Ex. 68-9).

The Referee assigned an 8 percent permanent impairment value for claimant's permanent personality disorder. However, in order to receive an award of permanent disability for a personality disorder, claimant must show that the disorder interferes with his long-term ability to adapt to the ordinary activities and stresses of daily living. Former OAR 436-35-400(3)(b). We do not find evidence that claimant's personality disorder interferes with his long-term ability to adapt to the ordinary activities and stresses of daily living. Therefore, we conclude that claimant is not entitled to a permanent impairment value for his personality disorder.

Claimant has also been diagnosed as having dysthymic disorder. The Referee concluded that that condition fits into Class 2 (OAR 436-35-400(4)(b)), which is characterized by loss of function due to psychoneurosis based on, in claimant's case, depressive reactions. He found that claimant lacked interest in activities, had appetite and sleep disturbances and felt suicidal on occasion. We agree that claimant's condition fits into Class 2, but find that claimant's permanent impairment is minimal, rather than mild as found by the Referee.

Dr. Sweetman, treating psychiatrist, who began treating claimant at the outset of his work-related psychological problems, stated that, at times even after claimant became medically stationary, he appeared better and was relating better with people but, at other times, he regressed to the point that some of the difficulties he has had since Dr. Sweetman began treatment re-emerge. (Ex. 68-10). Dr. Sweetman felt that claimant experienced continuing problems, in part because of the worsening of his psychological condition caused by his compensable injury, and that he has seen no progression in claimant's condition in one direction or the other. However, Dr. Sweetman imposed no restrictions, because of his psychological conditions, on the type of employment claimant could assume. (Ex. 68-8).

Dr. Parvaresh concluded that claimant's psychiatric impairment was minimal, and that the condition had returned to the same status as before the period when his dysthymic disorder was compensably worsened by stress on the job. (Ex. 64-4). After review of the psychiatrist's reports, we are more persuaded by the attending physician who began treating claimant from the onset. After de novo review of the evidence as discussed above, we conclude that claimant suffers 10 percent permanent impairment due to the work-related exacerbation of his dysthymic disorder.

Computation of Unscheduled Permanent Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 1, is added to his education value, 2, the sum is 3. When that value is multiplied by claimant's adaptability value 1, the product is 3. When that value is added to claimant's impairment value 10, the result is 13 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 13 percent.

Moreover, on this record, we do not find that there is clear and convincing evidence that claimant's permanent impairment is greater than 13 percent.

ORDER

The Referee's order dated April 5, 1990 is modified. In lieu of the Referee's and Determination Order's awards, claimant is awarded 13 percent (41.6 degrees) unscheduled permanent disability. Claimant's attorney fee shall be adjusted accordingly.

January 29, 1991 Cite as 43 Van Natta 163 (1991)

In the Matter of the Compensation of
JOSEPH M. EDNEY, Claimant
WCB Case No. 87-17748
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Myers' order that upheld the SAIF Corporation's denial of a claim for injuries sustained by claimant in a motor vehicle accident. On review, the issue is whether the injury was within the course and scope of claimant's employment. We affirm.

FINDINGS OF FACT

Claimant worked at the employer's offices in Coos Bay, Oregon. Claimant and a coworker, Ms. Mecone, were injured in a motor vehicle accident on the evening of September 4, 1987. At the time of the accident, claimant and Ms. Mecone were enroute back to Coos Bay from a one-day field trip to Port Orford, Oregon. Claimant was driving and they were traveling in his truck. The employer requires claimant to use his own vehicle on business trips and reimburses him for mileage.

On their way back to Coos Bay, claimant and Ms. Mecone stopped to eat dinner at Bandon. Claimant consumed two beers at dinner and Ms. Mecone drank one beer. Following dinner, they continued driving north on Highway 101, toward Coos Bay. At this point, Ms. Mecone began drinking from a pint bottle of whiskey she had purchased earlier that day.

Claimant and Ms. Mecone were scheduled to return that evening to the employer's offices in Coos Bay to report to their supervisor about the events of the day. Following dinner, claimant and Ms. Mecone decided to take a side-trip to Whiskey Run Beach to relax, watch the sunset, collect their thoughts and prepare their report. The detour to Whiskey Run Beach was not on their planned itinerary. It was common practice for claimant and other employees to stop and discuss the events of the day before returning to the office to report to the supervisor. Claimant and Ms. Mecone had not discussed all aspects of the day's events over dinner in Bandon because they considered the information to be proprietary and were concerned about being overheard. They did not discuss business while the truck was in operation because it was a very noisy vehicle.

The trip to Whiskey Run Beach took roughly 15 minutes, one-way--a distance of approximately 10 miles. Claimant and Ms. Mecone turned off Highway 101 between Bandon and Coos Bay, traveling northwest on Seven Devils Road, and then due west on Whiskey Run Road, which dead-ends at Whiskey Run Beach. Whiskey Run Road is the only beach access road in the immediate area, and claimant intended to return to Highway 101 via that road.

Claimant and Ms. Mecone arrived at the beach shortly before sunset. Claimant did not immediately park the truck but, instead, shifted into four-wheel drive and drove south down the beach on the wet sand adjacent to the water. Claimant intended to drive the truck on down the beach, stop the truck at some point, pull down the tailgate and talk while watching the sunset. After they had traveled a mile and one-half down the beach, they decided to stop and go for a walk. Before claimant began slowing the vehicle, it overturned and rolled. Claimant and Ms. Mecone were both injured; Ms. Mecone later died from her injuries.

Claimant was reimbursed for his mileage to and from the beach, and he included the time spent on the beach on the time sheet he submitted to the employer. One-third to one-half of claimant's work time is spent off the employer's premises. Claimant exercises a significant degree of personal discretion in scheduling his work activities.

FINDING OF ULTIMATE FACT

Claimant's injury did not occur within the course and scope of his employment.

CONCLUSIONS AND OPINION

In order to be compensable, claimant's injury must have occurred within the course and scope of his employment. Former ORS 656.005(8)(a). The ultimate inquiry is whether the relationship between the injury and employment is such that the injury should be compensable. Rogers v. SAIF, 289 Or 633 (1985).

The courts have adopted a seven-part test for determining whether an injury is sufficiently work-related to be compensable: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employee; (3) whether the risk was an ordinary risk of, and incidental to, the employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed by or acquiesced in by the employer; and (7) whether the employee was on a personal mission of his own. Mellis v. McEwen, 74 Or App 571, 575, rev den 300 Or 249 (1985). See also Preston v. SAIF, 88 Or App 327 (1987). All of the factors may be considered; no one factor is dispositive. Id.

The Referee applied the Mellis seven-part test to the circumstances surrounding the injury but concluded that the test was not dispositive. He went on to analyze the case under the so-called "coming and going rule" and the "dual purpose exception" to that rule. The parties also apply this rule in their briefs on review.

Under the "coming and going rule," injuries sustained by employees going to or coming home from their regular place of work are generally held not to be within the course and scope of employment. Brown v. SAIF, 43 Or App 447, 452-3 (1979). Under the "dual purpose exception" to the rule, an activity is a personal trip and outside the employment if it would have been made in spite of the failure or absence of the business purpose, or it would have been dropped in the event of failure of the private purpose though the business errand remained undone. Id. Relying on the rule, the Referee concluded that claimant did not fall under the "dual purpose exception" and was not within the course and scope of his employment at the time of the accident.

We agree with the Referee's ultimate ruling, but for different reasons. At the time of the accident, claimant was neither going to nor coming home from his regular place of business; he was enroute back to the employer's offices

from a one-day business trip to the coast. Accordingly, the "coming and going" rule is not applicable in this case.

Moreover, unlike the Referee, we conclude that the seven-part Mellis test is dispositive of the course and scope issue. SAIF does not dispute that the overall business trip to and from Port Orford was within the course and scope of employment. The pivotal issue is, instead, whether the detour to the beach and drive down the surf took claimant out of the course and scope. We analyze the detour to the beach under the seven factor Mellis test.

A number of factors support a finding that the injury occurred within the course and scope of employment. There is evidence that the detour to the beach was at least in part motivated by the business purpose of preparing for the report to the supervisor. Claimant testified that they were unable to talk enroute because the truck was too noisy. Furthermore, claimant had stopped to collect his thoughts on previous business trips, and there is evidence that the supervisor acquiesced in this practice. Neither the detour to the beach nor the drive along the surf were specifically prohibited by the employer.

Furthermore, claimant did receive reimbursement for the mileage to the beach and he included the hours on the beach on his time sheet. Although the injury did not occur on the employer's premises, claimant spent one-third to one-half of his work time away from the employer's offices. Accordingly, the fact that the injury occurred off the employer's premises weighs less heavily in SAIF's favor in this case. Finally, the significant discretion claimant had in conducting his work activity weighs in favor of compensability. See 1 Larson, Workmen's Compensation Law, Section 19.62 at 4-411 (1985).

While these factors support a compensability finding under the Mellis analysis, other circumstances surrounding the accident lead us to conclude that the injury was not sufficiently work related to be compensable. Assuming that claimant remained in the course and scope of employment when he initially detoured to the beach, he clearly deviated from any business purpose and was on a personal mission once he arrived at the beach. See Workmen's Compensation Law, supra, Section 19.35 at 4-387 thru 4-390, Section 19.61 at 4-406 to 4-407. At that point, instead of parking the car and discussing the day's events with Ms. Mecone, he continued driving the truck south, along the surf, in four-wheel drive. We are not persuaded that this part of the detour served any business purpose. See Hackney v. Tillamook Growers, 39 Or App 644 (1979).

The employer did not direct claimant to drive along the surf. By claimant's own admission, he and Ms. Mecone were unable to discuss business while he was driving and, therefore, could not have done so while driving along the surf. Furthermore, there is no evidence that traveling in a pickup truck on a beach was an ordinary risk of claimant's employment. In driving along the surf, claimant created the hazard that caused the accident. See Workmen's Compensation Law, supra at 4-406 to 4-407. Moreover, the injury occurred after claimant had driven a mile and one-half down the beach, traveling away from Whiskey Run Road, the only road in the immediate area back to Highway 101. Therefore, it cannot be said that they had resumed their business trip at the time of the accident. See Workmen's Compensation Law, supra at 4-390.

Under these circumstances, we conclude that claimant had deviated from the course and scope of his employment at the time of the accident. Accordingly, we affirm the Referee's ruling that the claim is not compensable.

ORDER

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

In the Matter of the Compensation of
KATHLEEN A. MECONE, (DECEASED), Claimant
WCB Case No. 87-17212
ORDER ON REVIEW
Malagon & Moore, Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Brittingham, Nichols and Crider.

The SAIF Corporation requests review of Referee Brown's order that set aside its denial of a claim for fatal injuries sustained by claimant in a motor vehicle accident. On review, the issue is whether the fatal accident occurred within the course and scope of claimant's employment. We reverse.

FINDINGS OF FACT

Claimant worked at the employer's offices in Coos Bay, Oregon. Claimant and her immediate supervisor, Mr. Edney, were injured in a motor vehicle accident on the evening of September 4, 1987. At the time of the accident, claimant and Mr. Edney were enroute back to Coos Bay from a one-day field trip to Port Orford, Oregon. Mr. Edney was driving and they were traveling in his truck. The employer requires Mr. Edney to use his own vehicle on business trips and reimburses him for mileage.

On their way back to Coos Bay, claimant and Mr. Edney stopped to eat dinner at Bandon. Mr. Edney consumed two beers at dinner and claimant drank one beer. Following dinner, they continued driving north on Highway 101, toward Coos Bay. At this point, claimant began drinking from a pint bottle of whiskey she had purchased earlier that day.

Claimant and Mr. Edney were scheduled to return that evening to the employer's offices in Coos Bay to report to their supervisor about the events of the day. Following dinner, claimant and Mr. Edney decided to take a side-trip to Whiskey Run Beach to relax, collect their thoughts and prepare their report. The detour to Whiskey Run Beach was not on their planned itinerary. On a previous field trip, they had stopped on their way home to discuss the day's events. On the trip at issue here, claimant and Mr. Edney had not discussed business over dinner in Bandon because they considered the information to be proprietary and were concerned about being overheard. They did not discuss business while the truck was in operation because Mr. Edney felt driving required his full concentration.

The trip to Whiskey Run Beach took 15 to 20 minutes, one-way, a distance of 10 to 12 miles. Claimant and Mr. Edney turned off Highway 101 between Bandon and Coos Bay, traveling northwest on Seven Devils Road, and then due west on Whiskey Run Road, which dead-ends at Whiskey Run Beach. Whiskey Run Road is the only beach access road in the immediate area.

Claimant and Mr. Edney arrived at the beach shortly before sunset. Mr. Edney did not immediately park the truck but, instead, shifted into four-wheel drive and drove south down the beach on the wet sand adjacent to the water. The truck overturned and rolled after they had driven a mile to a mile and one-half down the beach. Claimant and Mr. Edney were both injured. Claimant later died as a result of her injuries.

FINDING OF ULTIMATE FACT

Claimant's injury did not occur within the course and scope of her employment.

CONCLUSIONS OF LAW AND OPINION

In order to be compensable, claimant's injury must have occurred within the course and scope of her employment. Former ORS 656.005(8)(a). The ultimate inquiry is whether the relationship between the injury and employment is such that the injury should be compensable. Rogers v. SAIF, 289 Or 633 (1985).

Neither party challenges the Referee's finding that the overall business trip to and from Port Orford was within the course and scope of employment. The pivotal issue is, instead, whether the detour to the beach and drive along the surf took claimant out of the course and scope.

The Referee apparently analyzed the detour to the beach under the so-called "coming and going rule" and the "dual purpose exception" to that rule. SAIF also applies this rule in its brief on review. Under the rule, injuries sustained by employees going to or coming home from their regular place of work are generally held not to be within the course and scope of employment. Brown v. SAIF, 43 Or App 447, 452-3 (1979). Under the "dual purpose" exception to the rule, an activity is a personal trip and outside the employment if it would have been made in spite of the failure or absence of the business purpose, or it would have been dropped in the event of failure of the private purpose though the business errand remained undone. Id.

The Referee concluded that the "dual purpose" exception applied only to Mr. Edney and not to claimant because claimant did not have control over Mr. Edney's actions, and Mr. Edney's status as claimant's supervisor constituted a sufficient work relationship between the activity and claimant's employment to make the accident compensable as to claimant. We disagree with the Referee's analysis. At the time of the accident, claimant was neither going to nor coming home from her regular place of business; she was engaged in a side-trip while traveling back to the employer's offices from a one-day business trip to the coast. Accordingly, the "coming and going" rule is not applicable in this case.

We, instead, analyze the detour to the beach under the seven-factor test adopted by the court in Mellis v. McEwen, 74 Or App 571, 575, rev den 300 Or 249 (1985): (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employee; (3) whether the risk was an ordinary risk of, and incidental to, the employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed by or acquiesced in by the employer; and (7) whether the employee was on a personal mission of his own. See also Preston v. SAIF, 88 Or App 327 (1987).

Here, there is evidence that claimant and Mr. Edney agreed to go to the beach at least in part for the business purpose of preparing for the report to their supervisor. Mr. Edney testified that they were unable to talk enroute because he needed to concentrate on his driving. Furthermore, Mr. Edney and his supervisor both testified that claimant and Mr. Edney had stopped while traveling home from a previous business trip to discuss the events of the day, and the employer acquiesced in this practice. Neither the detour to the beach, nor claimant's consumption of whiskey, nor the drive along the surf were specifically prohibited by the employer. Mr. Edney received reimbursement for the mileage to the beach.

While these factors support a compensability finding under the Mellis analysis, after considering the other circumstances surrounding the accident we conclude that the injury was not sufficiently work related that it should be compensable. Assuming that claimant remained in the course and scope of employment when she and Mr. Edney initially detoured to the beach, they clearly

deviated from any business purpose and were on a personal mission once they arrived at the beach. See 1 Larson, Workmen's Compensation Law, Section 19.35 at 4-387 thru 4-390, Section 19.61 at 4-406 to 4-407 (1985).

At that point, instead of parking the car and discussing the day's events, they continued driving the truck south, along the surf, in four-wheel drive. We are not persuaded that this part of the detour served any business purpose. See Hackney v. Tillamook Growers, 39 Or App 644 (1979). The employer did not direct them to drive along the surf. By Mr. Edney's own admission, he and claimant were unable to discuss business while he was driving and, therefore, could not have done so while driving along the surf. Furthermore, there is no evidence that traveling in a pickup truck on a beach was an ordinary risk of claimant's employment. In driving along the surf, claimant and Mr. Edney created the hazard that caused the accident. See Workmen's Compensation Law, supra at 4-406 to 4-407. Moreover, the injury occurred after claimant and Mr. Edney had driven a mile and one-half down the beach, traveling away from Whiskey Run Road, the only road in the immediate area back to Highway 101. Therefore, it cannot be said that they had resumed their business trip at the time of the accident. See Workmen's Compensation Law, supra at 4-390.

For these reasons, we find that claimant's injury did not occur within the course and scope of her employment. In so finding, we disagree with the Referee's conclusion that claimant should not be held accountable for the deviation because she did not have control of the vehicle. In support of this position, the Referee relied on the "employer's conveyance doctrine" discussed by Larson in The Law of Workmen's Compensation, supra, Section 17.10 at 4-209 to 4-218. Under this doctrine, if a trip to and from work is made in a vehicle under the control of the employer, an injury during that trip is incurred in the course of employment. Assuming without deciding that the "employer conveyance doctrine" is applicable where the vehicle is neither owned nor leased by the employer, we conclude that claimant's injury is not compensable under the doctrine.

The doctrine requires some measure of control over the vehicle by the employer. Id. As claimant's beneficiaries have the burden of proving that claimant was within the course and scope of employment at the time of the accident, the beneficiaries must establish that the degree of employer control was sufficient to keep the activity within the course and scope of employment. The Referee reasoned that the requisite employer control was established by the supervisor-employee relationship between claimant and Mr. Edney, and the fact Mr. Edney was driving the vehicle. We disagree. Mr. Edney testified that claimant agreed to the side-trip to the beach. There is no evidence in the record to support a finding that claimant was not an active participant in the subsequent decision to drive along the surf after they arrived at the beach. Thus, claimant's beneficiaries have not carried their burden of proving that the employer had sufficient control over the vehicle to keep her within the course and scope of her employment.

Finally, we note the argument of claimant's beneficiaries that this case is compensable under the "traveling employee rule." Under that rule, any employee whose work entails travel away from the employer's premises is held to be within the course and scope of employment continuously during the trip, except when a distinct departure on a personal errand is shown. Simons v. SWF Plywood Co., 26 Or App 137, 143 (1976). We conclude that the traveling employee rule is not applicable to the type of one-day business trip at issue here, where the employee is not required to stay away from home overnight. Moreover, assuming the rule were applicable here, for the reasons stated above we would conclude that the drive down the beach was a distinct departure on a personal errand.

Accordingly, we conclude that claimant's injury is not compensable, and we reverse the Referee's ruling to the contrary.

ORDER

The Referee's order dated February 11, 1988 is reversed. The SAIF Corporation's denial is reinstated and upheld. The $3,000 assessed attorney fee awarded by the Referee is reversed.

Board Member Crider dissenting.

I do not agree with my colleagues' view that claimant left the course and scope of employment when her supervisor, the driver of the vehicle in which the accident occurred, drove along the surf after reaching the beach. Claimant was on a business trip. She did not choose to deviate from it. Rather, the record suggests that the supervisor chose to deviate from it. As passenger and subordinate, she had no choice but to remain in the vehicle. Therefore, I would hold that she remained in the course and scope of employment when the fatal accident occurred.

I have not quarreled with the majority's decision not to award benefits to the supervisor because, in driving down the surf, he embarked on a mission of his own, i.e., a joy ride. Joseph M. Edney, 43 Van Natta 163 (1991). This departure added risk beyond the ordinary risks of business travel. Nevertheless, claimant did not choose to engage in the joy ride. Thus, she cannot be said to have engaged in any personal mission of her own. The record indicates that claimant and her supervisor decided that they needed to stop to talk and that they should do so at the beach. (Tr. 22.) However, the decision to drive down the surf was apparently not mutual; indeed, the supervisor testified that when he reached the beach, he simply shifted into four-wheel drive and took off down the beach. (Tr. 23, 33.) Claimant's situation was that of a worker/passenger who is injured when, during what commenced as a business trip, the driver takes a detour for a private purpose. Such workers are entitled to compensation. See Lind Engineering Co.v. Auxer, 519 P.2d 1211 (Colo. App. 1984). Under these circumstances, I am persuaded that claimant cannot be said to have left the course and scope of her employment. Therefore, I would affirm.

January 29, 1991 Cite as 43 Van Natta 169 (1991)

In the Matter of the Compensation of
LYLE L. SMITH, Claimant
WCB Case No. 89-20618
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Daron's order which: (1) upheld the SAIF Corporation's denial of his aggravation claim for his right knee condition; (2) declined to award temporary disability benefits from December 20, 1989 through January 4, 1990; (3) declined to assess penalties and attorney fees for SAIF's allegedly unreasonable denial; (4) declined to assess penalties and attorney fees for SAIF's allegedly late denial; and (5) declined to assess penalties and attorney fees for SAIF's allegedly unreasonable failure to pay interim compensation. On review, the issues are aggravation, temporary disability benefits, and penalties and related attorney fees. We affirm in part and reverse in part.

FINDINGS OF OF FACT

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

In the December 1988 Stipulation and February 1989 Amended Stipulation, claimant stipulated that he was not in the work force in December 1988 and February 1989. (Exs. 32 & 33).

Claimant, who is 60 years old, has actively looked for other employment since December 1988 because he needed money to support himself and his family. (Tr. 16). In May 1989, claimant worked for the employer driving a tractor and plowing the employer's field for three to four days. (Tr. 15-16). Claimant raises 20-25 head of cattle and made approximately $300-$400 in 1989 from this activity. (Tr. 14-15).

Claimant's grandson assists him in caring for his cattle. (Tr. 19). In December 1988, claimant had been capable of dragging a bale of hay by hand out to the pasture, an act which, because of his painful right knee, he no longer can perform. (Tr. 14). Claimant cannot walk or stand as long as he could in December 1988. (Tr. 12). He cannot lift nor carry as much as he could in December 1988. (Tr. 12-13). His right knee becomes stiff more often than it did in December 1988. (Ex. 34A; Tr. 11).

On November 30, 1989, SAIF received Dr. Thomas' November 16, 1989 chart note indicating that claimant's right knee was more symptomatic with swelling and pain and that he had discussed with claimant the possibility of a total knee replacement. (Ex. 34A).

SAIF denied claimant's aggravation claim on January 4, 1990. (Ex. 37).

ULTIMATE FINDINGS OF FACT

Claimant has experienced an increased loss of use or function of his right knee/leg as a result of the worsening of his injury condition since the last arrangement of compensation.

At the time it issued its denial, SAIF had a legitimate doubt that claimant had experienced an increased loss of use or function of his right knee/leg since the last arrangement of compensation.

At the time claimant became disabled due to the worsening of his right knee, he was in the work force.

After the last arrangement of compensation, SAIF received notice of both a worsened condition and claimant's medically verified inability to work by November 30, 1989.

CONCLUSIONS OF LAW AND OPINION

Aggravation

The Referee held that claimant had not proven an aggravation of his compensable knee condition. We disagree.

In order to establish a compensable aggravation, claimant must prove a worsened condition resulting from his compensable knee injury. ORS 656.273(1); Perry v. SAIF, 307 Or 654 (1989). To prove a worsening of a scheduled body part, claimant must show that he has experienced increased loss of use or function of his right leg since the last award of compensation, the February 1989 Amended Stipulation. See International Paper Co. v. Turner, 304 Or 354 (1988).

In June 1989, Dr. Thomas wrote that claimant's condition "is gradually deteriorating." (Ex. 36). In November 1989, Dr. Thomas wrote that claimant's "right knee is becoming more symptomatic with swelling and pain" and that claimant is unable to perform his previous job. (Ex. 34A). Claimant testified that because of the pain in his right knee he is unable now to perform many activities that he could do in December 1988. We are persuaded that claimant experienced a worsening of his compensable knee condition, due to degeneration, which diminished the use or function of his right leg since the December 1988 Stipulation and February 1989 Amended Stipulation.

Accordingly, we conclude that claimant has sustained a compensable aggravation of his right knee/leg condition.

Penalties and Attorney Fee For Unreasonable Denial

Penalties and attorney fees may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10); 656.382(1). The standard for determining the reasonableness of a denial is whether the carrier had a legitimate doubt as to its liability. Reasonableness and "legitimate doubt" are considered based upon the information available to the carrier at the time of its denial. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n.3 (1985); Mt. Mazama Plywood Co. v. Beattie, 62 Or App 355, 358 (1983).

On November 30, 1989, SAIF received Dr. Thomas' November 16, 1989 chart note indicating that claimant's right knee had become more symptomatic with swelling and pain. (Ex. 34A). At the time of the denial SAIF had also received Dr. Thomas' June 1989 letter to claimant's attorney indicating that claimant's right knee was getting worse by gradually deteriorating. Additionally, at the time of the denial, SAIF had received Dr. Thomas' November 20, 1989 letter. However, in his November 20, 1989 letter, Dr. Thomas wrote:

> "[Claimant] is gradually deteriorating as we anticipated, and as mentioned in the first paragraph of your letter. To me, his situation is about the same ... *** I feel his condition is medically stationary with the previous impairment level as indicated in paragraph one." (Ex. 35) (emphasis added).

We conclude that, although Dr. Thomas' letters and chart note indicate an aggravation of claimant's condition, Dr. Thomas' November 20, 1989 letter created a legitimate doubt as to whether claimant had sustained an increased loss of use or function of his right knee since the last arrangement of compensation. See International Paper Co. v. Turner, supra. Accordingly, we conclude that SAIF's denial was not unreasonable based upon the information it had at the time of its denial.

Penalties and Attorney Fees for Late Denial

Claimant additionally argues that SAIF's denial, issued on January 4, 1990, is a late denial. An insurer must accept or deny a claim within 60 days after notice of the claim, or risk the imposition of penalties and attorney fees. ORS 656.262(6) & (10). As the Referee stated, although Dr. Thomas wrote a letter regarding claimant's aggravated condition to claimant's attorney in June 1989, there is no indication in the record when SAIF received this letter. The evidence in the record indicates that notice to SAIF was given by Dr. Thomas' November 16, 1989 chart note which is date-stamped as received by SAIF on November 30, 1989. The record does not establish earlier notice of the claim. SAIF's January 4,

1990 denial was issued within 60 days of the November 30, 1989 notice and was not, therefore, a late denial.

Entitlement to Interim Compensation Benefits

The Referee held that because claimant, in the Stipulations, had agreed that he had withdrawn from the work force, he "cannot legally renege on that agreement." Therefore, the Referee concluded, claimant was "not in the work force" and is not entitled to interim compensation. Based upon the following reasoning, we find that claimant was in the work force at the time of his aggravation.

To receive temporary disability upon aggravation of a work-related injury, claimant must be in the work force at the time of aggravation. Cutright v. Weyerhaeuser, 299 Or 290 (1985). The critical time for determining whether claimant has withdrawn from the work force is at the time of his disability. Weyerhaeuser Co. v. Kepford, 100 Or App 410, 414 (1990). In December 1988 and February 1989, when the Stipulations were approved, claimant considered himself out of the work force. However, withdrawal from the work force is not irrevocable. Wausau Ins. Companies v. Morris, 103 Or App 270, 273 (1990); see also SAIF v. Stephen, 303 Or 41 (1989). Claimant can reenter the work force for aggravation purposes if, although not employed at the time, he is willing to work and is making reasonable efforts to obtain employment, or is willing to work, although not employed at the time of disability and not making reasonable efforts to obtain employment because of his work related injury/condition, where such work-finding efforts would be futile. Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989).

In this case, the employer hired claimant for temporary work in May 1989, after approval of the Stipulations. Additionally, claimant testified that he has filled out applications, made phone calls and/or personally talked to people with 50-60 companies regarding his employment prospects and is still actively looking for other work. (Tr. 21). We find that testimony persuasive. Accordingly, we conclude that claimant was in the work force at the time of his aggravation.

In an aggravation situation, an insurer must make the first payment of interim compensation no later than 14 days after the insurer has notice or knowledge of a worsening and of claimant's medically verified inability to work. ORS 656.273(6); Berkey v. Fairview Hospital, 94 Or App 28 (1988). Claimant has the burden of proving the date on which the insurer received the notice. Here, Dr. Thomas' November 20, 1989 letter was received by SAIF on November 30, 1989. Dr. Thomas wrote that claimant "is unable to perform his regular job but he could perform a sedentary job ..." We conclude that Dr. Thomas' letter constitutes a medical verification of claimant's inability to work and that claimant is entitled to temporary disability as of November 30, 1989, the date SAIF received the medical verification, to January 4, 1990, when SAIF denied the aggravation claim.

Penalties and Attorney Fees For Failure to Pay Interim Compensation

A carrier is liable for a penalty and associated attorney fee for unreasonably delaying or refusing to pay compensation due. ORS 656.262(10); ORS 656.382(1). SAIF has offered no justification for its failure to pay interim compensation after November 30, 1989. Accordingly, we conclude that SAIF's failure or refusal to pay interim compensation from November 30, 1989 was unreasonable and a penalty and fee are warranted. We assess a penalty of 25 percent of the temporary disability compensation due under this order. ORS 656.262(10).

The same conduct constitutes an unreasonable resistance to the payment of compensation. Consequently, claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee in the amount of $250 for services in connection with the unreasonable resistance to the payment of interim compensation. ORS 656.382(1).

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 aggravation issue is $2,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the moderate complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated March 15, 1990 is affirmed in part and reversed in part. The SAIF Corporation's aggravation denial is set aside and the claim is remanded to SAIF for processing according to law. That portion of the order that declined to award claimant interim compensation is reversed. That portion of the order that declined to assess a penalty and associated attorney fee regarding SAIF's failure to pay interim compensation is reversed. SAIF shall pay interim compensation benefits commencing November 30, 1989 through January 3, 1990, less amounts previously paid. Claimant is awarded a penalty in the amount of 25 percent of the interim compensation due under this order. For services regarding the penalty issue, claimant's attorney is awarded an assessed fee of $250, payable by SAIF. The remainder of the order is affirmed. Claimant's attorney is allowed an approved fee, in the amount of 25 percent of the interim compensation awarded under this order, not to exceed the $1,050 maximum fee provided by retainer agreement. For services at hearing and on review regarding the aggravation issue, claimant's attorney is awarded an assessed fee in the amount of $2,500, payable by SAIF.

January 29, 1991 Cite as 43 Van Natta 173 (1991)

In the Matter of the Compensation of
BUFORD M. SPENCER, Claimant
WCB Case No. 89-20285
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Lester R. Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Garaventa's order which: (1) found that claimant's claim had not been prematurely closed; and (2) affirmed a Determination Order award of 27 percent (86.4 degrees) unscheduled permanent disability for his low back condition. On review, the issues are premature claim closure and extent of unscheduled permanent disability. We affirm in part and modify in part.

FINDINGS OF FACT

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

Claimant sustained prior compensable low back injuries in 1978, 1980 and 1981. (Exs. 3, 6, 7).

Dr. Ito, radiologist, compared x-rays taken of claimant's lumbar and thoracic spine in 1978 to those taken in August 1985. (Ex. 1).

BBV Medical Service, Inc. (BBV) examined claimant three times -- January 1986, July 1986, and August 1989. (Exs. 12, 22 & 53). BBV noted claimant's previous compensable low back injuries in the August 1989 report. (Ex. 53-5). In July 1986, BBV recommended that claimant could return to modified work in the medium capacity. (Ex. 22). BBV's August 28, 1989 report included the most recent range of motion findings. (Ex. 53-6).

An MRI performed in June 1988 indicated that claimant has a disc protrusion at L4-5 and a bulge at L5-S1 level. (Ex. 42).

Claimant was medically stationary on April 11, 1989 and his claim closed by Determination Order on October 11, 1989. (Exs. 57-60). He is limited in his ability to sit, stand and lift repetitively. (Tr. 20-23).

CONCLUSIONS OF LAW AND OPINION

Medically-Stationary Date

We adopt the Referee's "Conclusions and Opinion" regarding the medically-stationary date.

Extent

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. Former OAR 438-10-010.

Because claimant's condition became medically stationary on April 11, 1989, and his claim was closed by Determination Order on October 11, 1989, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled 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. Former OAR 436-35-280.

In the present case, claimant does not dispute the values assigned by the Referee for claimant's age, formal education and skills. We adopt the values and reasoning related to those values assigned by the Referee and discuss only the issues of training, adaptability and impairment.

Training

Claimant argues that the Referee's assignment of a zero value for training is not appropriate because claimant's vocational training has not enabled him to find work.

Whether claimant is entitled to a value for training under former OAR 436-35-300(5) is dependent upon whether or not claimant has demonstrated competence in some specific vocational pursuit. Competence in some "specific vocational pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off the job to perform other than an entry-level position. Larry L. McDougal, 42 Van Natta 1544 (1990). Speculation as to claimant's employment prospects is not a factor to be used in determining a value under former OAR 436-35-300(5).

Here, claimant has demonstrated competence in a specific vocational pursuit. Therefore, the appropriate training value is 0. Former OAR 436-35-300(5).

Adaptability

Claimant argues that the Referee incorrectly assigned a value of 1 for adaptability. We agree.

Claimant was released to modified work in the medium capacity; there was no offer of modified work; claimant is not working at the present time; and claimant credibly testifies that he has limitations in his ability to sit, stand and lift repetitively.

The adaptability value for claimant, who is not working as a result of his compensable injury, is determined by claimant's residual physical capacity, without regard to claimant's physical capacity prior to the injury. Former OAR 436-35-310(4). When a worker's physical capacity falls within one of the four categories but he has limitations in the ability to sit, stand, walk, carry, stoop, crouch, kneel, or twist, the adaptability value shall be the average of the value for the category for which they qualify and the value for the next lower category. Former OAR 436-35-310(4).

Claimant has the physical capacity to perform medium work and has limitations in his ability to sit, stand and lift. The average of the value for the medium category of 1, and the value for the next lower category, light, of 4, is 2.5. Therefore, the appropriate adaptability value is 2.5. Former OAR 436-35-310(4)(b) & (c).

Impairment

The Referee noted that claimant has a preexisting disc condition at L4-5. BBV noted that x-ray films taken prior to the present injury indicate a "narrowing at L4-5" attributable to claimant's prior compensable injuries. (Ex. 53). A CAT scan taken in December 1986, and an MRI in 1988, indicate a disc protusion at L4-5 and a bulge at L5-S1 level. (Ex. 53-2). The weight of the evidence indicates that the disc bulge/protusions at L4-5 and L5-S1 are causally related to the current compensable injury. Accordingly, we assign a total value of 8 percent for the current disc derangements of claimant's lumbar spine. Former OAR 436-35-350(2).

Claimant flexes 60 degrees for a value of 3 percent. Former OAR 436-35-360(6).

Claimant extends 15 degrees for a value of 1.5 percent. Former OAR 436-35-360(7).

Claimant can bend to the left side 9 degrees for a value of 4.2 percent. Former OAR 436-35-360(8). Claimant can bend to the right side 8 degrees for a value of 4.4 percent. Former OAR 436-35-360(8).

There is no specific finding for claimant's range of rotation.

For a total rating of the thoracolumbar area the values for loss of motion are added for a total of 13.1 percent. Former OAR 436-35-360(10).

Claimant has limited ability to sit, stand and lift repetitively and is entitled to 5 percent impairment. Former OAR 436-35-320(4).

For a total rating of claimant's multiple residuals, the ratings are combined to reach a final impairment rating of 24.1. Former OAR 436-35-360(11).

Computation of Unscheduled Permanent Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 1, is added to his education value, 2, the sum is 3. When that value is multiplied by claimant's adaptability value, 2.5, the product is 7.5. When that value is added to claimant's impairment value, 24.1, the result is 31.6 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, 32 percent.

ORDER

The Referee's order dated March 20, 1990 is affirmed in part and modified in part. In addition to the 27 percent (86.4 degrees) unscheduled permanent disability awarded by the Determination Order, claimant is awarded 5 percent (16 degrees) unscheduled permanent disability, giving him a total award to date of 32 percent (102.4 degrees) unscheduled permanent disability for his low back injury. Claimant's attorney is awarded 25 percent of the increased unscheduled permanent disability benefits awarded by this order in an amount not to exceed $3,800. The remainder of the Referee's order is affirmed.

January 29, 1991 Cite as 43 Van Natta 176 (1991)

In the Matter of the Compensation of
KAREN J. VEGA, Claimant
WCB Case No. C0-00616
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Michael B. Dye, Claimant Attorney
Schwabe, et al., Defense Attorneys

On January 2, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

Former OAR 436-60-145(6) requires that a claim disposition agreement contain specified information concerning claimant and the history of the claim. A proposed disposition that does not contain the required information will not be approved by the Board. See former OAR 436-60-145(8). Such an agreement is deemed unreasonable as a matter of law. ORS 656.236(1)(a); OAR 438-09-020(2).

Here, the proposed disposition recites that claimant incurred an injury to her right thumb, neck, upper back and right shoulder. The proposed disposition also states that, as a result of claimant's injury, she suffered right thumb tendonitis and right shoulder rotator cuff tendonitis. The rules provide that a proposed claim disposition agreement must identify the accepted conditions that

are the subject of the disposition. Former OAR 436-60-145(6)(b). However, we are unable to ascertain which of claimant's conditions were accepted. This information is required pursuant to former OAR 436-60-145(6). Under these circumstances, the proposed disposition is unreasonable as a matter of law. Accordingly, we decline to approve the agreement and it is therefore returned to the parties.

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

We note that, as a result of our disapproval, any new disposition submitted by the parties will be subject to the current rules which became effective December 26, 1990. See OAR 436-60-003(4). Such dipositions must include the bold face notice required by current OAR 436-60-145(4)(g). In addition, the disposition must provide the order clause as required by current OAR 438-09-020(1)(c).

Following our standard procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

January 30, 1991 Cite as 43 Van Natta 177 (1991)

In the Matter of the Compensation of
DIANE E. BACKES, Claimant
WCB Case No. C1-00021
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Bischoff & Strooband, Claimant Attorneys
Roberts, et al., Defense Attorneys

On January 8, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

OAR 436-60-145(2) requires the insurer or self-insured employer provide claimant with certain information concerning claims disposition agreements. OAR 436-60-145(4)(f) requires that a proposed agreement contain a recital that such information was provided to claimant. Similarly, OAR 436-60-145(4)(g) requires that claimant be provided with a specified notice in prominent or bold face type. OAR 436-60-145(4)(g), however, requires the specified notice to be in the proposed agreement as opposed to merely reciting that claimant has received such notice.

Here, although the notice required pursuant to OAR 436-60-145(4)(g) is in the file, it is not in the actual agreement, nor is it incorporated into the agreement. A proposed disposition that does not contain the required notice will not be approved by the Board. See OAR 436-60-145(5); 438-09-020(1). Such an agreement is deemed unreasonable as a matter of law. ORS 656.236(1)(a); OAR 438-09-020(2). Under these circumstances, the proposed disposition is unreasonable as a matter of law. See OAR 438-09-020(2). Accordingly, we decline to approve the agreement and return it to the parties.

We also note that the proposed agreement is not clear regarding the closure of claimant's claim, particularly in regard to when unscheduled permanent disability was awarded. The proposed disposition notes both March 21, 1989 and August 14, 1990 as dates of closure.

Finally, we note that the parties' failed to provide the order clause as required by OAR 438-09-020(1)(c).

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROSE BUTTS, Claimant
WCB Case Nos. 89-19867 & 89-19868
ORDER ON REVIEW
Callahan & Gardner, Claimant Attorneys
Cummins, et al., Defense Attorneys
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Barber's order which: (1) set aside the SAIF Corporation's denial, on behalf of Elderest Home, of responsibility for claimant's aggravation claim for an occupational disease; and (2) upheld SAIF's denial, on behalf of Fairview Hospital, of compensability and responsibility of the same condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

Claimant has a previously accepted claim with Elderest Home for dermatitis of her hands. She received an award of 5 percent scheduled disability for each hand. Medical experts anticipated that claimant's disease would flare-up any time she was exposed to conditions requiring her hands to be wet.

Claimant changed jobs hoping to avoid exposure to moisture, and began working for Fairview Hospital as a psychiatric aide in late 1987. However, even on that job, her hands were exposed to wet conditions when she helped patients brush their teeth, bathe and clean up. She was free from symptoms for some time when in May or June 1989 she sought treatment for a rash on both hands, and subsequently began treating with Dr. Wright, dermatologist, in June 1989.

In a skin test, claimant tested positive to a number of substances to which she was exposed at Elderest and Fairview.

Dr. Wright diagnosed claimant as having dyshidrotic eczema, allergic and irritant contact dermatitis plus secondary pyoderma. Various combinations of each produce the symptoms that claimant experiences.

ULTIMATE FINDINGS OF FACT

Claimant's dermatitis resulted in major part from her work exposure with Elderest Home and Fairview Hospital.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found that it was claimant's burden to establish a compensable claim against the second employer, Fairview Hospital. We disagree. Claimant may show that her condition is compensable as to either or both employers.

Claimant's treating dermatologist, Dr. Wright, stated that claimant suffers from dyshidrotic eczema as well as allergic and irritant contact dermatitis. He opined that claimant had become sensitized from previous exposures at Elderest Home, but that her most recent contact, at Fairview Hospital, was the major contributing cause of the most recent episode of dermatitis. (Exs. 35, 37). Dr. Parker, chairman of the Department of Dermatology at Oregon Health Sciences University, stated that it was likely claimant's work caused her dermatitis, and he thought it was likely that she would experience dermatitic flares, given her past history. (Exs. 27, 30).

The evidence establishes that claimant's employment with one or both employers was the major contributing cause of her dermatitis. Accordingly, we conclude that claimant has met her burden of proving that her current dermatitis is compensable.

Responsibility

Responsibility for claimant's dermatitis remains with her first employer, Elderest Home, unless subsequent employment independently contributed to a worsening of her underlying condition. Bracke v. Baza'r, 293 Or 239 (1982); Roseburg Lumber Co. v. Louisiana-Pacific, 81 Or App 454 (1986); Industrial Indemnity v. Weaver, 81 Or App 493 (1986); Fred Meyer v. Ben Franklin Savings & Loan, 73 Or App 795 (1975). We find that it did not.

In his opinion concerning the current exacerbation of claimant's dermatitis condition, Dr. Wright stated that combinations of allergic and irritant contact dermatitis were the cause of the flare-up. He initially stated that the exacerbation was a recurrence of the previous industrial injury, but he had not ruled out the possibility of a newly-acquired contact allergy. He later opined that the current exposure did not contribute to a material worsening of claimant's prior condition. (Ex. 35-2). Although the current episode was caused by claimant's most recent exposure to irritants at work, Dr. Wright felt that claimant had been previously sensitized and would continue to erupt. (Ex. 37). He also concluded that there was no underlying pathological change due to the most recent exposure. (Ex. 38-10).

After de novo review of the record, we conclude that it has not been proven by a preponderance of the evidence that claimant's exposure to irritants at her employment with Fairview Hospital independently contributed to a worsening of her underlying condition. Accordingly, responsibility remains with her first employer, Elderest Home.

ORDER

The Referee's order dated February 26, 1990, as reconsidered March 26, 1990, is affirmed.

In the Matter of the Compensation of
RODNEY L. KOSTA, Claimant
WCB Case Nos. 89-24174, 89-03008, 89-15824 & 89-15825
ORDER ON RECONSIDERATION
Merrill Schneider, Claimant Attorney
Scheminske & Lyons, Defense Attorneys
Lane, Powell, et al., Defense Attorneys
Williams & Peck, Defense Attorneys
Pamela Schultz, Defense Attorney

Claimant requested reconsideration of our December 18, 1990 Order on Review which: (1) upheld Liberty Northwest Insurance Corporation's denial, issued on behalf of the Oregonian, of claimant's aggravation claim for his current back condition; (2) upheld Liberty Northwest's denial, issued on behalf of Parker Pole Construction, of claimant's "new injury" claim for the same condition; (3) upheld Liberty Northwest's "de facto" denial, issued on behalf of ASB Construction, for the same condition; and (4) upheld Aetna Casualty Insurance Company's "de facto" denial, on behalf of SD Deacon Construction, for the same condition.

On January 9, 1990, in order to fully consider the matter, we abated our prior order and granted the parties an opportunity to respond. After reviewing responses from the Oregonian, SD Deacon Construction, ASB Construction, and Parker Poles, we make the following conclusions.

Claimant contends that the Referee erred in determining compensability of claimant's aggravation/new injury claim before determining the issue of responsibility. Specifically, claimant contends that Parker Poles stipulated at hearing that its July 11, 1989 denial denied only responsibility and, therefore, the only issue at hearing was responsibility. We disagree.

When compensability and responsibility are both at issue, as here, the threshold issue is compensability. Elizabeth Coomer, 41 Van Natta 2300 (1989). In our de novo review, we found that claimant had not experienced a compensable aggravation. Further, we concluded that the subsequent employers did not materially contribute to claimant's disability or need for treatment. Consequently, inasmuch as claimant's claim was found to be noncompensable, there was no basis for shifting responsibility. See Columbia County School District #13 v. Thurston, 96 Or App 686 (1989).

Additionally, although we found that Parker Pole did stipulate at hearing that its July 11, 1989 denial denied only responsibility, the remaining parties, the Oregonian, SD Deacon Construction and ASB Construction, continued to argue compensability at hearing. The Oregonian, which accepted claimant's 1984 injury claim, specifically issued a denial encompassing both compensability and responsibility. Accordingly, the fact that one potentially responsible party has stipulated that its denial is solely one of responsibility, does not alter the fact compensability remained in issue.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
JACK E. METZ, Claimant
WCB Case No. 89-22155
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of that portion of Referee Seifert's order that increased claimant's unscheduled permanent disability award for a bilateral shoulder injury from 32 percent (102.4 degrees), as awarded by a Notice of Closure, to 46 percent (147.2 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

Claimant was 56 years old at hearing. On July 25, 1986, he injured his shoulders while moving a ladder at work. SAIF accepted torn rotator cuffs of the left and right shoulders. The claim was closed on October 26, 1989 by Notice of Closure which awarded 32 percent unscheduled disability for claimant's bilateral shoulder condition.

Before the injury now in issue and after right rotator cuff surgery in 1985, claimant returned to construction work. In March 1987, after the present injury, Dr. Schachner performed left rotator cuff repair.

Claimant is a high school graduate. He is competent in a specific vocational pursuit, having practiced carpentry successfully for over 20 years.

Claimant's work at injury required heavy lifting. After this injury, claimant returned to modified work as a construction foreman (in the sedentary range) for the same employer. On December 7, 1989, he was terminated for reasons unrelated to his injury.

Claimant has lost about 30 percent of his former shoulder strength and suffers pain which limits the use of his shoulders. He retains the following ranges of motion in his shoulders: 95 degrees abduction, bilaterally; 115 degrees forward elevation, bilaterally; 40 degrees backward elevation, bilaterally; 30 degrees left internal rotation; 40 degrees right internal rotation; and 40 degrees external rotation, bilaterally.

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 former ORS 656.726(3)(f). See former ORS 656.283(7). Specifically, we apply the version of former OAR 436-35-001 et seq, in effect at the time of the October 26, 1989 Notice of Closure from which claimant requested a hearing.

After claimant's 1985 surgery, he returned to construction work and "effectively did quite well." (Ex 3-1). However, since his accepted 1986 injury, claimant has suffered continuous symptoms in both shoulders. Inasmuch as there is no evidence of intervening or off-work factors affecting claimant's bilateral shoulder condition, we conclude that claimant's current problems are related to his 1986 injury.

We rate claimant's impairment as of the date of hearing. In this regard, we rely primarily on the January 31, 1990 measurements made by Dr. Woolpert.

Claimant is entitled to a 10.5 percent rating for lost range of motion in his right shoulder and 11.5 percent rating for lost range of motion in his left shoulder. (See Ex. 35-3). Former OAR 436-35-330(17). In addition, the medical evidence supports ratings of 5 percent for claimant's chronic conditions, which limit repetitive use of each shoulder, and 5 percent for the 1987 surgery to his left shoulder. Claimant is not entitled to a rating for his 1985 surgery, because it predated, and was not "due to," his 1986 injury. See former ORS 656.214(5).

Drs. Woolpert and Schachner reported claimant's loss of strength related to his bilateral shoulder damage. Schachner noted that beyond 60 degrees abduction, "give-way can be accomplished with a moderate degree of resistance. At 90 degrees it takes little in the way of resistance to bring his arm back down to his side." (Ex. 29-2). On this basis, we conclude that claimant has lost about 30 percent of strength in each shoulder, resulting in impairment values of 14.4 percent each. See former OAR 436-35-330(19).

The impairment values for each shoulder are combined, resulting in totals of 27.22 percent for the right shoulder and 31.63 percent for the left shoulder. Former OAR 436-35-005(4). These values are combined for a total impairment value of 50.24 percent. Former OAR 436-35-320(2).

The Referee's age, formal education and skills values of 1, 0 and 1, respectively, are not disputed. We adopt those values. Inasmuch as claimant has 20 years' experience in carpentry and worked as construction foreman after his 1986 injury, we conclude that he has demonstrated competence in a specific vocational pursuit. Consequently, he is not entitled to a value for training. Former OAR 436-35-300(5).

Claimant contends that his adaptability factor should be 8, under former OAR 436-35-310(4), because Schachner limited him to sedentary work. However, inasmuch as claimant returned to modified work after his injury and his nonworking status at hearing is unrelated to his injury, we apply former OAR 436-35-310(3). See Pamela R. Phillips, 42 Van Natta 2696 (1990).

Claimant's pre-injury work required heavy lifting. SAIF concedes that his post-injury work was in the sedentary range. Therefore, under the matrix, claimant's adaptability factor is 3. (Id.)

When the sum of claimant's age and education values, 2, is multiplied with his adaptability factor, 3, the product is 6. When that product is added to his impairment total, 50.25, the total is 56.25. This value is rounded to the next higher whole number, 57. Former OAR 436-35-280(7). Claimant is entitled to 57 percent permanent disability under the standards.

Claimant contends that the record as a whole indicates, by clear and convincing evidence, that he is entitled to 100 percent permanent disability, due to his shoulder conditions. In this regard, claimant relies on Schachner's evaluation of his physical limitations and alleged lack of transferable skills. We disagree, for several reasons. First, we note that an evaluation of claimant's job skills is beyond the expertise of a medical professional. Consequently, his opinion in this regard is not persuasive. Second, we find that, inasmuch as claimant successfully performed in a supervisory capacity -- as construction foreman -- after his injury, he does have skills transferable from his carpentry background. Finally, viewed as a whole, we find that the record does not constitute clear and convincing evidence that claimant suffers greater disability than provided under the standards. See Riley Hill General Contractor Inc. v. Tandy Corp., 303 Or 390 (1987).

ORDER

The Referee's order dated March 28, 1990 is modified. In lieu of the Referee's award and in addition to the 32 percent (102.4 degrees) awarded by the Notice of Closure, claimant is awarded 25 percent (80 degrees) unscheduled permanent disability, giving him a total award to date of 57 percent (182.4 degrees). 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.

January 30, 1991 Cite as 43 Van Natta 183 (1991)

In the Matter of the Compensation of
KEITH L. NUTTING, Claimant
WCB Case No. 89-16708
ORDER ON REVIEW
Gastineau & Smith, Claimant Attorneys
David Schieber (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Crider.

Claimant requests review of Referee Mongrain's order that declined to assess a penalty and attorney fee for the SAIf Corporation's unreasonable claims processing. On review, the issues are penalties and attorney fees. We reverse.

FINDINGS OF FACT

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

At the time claimant returned to work for the employer, the parties intended that claimant would work 30-35 hours per week.

After 16 hours of work, claimant left work on April 28, 1989. He left work due to the compensable injury.

FINDINGS OF ULTIMATE FACT

SAIF unreasonably delayed and resisted the payment of compensation by paying claimant temporary disability benefits at a rate based on a work schedule of 20 hours per week rather than 30-35 hours per week.

CONCLUSIONS OF LAW AND OPINION

When a worker leaves work due to a compensable injury, he is entitled to temporary total disability compensation. The amount of that compensation is based on the worker's average weekly wage. ORS 656.210. When a worker is employed for varying hours, shifts or wages, his rate is to be computed in accordance with former OAR 436-60-020(7)(c), which in turn provides that the average weekly wage be calculated utilizing the averaging method described in OAR 436-60-020(7)(a). That rule provides as follows:

> "Use average weekly earnings for past 26 weeks, if available, unless periods of extended gaps exist, then use no less than last 4 weeks of employment to arrive at average. For workers employed less than 4 weeks, or where extended gaps exist within the 4 weeks, use intent at the time of hire as confirmed by employer and worker." (Emphasis added.)

Although it is now conceded that SAIF miscalculated claimant's compensation under this rule and failed to pay him at the appropriate rate until his attorney intervened, the Referee nonetheless declined to assess a penalty and attorney fee. The Referee reasoned that because the evidence did not permit him to determine whether the employer or SAIF was at fault, and because SAIF corrected the error promptly in December 1989 after claimant's attorney presented it with documentation from the employer of the facts determinative of claimant's entitlement, the claimant had failed to establish unreasonable conduct. We disagree.

The insurer has a duty to timely pay compensation in accordance with the statute and rules. The insurer is not entitled to wait for claimant's attorney to calculate the rate of compensation for it. That SAIF corrected its error more than six months after compensation was due, at the insistance of claimant's attorney, is at best a factor in mitigation; it is not reason to find otherwise unreasonable conduct to be reasonable.

In processing a claim, the employer's knowledge is imputed to the insurer. The employer clearly knew what hours the parties intended that claimant would work. Moreover, it would appear that SAIF did not contact claimant to determine intent at the time of hire despite the clear requirement of the rule. Whether it was SAIF or the employer that erred in this case is immaterial insofar as claimant's rights are concerned. By failing to calculate claimant's temporary total disability rate in accordance with a clear administrative rule, SAIF acted unreasonably and resisted the payment of compensation. Therefore, claimant is entitled to a penalty and assessed attorney fee.

ORDER

The Referee's order dated April 3, 1990 is reversed. Claimant is awarded a penalty of 25 percent of the additional compensation paid pursuant to the recalculation of his temporary total disability rate. Claimant's attorney is awarded a penalty-related fee of $500, payable by SAIF.

In the Matter of the Compensation of
DEBBIE L. MUSE, Claimant
WCB Case No. 90-04624
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Howell and Speer.

The insurer requests review of that portion of Referee Brown's order which awarded 29 percent (92.8 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 permanent disability. We modify.

FINDINGS OF FACT

Claimant sustained a compensable low back injury on November 1, 1989. Her claim was closed on February 22, 1990 by a Determination Order awarding no permanent disability.

Claimant was 32 years old at the time of hearing. She has a 10th grade education. Claimant has demonstrated competence in specific vocational pursuits, namely cashier, assistant service station manager (service station attendant), waitress (take out) and fast food cook. The highest SVP for any job

satisfactorily performed by claimant in the 10 years prior to the date of hearing was 5, as a cashier (DOT # 211.362-010).

Claimant was not working at the time of hearing as a result of her injury and she had been given no "work offer." She is limited to lifting and carrying 20 pounds with restrictions on crouching, climbing, crawling, bending, twisting and kneeling.

Claimant has permanent impairment in the form of a chronic condition limiting repetitive use of her back.

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. Former OAR 438-10-010.

Because claimant's condition became medically stationary on January 23, 1990, and her claim was closed by Determination Order on February 22, 1990, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled 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 claimant is more or less than the entitlement indicated by the "standards." Former 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).

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 and Education

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

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

The highest specific vocational pursuit (SVP) level demonstrated by a claimant during the ten years preceding the date of determination is used to determine a value for skills. Former OAR 436-35-300(4). For our purposes, permanent disability is determined on the date of hearing. The position which claimant successfully performed during the ten years preceding the date of hearing, which has the highest specific vocational pursuit (SVP) level, was a Cashier (DOT # 211.362-010). That SVP level is 5. Therefore, the appropriate value for skills is 2. Former OAR 436-35-300(4).

Whether claimant is entitled to a value for training under former OAR 436-35-300(5) is dependent upon whether or not claimant has demonstrated competence in some specific vocational pursuit. Competence in some "specific vocational

pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off the job to perform other than an entry-level position. Larry L. McDougal, 42 Van Natta 1544 (1990).

Here, claimant has demonstrated competence in specific vocational pursuits. She has skills to perform more than entry-level positions. She has the skills of a cashier, waitress (take out), automobile service station attendant and fast food cook. Therefore, rather than a +1 value, the appropriate training value is 0. Former OAR 436-35-300(5).

Adaptability

The Referee concluded that former OAR 436-35-310(4) was the appropriate rule to use in determining claimant's adaptability value because claimant was not working as a result of her injury, and because there was no evidence in the record to show that claimant had been offered work. We agree.

As used in former OAR 436-35-290 through 436-35-310, work offer means "delivery in person or by certified mail, return receipt requested, of a written offer of work by the employer to which there is a physician's release." Although claimant testified that she had received and refused a written offer, there is no evidence in the record that the written offer was delivered in person or by certified mail, as required by the rule. Former OAR 436-35-270(3)(d). Additionally, the record contains no evidence that claimant's treating physician agreed that claimant was physically capable of performing the job the employer had offered. Former OAR 436-35-270(3)(c). Thus, the record does not establish that claimant received a "work offer." The appropriate rule for determining claimant's adaptability value is former OAR 436-35-310(4).

In reaching this conclusion, we note that, following the issuance of the Referee's order, the insurer attempted to submit documentation concerning a written work offer. We agree with the Referee's rejection of such an unexplained and belated submission. Because the Referee did not reopen, and make the materials a part of the record, such materials have not been considered. ORS 656.295(5).

We turn to a determination of the adaptability value. Such a value for a claimant who is not working as a result of her compensable injury/condition 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).

The Referee relied on the February 26, 1990 independent medical examination of Drs. Potter and Kho in determining claimant's residual physical capacity. We agree because their evaluation was thorough, well-reasoned and based on a complete understanding of claimant's medical history. Even though these physicians found inconsistencies between the objective and subjective findings, they persuasively concluded, as a result of their examination, that claimant was limited to lifting 20 pounds and carrying 20 pounds. She was also restricted from crouching, crawling, climbing a ladder, bending, twisting, kneeling and climbing stairs.

A lifting restriction of 20 pounds places claimant in the light category. Additionally, because claimant also has limited ability to crouch, crawl, climb, bend and twist, her adaptability value shall be the average of the value for light capacity (4) and the value for the next lower category, sedentary (8). Former OAR 436-35-310(4). Therefore, the appropriate adaptability value is 6. Former OAR 436-35-310(4)(c).

Impairment

The insurer argues that claimant suffers no permanent impairment due to her compensable injury. The Referee found that claimant has a chronic condition limiting repetitive use of her back and assigned 5 percent permanent impairment. We agree with the Referee.

The Orthopaedic Consultants examined claimant on January 23, 1990, prior to claim closure. Because they found that subjective complaints outweighed the objective findings, the physicians determined that claimant's range of motion findings were not accurate. Consequently, they opined that claimant had suffered no permanent impairment and could return to her prior employment without restrictions. Dr. Kendall, claimant's treating physician, concurred with this opinion, although at about the same time, he was imposing limitations on claimant's ability to work. (Exs. 6 & 6b).

On February 26, 1990, just after claim closure, Med Review (Drs. Potter and Kho) performed a second independent medical examination at the request of the insurer. As discussed above, Drs. Potter and Kho found that claimant had permanent impairment resulting from her back injury. Dr. Kendall also concurred with that finding.

Claimant's treating physician, Dr. Kendall, has concurred with two conflicting reports. However, even when he stated agreement with Orthopaedic Consultants, he was imposing restrictions on claimant's ability to work. On the whole we find Dr. Kendall's opinion more consistent with that of Med Review.

After de novo review, we are more persuaded by the report of Med Review than that of Orthopaedic Consultants. The Consultants stated that claimant had no objective impairment findings and that subjective interference was present in her examination.

Med Review was aware of claimant's continuing complaints, as noted in Dr. Kendall's report. Although they also noted inconsistencies between objective and subjective findings, Med Review, nevertheless, concluded that claimant suffered impairment due to her compensable injury. We find that opinion, as supported in some degree by the opinion of the attending physician, to be persuasive . Accordingly, we agree with the Referee that claimant suffers from chronic conditions limiting repetitive use of her back and assign an impairment value of 5 percent. Former OAR 436-35-320(4).

Computation of Unscheduled Permanent 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 impairment value, 5, the result is 23 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 23 percent.

We do not find clear and convincing evidence that claimant's permanent disability is more or less than 23 percent.

ORDER

The Referee's order dated July 24, 1990 is modified. In lieu of the Referee's award of 29 percent (92.8 degrees) permanent partial disability, claimant is awarded 23 percent (73.6 degrees) permanent partial disability. Claimant's attorney fee shall be adjusted accordingly.

In the Matter of the Compensation of
JOANN M. OLSON, Claimant
WCB Case No. C1-00090
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Rick W. Roll, Claimant Attorney
David O. Horne, Defense Attorney

On January 15, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

OAR 436-60-145(4) requires that a claim disposition agreement contain specified information concerning claimant and the history of the claim. A proposed disposition that does not contain the required information will not be approved by the Board. See OAR 436-60-145(5); 438-09-020(1). Such an agreement is deemed unreasonable as a matter of law. ORS 656.236(1)(a); OAR 438-09-020(2).

Here, the proposed disposition does not provide the bold face notice as required pursuant to OAR 436-60-145(4)(g) either as part of the document or incorporated by reference. Under these circumstances, the proposed disposition is unreasonable as a matter of law. See OAR 438-09-020(2). Accordingly, we decline to approve the agreement and return it to the parties.

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

We also note that the specific identification of compensation benefits on page 2 has been omitted.

Following our standard procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
DOUGLAS D. RYAN, JR., Claimant
WCB Case No. C1-00047
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Nelson, et al., Defense Attorneys

On January 10, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

OAR 436-60-145(4) requires that a claim disposition agreement contain specified information concerning claimant and the history of the claim. A proposed disposition that does not contain the required information will not be approved by the Board. See OAR 436-60-145(5); 438-09-020(1). Such an agreement is deemed unreasonable as a matter of law. ORS 656.236(1)(a); OAR 438-09-020(2).

Here, the proposed disposition incorporates attached exhibits A & B, which purport to include the bold face notice required pursuant to OAR 436-60-145(4)(g). Under these circumstances, the proposed disposition is unreasonable as a matter of law. See OAR 438-09-020(2). Accordingly, we decline to approve the agreement and return it to the parties.

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

We also note that the parties failed to provide the order clause as required in claims disposition agreements received after December 31, 1990. OAR 438-09-020(1)(c). We further note parenthetically that the total amount of the disposition as stated in the claim disposition agreement differs from that reported on the summary sheet.

Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS H. STEWARD, Claimant
WCB Case No. 89-23123
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Robert J. Jackson (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

The SAIF Corporation requests review of Referee Quillinan's order which set aside its denial of claimant's claim for spa membership. 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

Claimant is entitled to medical services for conditions resulting from his injury for such period as the nature of the injury or the process of the recovery requires. ORS 656.245(1).

Former OAR 436-10-040(8) states in pertinent part: "Trips to spas, to rest areas or retreats, whether prescribed or in association with a holistic medicine regime, are not reimbursable unless special medical circumstances are shown to exist."

The Referee concluded that "trips," as used in the rule, specifically refers to travel. We disagree. In Deborah S. O'Shea-Mathews, 40 Van Natta 1834, 1837 (1988) we concluded that the rule addressing "trips to spas" is applicable to claimant's swim therapy. The rule applies to the "prescribed" medical service, not simply travel to and from the place that service is obtained. Accordingly, former OAR 436-10-040(8) applies in this case.

SAIF argues that former OAR 436-10-050(2) also applies in this case. We agree. That rule requires the attending physician to maintain direct control and supervision over treatment provided by persons not licensed to provide a medical service, and we have previously held that membership in an athletic club is subject to the rule. See Kelly B. Worden, 41 Van Natta 1758 (1989). "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 (if that person is not licensed). OAR 436-10-005(9); see Bryan Thompson, 42 Van Natta 1532, 1534 (1990).

Claimant argues that his treatment is supervised by spa personnel and that Dr. White and a physical therapist advise claimant on his program and discuss the program with him once a month. However, that does not establish direct control and supervision by Dr. White. Further, we find no evidence of a licensed provider administering the prescribed medical service while claimant is participating in the spa program. Accordingly, even if we were to find that special medical circumstances existed to justify claimant's spa membership under former OAR 436-10-040(8), we conclude that the services provided claimant at the spa are not in compliance with former OAR 436-10-050(2). SAIF is not, therefore, responsible to reimburse claimant for those services.

ORDER

The Referee's order dated March 26, 1990 is reversed. The SAIF Corporation's denial dated October 25, 1989 is reinstated and upheld. The Referee's award of an assessed attorney fee of $1,800 is reversed.

In the Matter of the Compensation of
JACK ALLEN, Claimant
WCB Case No. 89-19678
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The insurer requests review of Referee Brown's order which set aside its partial denial of claimant's degenerative disc and facet disease of the cervical spine. On review, the sole issue is compensability. We affirm.

FINDINGS OF FACT

Claimant has preexisting significant degenerative changes in his cervical spine. These date from a noncompensable motor vehicle accident in 1985. Following surgery, claimant returned to his regular work as a truck driver. His neck was asymptomatic.

On October 28, 1988, claimant compensably injured his cervical spine when he swerved to avoid an oncoming car and rolled his truck. Claimant struck his head in the injury. The insurer accepted the claim. Claimant's neck became symptomatic as a result of this injury. The cause of claimant's pain is that the compensable injury exacerbated the degenerative changes in claimant's cervical spine.

Claimant's family physician, Dr. Wahls, wrote a chart note on March 28, 1989 in which he indicated that it was doubtful that claimant's degenerative

disc disease and bulging disc contributed to claimant's symptoms; however, he considered neurosurgery a possibility and declined to find claimant medically stationary until claimant had been evaluated by a neurosurgeon.

Following an independent medical examination with Dr. Schachner, the insurer issued its partial denial.

CONCLUSIONS OF LAW AND OPINION

Claimant argues, and the Referee concluded, that the insurer's denial was an improper precautionary denial and was therefore void. The Referee relied on our decisions in Sharon Evans, 42 Van Natta 227 (1990) and Alvin Despain, 40 Van Natta 1823 (1988). The insurer argues that this case should be controlled by Sidney M. Brooks, 38 Van Natta 925 (1986), rather than Evans and Despain. We agree with the insurer.

In Brooks we said:

> "SAIF's precautionary denial of carpal tunnel syndrome was appropriate to avoid the appearance of having accepted an unrelated condition because claimant's doctors were investigating it at the same time they were treating claimant's accepted low back strain injury." Brooks, supra at 926.

In Despain, on the other hand, we concluded that "a precautionary denial" was not procedurally proper because the insurer had received no claim for the denied condition. All it had was a diagnosis of the condition in a report by an independent medical examiner.

In Evans, we relied on Despain and distinguished Brooks. In both Evans and Despain, we found that the mere diagnosis of a condition in an IME report is insufficient to make a claim for that condition. Furthermore, in both cases, no treatment was contemplated for the denied conditions. Consequently, we concluded, in Evans, that the denial should be set aside as premature. We said of Brooks:

> "In Sidney M. Brooks, 38 Van Natta 925, 926 (1986), we held that 'precautionary denials' are appropriate to avoid the appearance of having accepted an unrelated condition. However, in Brooks, the claimant's physicians were investigating an unrelated condition at the same time they were treating an accepted condition." Evans, supra at 228 (emphasis in original).

In this case, the degenerative disc disease was diagnosed by claimant's treating physician, and not as a result of an independent medical examination. Furthermore, the treating physician indicated that he could not find claimant medically stationary until another expert had determined whether treatment was necessary for the degenerative disc disease. Following the guidance of Brooks, we conclude that Dr. Wahl's report put the insurer on notice of a possible claim for the degenerative disc disease so that it was proper for the insurer to partially deny that condition. The denial was procedurally proper and should not have been set aside on that basis.

On the merits, we conclude that claimant has proven by a preponderance of the evidence that the compensable injury worsened the preexisting degenerative disc disease. Therefore, claimant has established the compensability of the

degenerative disc disease. We base our conclusion on the uncontroverted deposition testimony of Dr. Schachner, the independent medical examiner, that "the accident did exacerbate the underlying degenerative changes and thereby made him symptomatic...." Accordingly, the partial denial will be set aside.

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 $800, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 20, 1990 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $800, to be paid by the insurer.

January 31, 1991 Cite as 43 Van Natta 192 (1991)

In the Matter of the Compensation of
MARIA CAMPOS, Claimant
WCB Case No. 87-08331
ORDER ON REMAND (Remanding)
Ginsburg, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Campos v. Hood River Care Center, 104 Or App 261 (1990). The court found our prior order, which had affirmed and adopted a Referee's dismissal order, inadequate for judicial review. Specifically, the court held that neither our order nor the Referee's order contained "findings of fact or conclusions of law on whether claimant had good cause for failing to appear" at hearing. 104 Or App at page 264. Moreover, noting that our order did not address claimant's assertion that the record was insufficiently developed concerning the issue of good cause, the court concluded that it could not determine why this matter had not been remanded to the Referee. Consequently, the court has remanded for reconsideration.

FINDINGS OF FACT

Claimant did not appear at her scheduled December 22, 1987 hearing. Her attorney was present at the hearing and moved for postponement. This request was based on a recent telephone conversation with "someone at [claimant's] household" who indicated that claimant was in Mexico tending to "an emergency" and was not "expected back until after the first of the year." The insurer moved for dismissal of claimant's hearing request, contending that claimant's counsel's representations did not constitute "good cause."

The Referee dismissed the hearing request, noting that the dismissal order could be reconsidered if claimant's counsel filed a document establishing "good cause" for her failure to appear at the hearing. The Referee's dismissal order issued January 4, 1988.

On February 2, 1988, claimant's counsel mailed to the Hearings Division a motion for reconsideration of the Referee's dismissal order. Enclosed with the motion was claimant's affidavit providing an explanation concerning her absence at the hearing. Claimant asked that the dismissal order be set aside and a new

hearing scheduled. The following day, before the Referee could reconsider the dismissal order, claimant's counsel requested Board review of the Referee's order.

CONCLUSIONS OF LAW

At the time of the December 22, 1987 hearing, former OAR 438-06-070 provided that:

> "Failure of a party to appear at a hearing without good cause constitutes a waiver of appearance. If the party failing to appear is the party that requested the hearing, the request for hearing may be dismissed unless good cause is shown and the other party is not prejudiced thereby."

In announcing that he would be dismissing the hearing request for claimant's failure to appear at the scheduled hearing, the Referee advised claimant's counsel that he could reconsider his decision if claimant filed a document demonstrating good cause for her failure to appear. Thereafter, the Referee issued his dismissal order.

While the Referee retained the authority to reconsider his order, claimant's counsel submitted an affidavit providing her explanation for her failure to appear at the hearing. Based on this affidavit, claimant sought reconsideration of the dismissal order and reinstatement of her hearing request. However, before the Referee could address the reconsideration motion, claimant also requested Board review of the dismissal order. Thus, authority to consider the matter shifted to the Board. Ramey S. Johnson, 40 Van Natta 370 (1988).

As noted by the court, claimant is not contending that her counsel's appearance on her behalf rectified her failure to appear at the hearing. Campos v. Hood River Care Center, supra, at page 263, n. 2. Instead, arguing that the record concerning the issue of good cause for her failure to appear has been incompletely developed, she seeks remand to the Referee for further evidence. We grant her request.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Remand is generally appropriate only on a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

We conclude that remand is appropriate. In response to the Referee's statements that the dismissal order could be reconsidered if evidence supporting good cause for claimant's failure to appear was submitted, claimant offered her affidavit. The affidavit presents claimant's explanation concerning her failure to attend the scheduled hearing. Because claimant contemporaneously requested Board review, the Referee was unable to consider claimant's submission or solicit any response from the insurer. Since this evidence was not considered by the Referee, it is likewise not subject to our review. ORS 656.295(5).

Without the aforementioned evidence, as well as the insurer's opportunity to present evidence in rebuttal and/or evidence establishing any prejudice caused by claimant's failure to appear, we consider the record inadequately developed. Consequently, this matter shall be remanded to the Referee.

Accordingly, the Referee's dismissal order is vacated and this matter remanded to Referee Menashe for further proceedings. On remand, the Referee shall determine whether claimant has established good cause for her failure to appear

at the scheduled hearing pursuant to former OAR 438-06-070. In addition to claimant's affidavit, the Referee shall consider evidence from the insurer in rebuttal and/or evidence concerning any prejudice to the insurer caused by claimant's failure to appear. Claimant shall also be granted the opportunity to submit evidence in a final reply. The proceeding to consider this matter shall be held in any manner that will afford substantial justice to all parties and insure a complete and accurate record of all examination and/or testimony.

If the Referee determines that claimant has not established good cause for her failure to appear at the December 22, 1987 hearing or that the insurer has been prejudiced by claimant's failure to appear, the matter may be dismissed by a final, appealable order. Should the Referee determine that claimant has established good cause for her failure to appear and that the insurer has not been prejudiced by claimant's failure to appear, the Referee shall issue an interim order so finding and proceed with a hearing on the merits of claimant's hearing request.

Although not required by this order, if the Referee concludes that such a procedure would afford substantial justice to all parties, the proceeding to determine the "failure to appear" issue may be held in conjunction with the hearing on the merits of claimant's hearing request. However, the Referee shall also have the discretion to bifurcate the proceedings concerning these matters.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROLLIE CLARK, Claimant
WCB Case No. C1-00035
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Philip H. Garrow, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Crider and Brittingham.

On January 10, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum to be paid as a structured settlement, claimant releases his rights to future workers' compensation benefits for the compensable injury. We set aside the proposed disposition.

We shall not approve a proposed claim disposition agreement 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 it exceeds the bounds of existing statutes or rules. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990). When a claim disposition agreement is approved under the provisions of ORS 656.236 and OAR 438-09-020, an attorney fee may be approved by the Board in an amount up to 25 percent of the first $12,500 of the agreement proceeds plus 10 percent of any amount of the proceeds in excess of $12,500. OAR 438-05-052. Under extraordinary circumstances, a fee may be approved in excess of 25 percent of the proceeds. Id. Accordingly, a fee in excess of 25 percent of the proceeds will not be approved by the Board when no indication of extraordinary circumstances appears in the document. Here, the attorney fee exceeds the amount allowed under OAR 438-15-052. The agreement does not indicate any extraordinary circumstances justifying a larger fee. Consequently, the Board finds that the agreement is unreasonable as a matter of law and sets it aside. See ORS 656.236(2); Louis R. Anaya, supra.

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) & (6)(e).

We also note that the parties failed to provide the order clause as required by OAR 438-09-020(1)(c).

Following our standard procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

January 31, 1991 Cite as 43 Van Natta 195 (1991)

In the Matter of the Compensation of
ROY DIEDE, Claimant
WCB Case No. 88-21021
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of that portion of Referee Crumme's order that increased claimant's unscheduled permanent disability award for a low back condition from 30 percent (96 degrees), as awarded by Determination Order, to 39 percent (124.8 degrees). 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" with the following supplementation.

The Referee's order at page 3 contains a clerical error as to the date of the Determination Order. The Determination Order issued on July 21, 1988, rather than 1989.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Opinion and Conclusions" with the following comments.

The sole issue raised on review is whether the Referee erred by not awarding additional disability beyond the "standards" rating based on a "clear and convincing" argument. Neither party contests, and we adopt, the Referee's "standards" rating of 39 percent permanent partial disability.

Clear and Convincing Evidence

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". Former 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 argues on review that vocational expert, Mr. McNaught, testified that he is foreclosed from participating in 56 percent of the labor market previously open to him (pre-injury). Therefore, argues claimant, he has a 56 percent permanent disability, rather than the 39 percent that was awarded under the "standards." Thus, concludes claimant, there is "clear and convincing" evidence that he is entitled to a 17 percent increase in his disability award pursuant to former ORS 656.283(7). We find this argument without merit.

Earning capacity is based upon not only the number of job titles that a worker can theoretically 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 many factors that determine a worker's earning capacity. See Goldie M. Ames, 42 Van Natta 1657 (1990); Gregory D. Marshall, 42 Van Natta 2022 (1990).

Accordingly, we conclude that it is not "highly probable" that claimant's loss of earning capacity exceeds his award of 39 percent unscheduled permanent disability based on Mr. McNaught's statements. Riley Hill General Contractor v. Tandy Corp., supra.

ORDER

The Referee's Order on Reconsideration dated April 23, 1990 is affirmed.

January 31, 1991 Cite as 43 Van Natta 196 (1991)

In the Matter of the Compensation of
ROGER D. ESTEP, Claimant
WCB Case No. 89-23535
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
David Jorling, Defense Attorney

Reviewed by Board Members Cushing & Myers.

The self-insured employer requests review of Referee Tenenbaum's order which dismissed claimant's request for hearing without prejudice. On review, the employer contends that claimant's request for hearing should have been dismissed with prejudice. We affirm.

FINDINGS OF FACT

Claimant requested a hearing on November 21, 1989. The only issue raised was extent of scheduled permanent partial disability. Employer did not file a cross-request for hearing. Hearing was scheduled for March 27, 1990.

At the time of hearing, claimant asked that his request for hearing be dismissed. At that time, the employer did not raise, argue or move for an order of dismissal with prejudice. Claimant assumed the dismissal would be without prejudice.

The Referee's Order of Dismissal issued April 6, 1990. The order indicated the hearing request had been dismissed with prejudice. On April 20, 1990, a hearing was held before the Referee on claimant's motion to amend the order to reflect dismissal without prejudice. On April 27, 1990, the Referee issued an Amended Order of Dismissal without prejudice.

CONCLUSIONS OF LAW AND OPINION

When the party requesting a hearing moves for dismissal, and there is no cross-request for hearing, the referee has discretion to set the terms and conditions of an order of dismissal as he/she deems proper. We will not disturb the terms and conditions imposed by the Referee except under a showing of an abuse of discretion. See Julie Mayfield, 42 Van Natta 871 (1990).

In the present case, claimant filed the request for hearing. The employer filed no cross-request for hearing. The employer contended that the Referee's Order of Dismissal without prejudice was an abuse of discretion. However, when claimant withdrew his request for hearing, the employer did not raise, argue or move for an order of dismissal with prejudice. (Tr. 2). Under the circumstances, the Referee had discretion to dismiss the request for hearing and to set the terms and conditions of the order. In this regard, we find no abuse of discretion here. See Julie Mayfield, supra.

Since this case was brought upon the employer's appeal, an assessed fee is governed by ORS 656.382(2). That statute limits such fees to cases where the employer seeks a reduction in compensation and we find that compensation should not be disallowed or reduced. Since the employer in this case does not seek a reduction in compensation, and we have made no finding that it should be disallowed or reduced, no assessed fee can be awarded. See MacDonald v. Safeway, 87 Or App 86 (1987); Saxton v. SAIF, 80 Or App 631 rev den 302 Or 159 (1986); Julie Mayfield, supra.

ORDER

The Referee's order of dismissal dated April 6, 1990, as amended April 27, 1990, is affirmed.

January 31, 1991 Cite as 43 Van Natta 197 (1991)

In the Matter of the Compensation of
FREDERICK FOX, Claimant
WCB Case Nos. 88-11674 & 89-19796
ORDER ON REVIEW
Scott McNutt, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of that portion of Referee Mongrain's order that increased his unscheduled permanent disability for a right shoulder injury from 17 percent (54.4 degrees), as awarded by a Determination Order, to 18 percent (57.6 degrees). On review, the issue is extent of unscheduled permanent partial disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had sustained 28 percent unscheduled permanent disability under the "standards". However, the Referee reduced claimant's award by the 10 percent previously awarded for a prior injury. Therefore, the Referee awarded claimant 18 percent unscheduled permanent disability.

The parties agree with the Referee's reasoning and conclusions as to the following values: age (1), formal education (0), skills (1), training (0), impairment (25). Accordingly, we adopt these values and only address the values for adaptability.

The Referee awarded claimant an adaptability value of 1.5 pursuant to former OAR 436-35-310(3). The Referee found that, because light work was available to claimant, his adaptability should be rated pursuant to the matrix found in former OAR 436-35-310(3). We agree with the value assigned by the Referee, but do so because following his compensable shoulder injury claimant returned to light work for his employer. Accordingly, we assign claimant an adaptability value of 1.5.

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 1, the sum is 2. When that value is multiplied by claimant's adaptability value 1.5, the product is 3. When that value is added to claimant's impairment value 25, the result is 28 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 28 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 claimant is more or less than the entitlement indicated by the "standards." Former 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 (1987).

Here, however, there is no evidence that claimant suffers permanent disability in excess of that awarded under the standards. Therefore, we do not find clear and convincing evidence that claimant suffers more than 28 percent unscheduled permanent disability.

Finally, claimant argues that the Referee erred in reducing his unscheduled permanent partial disability award by the 10 percent unscheduled permanent disability previously awarded for a prior injury. We disagree. Since the Referee's order issued we have issued our opinion in Mary A. Vogelaar, 42 Van Natta 2846 (1990). In that case, we held that an injured worker is entitled to that unscheduled permanent disability which results from the injury in question. However, we further reasoned in Vogelaar that the worker is not entitled to be doubly compensated for a permanent loss of earning capacity which would have resulted from the injury in question, but which had already been produced by an earlier accident and compensated by a prior award. Mary A. Vogelaar, supra. See Thomason v. SAIF, 73 Or App 319, 322 (1985); Lawrence W. Scott, 40 Van Natta 1721 (1988). In Vogelaar, we determined that in cases where the claimant has prior unscheduled permanent disability, extent of permanent disability is determined by both an application of the standards and by consideration of any prior permanent disability awards. Mary A. Vogelaar, supra.

Here, we find that the Referee properly reduced claimant's unscheduled permanent partial disability award by the 10 percent unscheduled permanent disability awarded by a prior Determination Order for a prior injury. Accordingly, we affirm the Referee's award of 18 percent unscheduled permanent disability for claimant's right shoulder injury.

ORDER

The Referee's order dated March 2, 1990 is affirmed.

In the Matter of the Compensation of
JIMMY K. HICKS, Claimant
WCB Case No. 87-02601
ORDER ON REVIEW
Charles G. Duncan, Claimant Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of those portions of Referee Miller's order which: (1) awarded 3 percent (5.76 degrees) scheduled permanent disability for loss of use or function of the left arm, whereas a Determination Order had awarded no permanent disability; and (2) affirmed a Determination Order awarding 20 percent (64 degrees) unscheduled disability for injury to the left shoulder. On review, the issues are extent of permanent disability, scheduled and unscheduled. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following clarification. Claimant retains 95 degrees right and 90 degrees left external shoulder rotation.

Claimant has full and equal upper extremity muscle strength and sensation intact to light touch and pinprick.

Claimant achieved his highest specific vocational pursuit (SVP) level of 4 for his work as a dryer grader. He has acquired on-the-job training sufficient to perform other than entry level employment. Claimant has returned to work as a general construction laborer.

Claimant's at-injury job required the ability to perform medium level work activity. Claimant is able to perform light to medium level work activity but is unable to use his left upper extremity at or above shoulder level.

Claimant became medically stationary June 12, 1989.

The Determination Order issued August 11, 1989.

FINDINGS OF ULTIMATE FACT

Claimant has sustained a 16 percent permanent loss of earning capacity as a result of his compensable left shoulder injury.

CONCLUSIONS OF LAW AND OPINION

The Referee applied the "standards" which were effective July 1, 1988. For purposes of determining work-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's condition became medically stationary on June 12, 1989, and his claim was closed by Determination Order on August 11, 1989. Accordingly, we apply the "standards" in effect from January 1, 1989 through September 30, 1990 in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-010 through 436-35-260 apply to the rating of

claimant's scheduled permanent disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent disability.

Scheduled Disability

If an injury to an unscheduled portion of the body results in disability to both unscheduled and scheduled portions, a claimant is entitled to separate disability awards. Foster v. SAIF, 259 Or 86 (1971). The Referee concluded that claimant was entitled to no permanent disability for loss of grip strength under former OAR 436-35-110. However, finding by clear and convincing evidence that claimant has minimal limitation of left grip strength and arm muscle strength, the Referee awarded claimant 3 percent permanent disability for loss of use or function of the left arm. We agree that claimant is not entitled to a scheduled permanent disability award under the "standards."

A closing exam by Dr. MacRitchie, a specialist in rehabilitation medicine who was then claimant's treating physician, reveals claimant has equal muscle strength in the upper extremities, normal sensation, and near equal grip at 17 psi on the left and 18 psi on the right. Dr. Carlstrom, claimant's current treating chiropractic physician, has not reported any loss of left hand/arm function.

Loss of grip strength is assigned a value when due to median, radial or ulnar nerve damage. Former OAR 436-35-110(3)(a). Based on MacRitchie's findings of nearly identical grip strength and Carlstrom's lack of reported loss of function, we are not persuaded that claimant has suffered a loss of grip strength. Moreover, even if claimant sustained a loss of grip strength, any such impairment would be due to a left brachial plexopathy, rather than nerve damage. Therefore, he would not be entitled to an award for loss of grip strength under the rule. Neither do we find a basis for giving claimant a value for a chronic condition limiting repetitive use of his left hand and, therefore, we give no value under former OAR 436-35-010(7). Accordingly, like the Referee, we find that claimant has no scheduled disability under the "standards."

Unscheduled Disability

The Referee affirmed the Determination Order award of 20 percent unscheduled permanent partial disability for claimant's left shoulder impairment. On review, we calculate a different percent.

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 and Education

We agree with the Referee that the appropriate value for claimant's age of 28 years is 0, for his 9 years of formal education is 1, and for his specific vocational pursuit (SVP) skill level of 4 is 3. Former OAR 436-35-290; former OAR 436-35-300(3); former OAR 436-35-300(4).

We also agree that claimant has demonstrated competence in a specific vocational pursuit sufficient to perform other than an entry level position for a training value of 0. Former OAR 436-35-300(5); Larry L. McDougal, 42 Van Natta 1544 (1990).

Adaptability

Contrary to the Referee's statement, claimant testified that as of the date of hearing he had returned to modified work. The adaptability value for a claimant who has returned to modified work is determined from the matrix of values at former OAR 436-35-310(3)(a) rather than the definitions at former OAR 436-35-310(4). The applicable section of the rule 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 requires a light to medium physical capacity. Therefore, the appropriate adaptability value is 1.5. Former OAR 436-35-310(3)(a).

Impairment

The Referee awarded claimant an impairment value of 10 percent based on claimant's lost range of shoulder motion, lost strength in the left shoulder and arm, and lost ability to use the left shoulder to perform tasks requiring repetitive use. We, on the other hand, find that claimant is entitled to no award for either loss of shoulder range of motion or loss of strength.

Dr. MacRitchie reported full and normal shoulder ranges of motion. Similarly, Dr. Carlstrom reported no decrease in claimant's shoulder ranges of motion. Therefore, claimant is not entitled to an award under former OAR 436-35-330.

Loss of grip and arm strength is properly considered under scheduled disabilities as a loss of use or function of the forearm and/or arm. Former OAR 436-35-110. Moreover, claimant has no demonstrated loss of shoulder strength under former OAR 436-35-330(19). Dr. MacRitchie reported good shoulder strength as demonstrated by claimant's ability to do push-ups from the floor. Therefore, claimant is not entitled to an award for loss of shoulder strength.

Consistent with claimant's testimony, Dr. MacRitchie noted that claimant cannot do work at or above shoulder level. Therefore, we affirm the Referee's award of 5 percent for claimant's inability to use his left upper extremity at or above shoulder level to perform repetitive tasks. Former OAR 436-35-320(4).

Computation of Unscheduled Permanent 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 1.5, the product is 6. When that value is added to claimant's impairment value 5, the result is 11 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 11 percent.

Disability Outside the Standards

Claimant does not dispute the Referee's "standards" analysis. Rather, claimant's sole argument on review is that he has shown by clear and convincing evidence that his scheduled and unscheduled disabilities are greater than the entitlement indicated by the "standards." In this regard, 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." Former 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 (1987).

Scheduled Disability

Relying on his testimony alone, claimant contends that he is entitled to a clear and convincing award of 50 percent permanent disability due to his inability to pick up objects secondary to sensory loss, loss of control of the left arm and hand, cramping three fingers of that hand and numbness of the forearm.

In the absence of any corroborating medical evidence, we do not find claimant's perception of his degree of impairment to be persuasive. Consequently, we find claimant not entitled to any additional scheduled impairment outside the "standard" by clear and convincing evidence.

Unscheduled Disability

Again, relying on his testimony alone, claimant contends that the combined effects of his limited education, learning ability and work skills, inability to use his left shoulder for repetitive tasks, loss of eye to hand coordination, headaches, lower hourly wage rate, and decreased employment opportunities support an unscheduled disability award of 75 percent.

Claimant has had ongoing disabling headaches since his head injury. Although they have been described as migraine in type, they did not begin until after claimant was struck in the head during his compensable injury. Therefore, we find that an assignment of 5 percent for chronic headaches in appropriate.

There is no medical evidence in support of claimant's testimony of loss of eye to hand coordination. We have already considered claimant's limited education and limited work skills in assigning claimant's values under the standards for education.

Claimant has returned to work for another employer. He is unable to perform some of that work as a result of his inability to use his left arm at or above shoulder level. This impairment likewise has been considered under the standards in claimant's award for loss of repetitive use.

On this record, we find clear and convincing evidence that claimant has suffered greater disability, as a result of chronic headaches, than that provided under the "standards." We conclude that an additional 5 percent award adequately compensates claimant for his headaches, for a total award of 16 percent unscheduled permanent disability.

Conclusion

In the present case, the insurer has not cross-requested a reduction in either claimant's 3 percent scheduled or 20 percent unscheduled disability awards. On review, therefore, we do not disturb those awards. See Daniel M. Alire, 41 Van Natta 752 (1989).

ORDER

The Referee's order dated December 20, 1989 is affirmed.

In the Matter of the Compensation of
MICK L. HOUSE, Claimant
WCB Case No. 89-06918
ORDER ON REVIEW
Wilner & Associates, Claimant Attorneys
Tooze, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

The insurer requests review of that portion of Referee Knapp's order that set aside its denial of claimant's occupational disease claim for tinnitus. Claimant cross-requests review of that portion of the order that upheld the insurer's denial of claimant's occupational disease claim for hearing loss. On review the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Hearing Loss

The Referee found that claimant had failed to establish that his work exposure to noise with the insured was a material contributing cause to a worsening of his preexisting high frequency hearing loss. We agree with the Referee's conclusion that claimant has not established a compensable hearing loss claim; however, we reach our conclusion on the following basis.

For an occupational disease claim, the date of "injury" is the date upon which the claimant was last exposed to the employment conditions which could have caused 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 hearing loss condition occurred with the insured during 1989. Accordingly, the occupational disease law which became effective January 1, 1988, and before its amendment on July 1, 1990, is applicable. Donna E. Aschbacher, 41 Van Natta 1242 (1989).

At the outset, we note that claimant may establish a compensable hearing loss based on a contribution from all work activity, including work activity prior to his employment with this insured. Inkley v. Forest Fiber Products Co., 288 Or 337 (1980). However, we find no persuasive evidence in this record that claimant's prior employments contributed to his current hearing loss. Dr. Epley, claimant's treating physician, neither offered an opinion on this issue nor gave a history of noise exposure at any employer prior to claimant's work with this insured. Dr. Maurer, clinical audiologist who performed an independent examination opined that any work involving any noise level was potentially hazardous. Dr. Maurer did not find that it was medically probable that claimant's prior work experience was a contributing factor to claimant's hearing loss. Moreover, when asked whether claimant's prior work could have caused claimant's hearing loss, Dr. Maurer found that claimant's hunting activities were more likely the cause. Therefore, we find that the Referee was correct in analyzing the compensability of claimant's hearing loss claim based only on his employment with this insured.

To be compensable, claimant's occupational disease must fall within one of the three subsections of former OAR 656.802(1). Here, claimant spent 1/3 of his time working for the insured as a casting tender and 2/3 of his time on the pigging machine. Claimant's job involved exposure to noises from steam release,

furnace blast, banging of metal pans and crucibles on concrete floors, sledge hammers, diesel motors, welding torches and air hoses.

Under former ORS 656.802(1)(a), claimant is required to prove that his work was the major contributing cause of the onset or worsening of his hearing loss; however, pursuant to former ORS 656.802(1)(c) claimant need only prove that his work was a material contributing cause to his hearing loss. In this case, we need not decide whether claimant's hearing loss claim is properly analyzed pursuant to former ORS 656.802(1)(a) or (1)(c) because claimant has failed to prove that his exposure to noise at work was even a material contributing cause to his hearing loss.

Dr. Epley, opined that claimant's high frequency hearing loss is secondary to chronic noise exposure at high levels without proper ear protection. Therefore, Dr. Epley concluded that unless claimant had been exposed to high level noise outside his job, the injury is secondary to occupational noise exposure.

Dr. Maurer found a high frequency hearing loss but noted that claimant also had a high frequency hearing loss in 1974. In comparing claimant's audiology tests from 1974 and 1988, Dr. Maurer found no statistical change. In reaching his conclusion that claimant had no additional hearing loss, Dr. Maurer took into consideration a 5 percent competency factor, averaging of the serial audiograms and a significant presbycusis factor. Dr. Maurer discounted Dr. Epley's opinion stating that Dr. Epley failed to take into account the presbycusis factor in his calculation of claimant's hearing loss. Dr. Maurer, further opined that claimant's hearing loss cannot really be attributed to vocational noise exposure as long as hearing devices were worn. Therefore, Dr. Maurer concluded that the more likely cause of claimant's hearing loss was his off-work shooting activities.

We are not persuaded by the opinion of Dr. Epley. Rather, we give more weight to the opinion of Dr. Maurer. When there is a conflict of medical opinions, as is the case here, we rely on that opinion which is well reasoned and based upon complete information. Here we find that Dr. Epley failed to take an accurate and complete history of claimant's exposure to noise. In addition, Dr. Epley failed to consider a presbycusis factor when determining what, if any, high frequency hearing loss claimant was experiencing. We find that Dr. Epley's opinion is not well reasoned nor based upon complete information and therefore, not persuasive. See Somers v. SAIF 77 Or App 215 (1986).

We instead, defer to the well-reasoned opinion of Dr. Maurer who found no statistical change in claimant's preexisting high frequency hearing loss and no causal connection with claimant's current employment.

Accordingly, we find that claimant has failed to establish a compensable hearing loss claim. Therefore, we find that the Referee properly upheld the insurer's denial of claimant's hearing loss claim.

Tinnitus

The Referee held that claimant's tinnitus condition was aggravated by his work exposure in 1988. Therefore, the Referee concluded that claimant's noise exposure at work materially contributed to a worsening of claimant's tinnitus condition. We disagree.

Claimant argues that his work exposure to noise was a material contributing cause to the worsening of his tinnitus. Dr. Epley, claimant's treating physician, has opined that his tinnitus is caused by his high frequency hearing

loss. Because of what he says are various causes of tinnitus, Dr. Maurer would not render an opinion on the causation of that condition.

Insofar as we have found that claimant has failed to establish that noise exposure with the insured materially contributed to his high frequency hearing loss, and Dr. Epley directly relates claimant's tinnitus to his non-compensable high frequency hearing loss, we find that claimant's tinnitus is also not compensable. Therefore, we do not address the issue of whether claimant's work exposure to noise need be a material or the major contributing cause to his tinnitus condition.

Accordingly, we find that because claimant has failed to establish a compensable tinnitus condition the insurer's denial of this condition should be upheld.

ORDER

The Referee's order dated October 30, 1989, as amended December 15, 1989, is reversed in part and affirmed in part. The insurer's denial is reinstated and upheld in its entirety. The Referee's award of a $1,500 assessed fee is reversed. The remainder of the Referee's order is affirmed.

January 31, 1991 Cite as 43 Van Natta 205 (1991)

In the Matter of the Compensation of
ALAN V. JAMES, Claimant
WCB Case No. 89-21457
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Robert J. Jackson (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Gruber's order that increased claimant's unscheduled permanent disability award for a cervical spine condition from 21 percent (67.2 degrees), as awarded by a Determination Order, to 25 percent (80.0 degrees). The issue on review is extent of unscheduled permanent partial disability. We modify.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" with the exception of the fourth paragraph on page 2 of the Amended Opinion and Order, and as supplemented below.

Claimant's usual and customary job as a high school wrestling coach required heavy physical exertion. At the time of hearing, claimant's residual neck and shoulder problems required him to restrict his activities to light work which did not require lifting in excess of 20 pounds.

ULTIMATE FINDING OF FACT

Claimant has lost 26 percent of his earning capacity as a result of his compensable injury.

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(1).

Because claimant's condition became medically stationary on August 29, 1989 and his claim was closed by Determination Order on October 5, 1989, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled 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. Former OAR 436-35-280.

Age and Education

The appropriate value for claimant's age of 40 years is 1. Former OAR 436-35-290.

The appropriate value for claimant's 16 years of formal education is 0. Former OAR 436-35-300(3).

The highest specific vocational pursuit (SVP) level demonstrated by a claimant during the ten years preceding the date of determination is used to determine a value for skills. Former OAR 436-35-300(4). For our purposes, permanent disability is determined on the date of hearing. The position which claimant successfully performed during the ten years preceding the date of hearing, which has the highest specific vocational pursuit (SVP) level, was 7, as a teacher (DOT # 091.227-010). Therefore, the appropriate value for skills is 1. Former OAR 436-35-300(4).

Claimant requests a +1 rating in the "training" category because he is unable to use much of his training, and he believes, in the interest of adequate compensation, he should receive an adjustment factor. We disagree.

Whether claimant is entitled to a value for training under former OAR 436-35-300(5) is dependent upon whether or not claimant has demonstrated competence in some specific vocational pursuit. Competence in some "specific vocational pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off the job to perform other than an entry-level position. Larry L. McDougal, 42 Van Natta 1544 (1990).

Here, claimant has demonstrated competence in a specific vocational pursuit, namely teaching. Therefore, the appropriate training value is a 0. Former OAR 436-35-300(5).

Adaptability

In determining the exertional level of claimant's at-injury job, the Referee used the DOT description for a wrestling coach rather than the physical exertional level at which claimant actually performed his usual and customary work. Accordingly, the Referee determined claimant's at-injury job required medium strength. We modify.

The adaptability value for a claimant who has either returned to modified work or received a work offer [see former OAR 436-35-270(3)(d)] 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).

Under the "standards" effective prior to November 20, 1990, the Referee was not permitted to rely on DOT "strength" requirements, but rather was required to determine the physical capacity of claimant's usual and customary work based upon evidence in the record. See Sharon A. Ipox, 42 Van Natta 1568 (1990). Here, claimant's method of coaching involved personal participation in wrestling sessions. The full speed wrestling involved in claimant's usual and customary job required lifting in excess of 100 pounds and it, therefore, required heavy physical exertion.

Claimant's modified work required a light physical capacity. Therefore, the appropriate adaptability value is 2.5. Former OAR 436-35-310(3)(a).

Impairment

Claimant argues that under the Referee's impairment analysis the 8 percent rating for disc bulges, the 10 percent for lost range of motion, and the 5 percent for chronic condition should have been added instead of combined. We disagree. The Referee properly combined the multiple residuals. See former OAR 436-35-005(4) and 436-35-360(11). Except as noted by law, we adopt the Referee's conclusions regarding impairment values.

We observe that when the Referee added the cervical range of motion findings and came up with 9.44 percent, he rounded this sum upward to 10 percent. The impairment rating should not have been rounded at that point. Former OAR 436-35-280(7). Accordingly, we modify the impairment rating to 20.85 percent.

Computation of Unscheduled Permanent 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. 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, 20.85, the result is 25.85 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, 26 percent.

Clear and Convincing Evidence

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". Former 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 requests an increased permanent partial disability award based on clear and convincing evidence that he has lost more earning capacity than is

measured by the standards. For example, in the summer months claimant has done primarily heavy jobs such as dock worker, steel worker, and ranch hand. These jobs are all in the heavy work category. We are not persuaded that claimant has lost the ability to obtain and hold gainful employment in the broad field of general occupations to any greater degree than the 26 percent awarded under the standards.

ORDER

The Referee's amended order dated April 23, 1990 is modified. In addition to the Referee and Determination Order awards, claimant is awarded 1 percent (3.2 degrees) unscheduled permanent disability, giving him a total award to date of 26 percent (83.2 degrees) unscheduled permanent disability for a neck injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total attorney fees awarded by the Referee and Board orders shall not exceed $3,800.

January 31, 1991 Cite as 43 Van Natta 208 (1991)

In the Matter of the Compensation of
ROGER L. KEPHART, Claimant
WCB Case No. 89-24300
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Black's order that decreased his unscheduled permanent disability award for a low back injury from 41 percent (131.2 degrees), as awarded by Determination Order, to 36 percent (115.2 degrees). On review, the issue is extent of unscheduled permanent disability.

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

The Referee, in taking into consideration claimant's 30 percent unscheduled disability award, for a 1985 compensable low back injury, found that claimant had regained all but 5 percent of his lost earning capacity for which he was compensated by the earlier 1985 compensable injury. The Referee, in evaluating the extent of claimant's unscheduled permanent disability due to his current low back injury, applied ORS 656.222.

The Court of Appeals has recently held that ORS 656.222 ". . . is limited to subsequent awards for scheduled disability." City of Portland v. Duckett, 104 Or App 318 (1990) (Emphasis in original). But see Thomason v. SAIF, 73 Or App 319 (1985); Cascade Rolling Mills v. Madril, 57 Or App 398 (1982); Hannan v. Good Samaritan Hosp., 4 Or App 178 (1970). Here, the issue is extent of unscheduled permanent disability.

Nevertheless, former ORS 656.214(5) requires that unscheduled permanent disability due to a compensable injury be determined by comparing the worker before such injury and without such disability. Thus, we have concluded that under former ORS 656.214(5) an injured worker is entitled to that unscheduled permanent disability which results from the injury in question, but the worker is not entitled to be doubly compensated for a permanent loss of earning capacity which would have resulted from the injury in question but which had already been produced by an earlier accident and compensated by a prior award. See Mary A. Vogelaar, 42 Van Natta 2846 (1990).

Here, the Referee found that claimant's disability under the "standards", which is due to his December 1988 compensable injury, was 41 percent. Then, after finding that claimant regained practically all of his lost earning capacity resulting from his 1985 compensable injury, reduced claimant's unscheduled disability award by 5 percent. We agree with the Referee's findings and conclusions, but do so under an analysis of ORS 656.214(5).

ORDER

The Referee's order dated May 11, 1990 is affirmed.

January 31, 1991 Cite as 43 Van Natta 209 (1991)

In the Matter of the Compensation of
RILEY E. LOTT, JR., Claimant
WCB Case Nos. 89-23291, 89-14700, 89-14699, 89-14698, 89-14697 & 89-12184
ORDER ON REVIEW
Bennett, et al., Claimant Attorneys
Kevin L. Mannix, Defense Attorney
Schwabe, et al., Defense Attorneys
H. Thomas Anderson (Saif), Defense Attorney
David Horne, Defense Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Howell, Speer and Crider.

CNA Insurance Company (on behalf of Combustion Engineering) requests review of Referee Myzak's order that: (1) set aside its denial of claimant's occupational disease claim for his bilateral hearing loss condition; (2) upheld Wausau Insurance Company's denial (on behalf of Pacific Steel Fabricators) of claimant's occupational disease claim for the same condition; (3) upheld Wausau's denial (on behalf of Oregon Boiler Works) of claimant's occupational disease claim for the same condition; and (4) awarded an assessed attorney fee for claimant's counsel's services at hearing. On review, the issues are responsibility and attorney fees. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Responsibility

The Referee found that claimant's employment with CNA's insured, Combustion Engineering (CE), could have caused his hearing loss and CE had not shown that another employment was the sole cause of claimant's condition. She, therefore, assigned responsibility to CE. We disagree.

On review, CE contends that, where the worker never became disabled, the critical event for assigning responsibility is the date when medical treatment was first sought. See Progress Quarries v. Vaandering, 80 Or App 160 (1986); SAIF v. Carey, 63 Or App 68 (1983); Inez Horsey, 42 Van Natta 331 (1990). Once liability initially is fixed, responsibility may not be shifted forward to a subsequent employer unless that employer's work conditions contributed to the cause of, aggravated or exacerbated the underlying disease. Bracke v. Baza'r, 293 Or 239 (1982); Fred Meyer v. Benjamin Franklin Savings & Loan, 73 Or App 795, rev den 300 Or 162 (1985).

CE argues that, because claimant first sought treatment in 1983, the last prior employer, Oregon Boiler Works, should be responsible, and responsibility cannot be shifted unless a more recent employment worsened claimant's underlying condition. CE contends that actual, not potential, causation is required to shift responsibility. We agree.

CE contends, and claimant agrees, that treatment for hearing loss was first sought in March 1983, while claimant worked for Oregon Boiler Works. Claimant has not lost any time from work due to his hearing loss condition. We conclude that Oregon Boiler Works is responsible for claimant's hearing loss condition, unless a more recent employment actually worsened claimant's underlying condition.

In the present case, subsequent to his employment with Oregon Boiler Works, claimant worked for CE on three job sites in July, August, September and October 1987. In April 1988, he worked for Pacific Steel Fabricators. From March 2, 1989 through March 7, 1989, claimant worked as a boilermaker performing rigging duties for CE.

Claimant's audiograms were taken in March 1983, March 31, 1989 and October 1989. Dr. Hiatt performed the March 31, 1989 audiogram and found increased hearing loss since 1970. He reported that the decreased hearing was due to claimant's work as a boilermaker, but he could not attribute causation to any particular job.

Dr. Lipman examined claimant and performed an audiogram on October 2, 1989. In a letter dated October 3, 1989, Dr. Lipman stated that because claimant wore earplugs during his five day exposure at CE (and also because there was no appreciable change in his hearing test between 1983 and the present), it was his opinion that the period of employment (with CE) did not contribute to or aggravate his hearing loss. (Ex. 12-2).

In his deposition, Dr. Lipman testified that, based on the audiograms, he did not feel that there was a worsening of claimant's condition. However, later Dr. Lipman testified that, based upon the patient's history and comparing the 1983 audiogram to the March 1989 audiogram, he agreed that work exposure subsequent to 1983 contributed to the progression of noise-induced hearing loss.

Dr. Lipman testified that it was highly unlikely that five days of work exposure at CE could cause the difference or change in hearing loss. He also testified that the type of noise exposure claimant identified at CE was of the type that could cause hearing loss.

Although we find the opinion of Dr. Lipman to be somewhat inconsistent, we conclude that the medical evidence as a whole establishes that claimant's condition has worsened since his employment with Oregon Boiler Works. However, the medical evidence is not sufficient to show actual causation by claimant's employment with CE. The worsening could just as likely have resulted from the exposure claimant had with Oregon Boiler Works after March 1983. Therefore, we conclude that responsibility remains with Wausau's insured, Oregon Boiler Works, the employer with whom liability was originally fixed.

Attorney Fee at Hearing

The Referee found that claimant's counsel had "actively and meaningfully" participated at hearing and awarded claimant a $3,750 attorney fee payable by CE. On review, CE contends that no assessed fee may be awarded. CE argues that all carriers conceded compensability prior to hearing, so the only issue at

hearing was responsibility. CE also argues that claimant has not shown that his counsel's services at hearing will lead to an increase in compensation. Finally, CE requests that, if a fee is awarded, it should be reduced from the amount awarded by the Referee.

In the present case, no order issued pursuant to ORS 656.307. The Referee found that compensability had been contested up until the time of hearing. At hearing, claimant took the position that CE was responsible for his hearing loss condition.

Although the only issue actively and actually litigated at hearing was responsibility and claimant argued responsibility against an employer ultimately found not responsible, we conclude that a fee for services at hearing is appropriate. We conclude that, although responsibility was the only issue litigated, claimant's counsel was nonetheless required to protect against possible reassertions of compensability because the insurers had not obtained a .307 order and had not previously conceded compensability. We, therefore, conclude that claimant's counsel is entitled to an attorney fee for services at hearing. Joel D. Turpin, 41 Van Natta 1736 (1989). Because we have found that Oregon Boiler Works is the responsible employer, it shall be responsible for payment of the hearing level attorney fee.

Attorney Fee at Board Level

Although claimant's counsel has requested an assessed attorney fee for services on review, we conclude that an assessed fee is not warranted in this case. 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). We are aware of two potential statutory authorizations for the award of an assessed attorney fee here. The first is ORS 656.386(1), which provides:

> "In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee. * * *. Attorney fees provided for in this section shall be paid by the insurer or self-insured employer."

ORS 656.386(1) authorizes an award of an assessed fee if (1) the claimant initiates the review or appeal; (2) the appeal is from an order denying the claim; and (3) the claimant "finally prevails" on the issue of entitlement to compensation. Shoulders v. SAIF, 300 Or 606 (1986). Here, claimant has not initiated the review, nor is the appeal from an order denying the claim. Therefore, an assessed fee cannot be awarded under ORS 656.386(1).

The second potential statutory authorization for an assessed attorney fee is ORS 656.382(2), which provides:

> "If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the referee, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in an amount set by the referee, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal."

As interpreted by the Court of Appeals, ORS 656.382(2) authorizes attorney fees when claimant's right to compensation is at risk of disallowance or reduction. Ray Schulten's Ford v. Vijan, 105 Or App 294 (January 23, 1991). Here, claimant's right to compensation was not at risk of disallowance. At hearing, no party reraised the issue of compensability, therefore only responsibility was litigated. The Referee decided only the issue of responsibility. Because the compensability issue was not litigated at hearing, as a matter of practice and procedure we will not address it on review. See John J. Alcantar, 42 Van Natta 406, 617 (1990) (insurer precluded from raising compensability as a defense to a claim where only responsibility denied and litigated at hearing); see also Gunther H. Jacobi, 41 Van Natta 1031 (1989) (claimant precluded from arguing a new theory of compensability on review where theory not argued at hearing). To allow compensability to be raised as a defense on Board review would violate principles of fundamental fairness by denying claimant a reasonable opportunity to present evidence on that issue. See McNett v. Roy-Ladd Construction Co., 46 Or App 601, 606, rev den 289 Or 588 (1980); John J. Alcantar, supra.

We note that the facts presented here are distinguishable from those in Tanya L. Baker, 42 Van Natta 2818 (1990), where we awarded an assessed fee under ORS 656.382(2) even though compensability was not argued on review. In Baker, compensability was actually litigated at hearing and addressed in the Referee's order. The parties were, therefore, provided a full opportunity to present evidence on the issue. While compensability was not actively litigated on Board review, by virtue of our de novo review authority, compensability remained at risk on review as well. Destael v. Nicolai Co., 80 Or App 596 (1986). Here, by contrast, compensability was not litigated at hearing. As noted above, it would be fundamentally unfair and we will not address the compensability issue on review. Consequently, claimant's right to compensation was not at risk of disallowance. See Ray Schulten's Ford v. Vijan, supra.

ORS 656.382(2) also authorizes an assessed fee if claimant's compensation is at risk of reduction. Such would be the case if, for example, reassignment of responsibility on Board review might result in reduced temporary disability benefits. Dale S. Matsen, 41 Van Natta 163 (1989); Rhonda Bilodeau, 41 Van Natta 11 (1989). Here, claimant does not allege, nor does the record establish, that his temporary disability benefits would be reduced if CE successfully shifted responsibility to a different insurer on review. Nor has claimant established that his compensation is otherwise at risk of reduction on review. Therefore, claimant is not entitled to a carrier-paid fee for services rendered on review. Ray Schulten's Ford v. Vijan, supra.

Accordingly, claimant's counsel is entitled to an assessed attorney fee for services at hearing only. 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 is $1,000, to be paid by Wausau, on

behalf of the responsible employer, Oregon Boiler Works. In reaching this conclusion, we have particularly considered the risk that counsel's efforts might go unrecompensed, and the value of the interest to claimant.

ORDER

The Referee's order dated November 30, 1990, as amended December 13, 1989, is reversed in part and affirmed in part. Wausau Insurance Company's denial, on behalf of Oregon Boiler Works is set aside and Wausau is directed to accept claimant's claim and process it pursuant to law. CNA Insurance Company's denial (on behalf of Combustion Engineering) is reinstated and upheld. The Referee's assessed attorney fee award of $3,750 against CNA is reversed. For services at hearing, claimant's counsel is awarded a $1,000 attorney fee, payable by Wausau, on behalf of Oregon Boiler Works. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
BETTY J. McKIERNAN, Claimant
WCB Case No. 89-18859
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Silver & Staropoli, Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of those portions of Referee Peterson's order which: (1) declined to award temporary total disability benefits from January 11, 1989 through August 17, 1989; and (2) declined to assess penalties and related attorney fees for the insurer's allegedly unreasonable failure to pay temporary disability benefits on claimant's aggravation claim. On review, the issues are temporary disability compensation, offset, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

On July 6, 1989, the insurer received notice of claimant's medically verified inability to work due to a worsening of her compensable condition. No time loss benefits were paid.

FINDINGS OF ULTIMATE FACT

Dr. Tarlow's March 17, 1989 request for authorization for surgery in conjunction with the June 7, 1989 operative report provided the insurer with "knowledge" of medically verified claimant's inability to work resulting from a worsening of her compensable condition.

Claimant was in the work force and actively seeking work through the date she became unable to work.

Claimant was unable to work from the date of surgery, June 7, 1989, through the date she became medically stationary, July 25, 1989.

The insurer's failure to pay temporary total disability was an unreasonable resistance to the payment of compensation.

CONCLUSIONS OF LAW AND OPINION

Temporary Total Disability

On review, claimant contends that she is entitled to temporary total disability (TTD) benefits from January 11, 1989, the date claimant again sought medical treatment for her compensable injury, through August 17, 1989, the date her claim was closed by Determination Order. In the alternative, claimant asserts that she is at least entitled to TTD from the date of surgery through the date she became medically stationary. The insurer argues that claimant is not entitled to TTD because no physician authorized time loss so as to constitute medical verification of claimant's inability to work. Furthermore, the insurer asserts, as claimant had been laid-off work prior to her aggravation, she was not "away" from work as a result of her compensable injury. We reject both of the insurer's arguments.

Claimant is entitled to TTD from the onset of disability notwithstanding the fact the insurer may not at that time have received notice of medically verified inability to work to require it to begin paying interim compensation . Botefur v. City of Creswell, 84 Or App 627 (1987). No physician authorized time loss for claimant, who was 71 years of age in January 1989, when she suffered her aggravation. Nevertheless, while a physician's report of inability to work is evidence of the claimed disability, it is not the only evidence. Garbutt v. SAIF, 297 Or 148, 151. The entire record is relevant to whether claimant was entitled to TTD. Botefur, supra. It is to be inferred that when claimant was in the hospital, she was unable to work. See, e.g., Merlyn E. Langley, 42 Van Natta 2745 (1990). Accordingly, we find that the hospital reports of claimant's surgery establish disability.

Notwithstanding a finding that claimant was unable to work, in order to receive TTD upon aggravation of an industrial injury, claimant must also be in the work force at the time of the aggravation. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Cutright v. Weyerhaeuser, 299 Or 290 (1985); Joyce E. Mitts, 42 Van Natta 333 (1990). We concur with the Referee's specific findings that claimant both continued to work and to seek work following her compensable injury in November 1983. Claimant's efforts to acquire additional skills in order to increase her marketability and her persistent efforts to obtain employment are amply documented in the record. Moreover, we are unaware of any Board or court authority that has held that when a worker has been laid-off, she is no longer in the work force. On this record, then, we find that claimant had not withdrawn from the work force at the time she sustained an aggravation of her prior compensable injury. Accordingly, claimant is entitled to TTD from June 7, 1989, the date claimant was hospitalized for surgery.

We next determine the date through which the insurer was obligated to pay TTD. As a procedural matter, claimant is entitled to payment of temporary disability compensation until she was both medically stationary and released by the attending physician to return to regular work, or until she became medically stationary and her claim was closed. ORS 656.268(1) and (2); Fazzolari v. United Beer Distributors, 91 Or App 592, 595, on recon 93 Or App 103, rev den 309 Or 236 (1988). Claimant was never released by her attending physician to return to regular work. The Determination Order issued August 17, 1989.

Therefore, we find that claimant is procedurally entitled to payment of temporary disability compensation through August 17, 1989.

Nevertheless, claimant is only substantively entitled to temporary disability benefits until she became medically stationary. ORS 656.268; Fazzolari, supra; Tuong Canh Kha, 42 Van Natta 1072 (1990); Julie A. Trujillo, 40 Van Natta 1892 (1988). Claimant credibly testified that she was unable to work from the date of surgery through the recovery period. The medical reports support claimant's testimony. In this case, claimant became medically stationary on July 25, 1989. Therefore, we find that claimant is substantively entitled to TTD only from June 7, 1989, through July 25, 1989.

Nevertheless, as claimant received no TTD benefits while her claim was open, she is hereby awarded temporary total disability benefits from June 7, 1989, through August 17, 1989. We recognize that this award results in an overpayment of temporary total disability beyond the medically stationary date. Therefore, we authorize the insurer to offset the overpayment of temporary disability compensation between July 26, 1989 and August 17, 1989 against any future awards of permanent disability.

Penalty and Attorney Fee

The insurer must pay TTD benefits within 14 days of the date it has notice or knowledge of a medically verified inability to work resulting from a worsened condition. ORS 656.263(6); Silsby v. SAIF, 30 Or App 555 (1979). Penalties and attorney fees may be assessed when an insurer "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10); 656.382(1).

On February 24, 1989, Dr. Tarlow reported that claimant's knee had worsened three weeks earlier when claimant's knee joint popped out of place. On March 17, 1989, Dr. Tarlow requested authorization to perform surgery. We find that those reports in conjunction with the June 7, 1989 operative report constituted verification of claimant's inability to work resulting from a worsened condition and triggered the insurer's obligation to pay TTD until her claim was closed as provided by law. See Botefur, supra. The insurer took no action regarding the payment of TTD benefits, and at hearing offered no explanation for its failure to pay benefits. Because the insurer's failure to pay benefits was not based on a legitimate doubt as to claimant's entitlement to TTD, claimant is entitled to a penalty and penalty-related attorney fees. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Botefur, supra; Norgard v. Rawlinson, 30 Or App 999 (1977).

Accordingly, we assess a penalty of 25 percent of the unpaid TTD benefits due from June 7, 1989 through August 17, 1989, payable to claimant. In addition, 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 concerning the penalty issue is $250. In reaching this conclusion, we have particularly considered the value of the interest involved.

ORDER

The Referee's order dated February 14, 1990 is reversed in part and affirmed in part. That portion which declined to award TTD benefits is reversed. Claimant is awarded temporary total disability compensation from June 7, 1989 through August 17, 1989. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's

attorney. However, the total out-of-compensation fee paid under the Referee and Board orders shall not exceed $3,800. The insurer is authorized to offset TTD benefits paid between July 26, 1989 and August 17, 1989 against any future awards of permanent disability. That portion of the Referee's order that declined to assess a penalty and penalty-related attorney fee is reversed. The insurer shall pay to claimant a penalty of 25 percent of the unpaid temporary total disability due between June 7, 1989 and August 17, 1989. Claimant's attorney is awarded a penalty-related attorney fee of $250, to be paid by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
WAYNE PRICE, Claimant
Own Motion No. 91-0038M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his November 14, 1980, industrial injury. Claimant's aggravation rights expired February 22, 1986. SAIF has accepted responsibility for the proposed surgery and recommends that claimant's claim be reopened for the payment of temporary disability benefits.

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 begin on the date he is hospitalized for the proposed surgery. SAIF shall continue paying temporary total disability benefits until one of the following events 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. When appropriate, the claim shall be closed by SAIF under OAR 438-12-055.

Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. We note, however, that claimant has a pending request for hearing on a Determination Order dated January 26, 1987. (WCB Case No. 87-02054). One of the issues at that hearing is the extent of claimant's permanent disability, including permanent total disability. The Referee shall 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); Martin Schiller, 42 Van Natta 1351 (1990). On the other hand, if claimant is not medically stationary at the time of hearing, the Referee shall rate permanent disability as of the date he was last medically stationary. Pauline Travis, supra. If claimant is determined to have been permanently and totally disabled before the current worsening of his condition, he would qualify for wage-replacement benefits for this same period of claim reopening. Inasmuch as those benefits would not be reimbursable from the Reopened

Claims Reserve, the determination of permanent total disability may result in an overpayment from the Reopened Claims Reserve to SAIF.

IT IS SO ORDERED.

January 31, 1991 Cite as 43 Van Natta 217 (1991)

In the Matter of the Compensation of
MARK SCHREIBER, Claimant
WCB Case No. 89-22434
ORDER ON REVIEW
Ackerman, et al., Claimant Attorneys
Steven R. Cotton (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Garaventa's order that affirmed a Determination Order award of: (1) 68 percent (217.6 degrees) unscheduled permanent partial disability for injury to spinal nerves; and (2) 100 percent (192 degrees) scheduled permanent partial disability for loss of use or function of the right arm. On review, the issue is the extent of scheduled and 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 "Conclusions and Opinion" with the following supplementation.

The parties agree that the Evaluation Section correctly valued all disability factors except impairment.

Unscheduled Permanent Partial Disability

Impairment of Right Shoulder

Claimant contends that in addition to the 60 percent impairment assigned under former OAR 436-35-350(4) for brachial plexus injury, he is also entitled to an unscheduled impairment rating of 38 percent for loss of motion in his right arm; plus, 5 percent for chronic condition limiting repetitive use of this arm. See former OAR 436-35-330(1), (3), (5), (7), (9), and (11) and former OAR 436-35-320(4). We disagree.

Claimant has received the maximum scheduled award of 100 percent loss of use of the right arm. See former OAR 436-35-010(4), (5); ORS 656.214(2)(a). In addition, he has received the maximum unscheduled award (60 percent) for impairment to the brachial plexus with resultant loss of strength in his right shoulder and arm. To award claimant an additional unscheduled award for limitation of range of motion and chronic condition limiting repetitive use of the right shoulder, would give him a double recovery for the spinal injury (e.g., injury to the brachial plexus has already been rated under former OAR 436-35-350(4)).

We observe that former OAR 436-35-330 rates shoulder joint injuries and the resultant range of motion limitations caused by physical damage to the

shoulder. Claimant's injury is not to the physical structure of the shoulder but rather is an injury to the spine. Subsection (19) of former OAR 436-35-330 differentiates between loss of strength caused by physical damage to the shoulder verses loss of strength due to injury to the spinal nerves. For example, physical damage to the shoulder receives a maximum impairment value of 48 percent. Although subsection (19) does not cross-refer to former OAR 436-35-350(4), it dovetails the wording of that section. Thus, loss of strength due to spinal nerve damage is awarded separate maximum unscheduled impairment ratings depending on the nerve plexus involved. Here, claimant received a maximum of 60 percent, which is more than the 48 percent he would have been entitled to if the right shoulder/arm had been crushed instead of the brachial plexus.

Scheduled Permanent Partial Disability

Alleged Impairment of Left Arm

Although claimant has no injury to his left arm, he requests an award under former OAR 436-35-010(7) or, in the alternative, outside the standards. Claimant argues that he is under a medical restriction not to overuse his only good arm. To minimize the risk of injury to claimant's good arm, his physical therapist has recommended that claimant avoid repetitive use and heavy lifting, carrying, pushing, pulling, and overhead reaching involving his good left arm. We do not agree that claimant has a ratable "injury" to his left arm.

Pursuant to former OAR 436-35-010(2)(b), if there is no measurable impairment, no award for scheduled permanent disability is allowed. Scheduled permanent partial disability is defined as "loss of use or function of the injured member due to the industrial injury." See ORS 656.214(2) (emphasis added).

There is no basis for the Board to assign an impairment rating due to the risk factors involved in a "potential" future injury to claimant's left arm. See Roger J. Dickinson, 42 Van Natta 818 (1990).

ORDER

The Referee's order dated March 26, 1990 is affirmed.

January 31, 1991 Cite as 43 Van Natta 218 (1991)

In the Matter of the Compensation of
JAYLENE SCHWINDT, Claimant
WCB Case No. C1-00028
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Emmons, et al., Claimant Attorneys
Bailey & Associates, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

On January 8, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $3,000 by Kemper Insurance Company, claimant fully releases her right to future workers' compensation benefits, except medical services, for her compensable injury. In addition, claimant agrees that the current medical care being provided her would constitute palliative care. 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 the 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 of under ORS 656.236 and the rules promulgated thereunder. See OAR 436-60-145(1); 438-09-001(1).

Here, the proposed agreement purports to release claimant's further rights to workers' compensation benefits of any type, except medical services. The disposition then provides that the medical care claimant is currently receiving would constitute palliative care. This language could reasonably be interpreted to limit claimant's right to medical services under ORS 656.245 for conditions related to the compensable injury, particularly in light of the recent amendments to that provision. See ORS 656.245(1)(b). Any limitation on that right exceeds the bounds of ORS 656.236 and OAR 436-60-145(1) and 438-09-001(1). Accordingly, the proposed disposition is unreasonable as a matter of law and is set aside. See ORS 656.236(2).

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

We note that, as a result of our order, any new disposition submitted by the parties will be subject to the current rules which became effective December 26, 1990. See OAR 436-60-003(4). Such dispositions must include the bold face notice required by current OAR 436-60-145(4)(g). In addition, the disposition must provide the order clause required by current OAR 438-09-020(1)(c).

Following our standard procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID E. VILSON, Claimant
WCB Case Nos. 89-26074 & 89-21684
ORDER ON REVIEW
Mitchell, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Shultz's order that upheld a denial of claimant's injury claim on subjectivity grounds issued by the SAIF Corporation on behalf of Lolich Construction. On review, the issue is whether claimant was a subject worker.

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

We note that the general contractor is not responsible for workers' compensation coverage if the subcontractor provides coverage before the commencement of labor under the contract. ORS 656.029(1). Here, claimant subcontracted from Lolich Construction and purchased coverage before the commencement of the

contract, thus making himself the responsible party for providing coverage for all individuals performing labor under the contract, including himself. He then elected under ORS 656.128 not to cover himself. Therefore, Lolich Construction is not responsible for coverage.

ORDER

The Referee's order dated April 16, 1990 is affirmed.

January 31, 1991 Cite as 43 Van Natta 220 (1991)

In the Matter of the Compensation of
JOHN WYNCOOP, Claimant
WCB Case Nos. 89-24430 & 89-24431
ORDER ON REVIEW
Smith & Smith, Claimant Attorneys
Bottini, et al., Defense Attorneys
Stafford Hazelett, Defense Attorney

Reviewed by Board Member Cushing and Myers.

Claimant requests review of Referee Brown's order which upheld the self-insured employer's (Delta/McLean Trucking) medical services denial on the basis that claimant had failed to show good cause for failure to request a hearing to protest the denial within 60 days. On review, the issue is good cause.

We affirm and adopt the Referee's order with the following supplementation. We agree with the Referee that claimant's former attorney's letters to the insurer stating that claimant was not medically stationary because surgery was proposed were not sufficient to constitute a request for hearing to protest the denial of surgery. See Beth M. Murdock, 42 Van Natta 580 (1990). We note that the attorney lacked good cause for the late request for hearing and that his lack of good cause is attributable to claimant. Sekermestrovich v. SAIF, 280 Or 723 (1977).

ORDER

The Referee's order dated May 7, 1990, as amended May 10, 1990, is affirmed.

February 1, 1991 Cite as 43 Van Natta 220 (1991)

In the Matter of the Compensation of
DONNA L. BARTRUFF, Claimant
WCB Case No. 89-14710
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
Alan L. Ludwick (Saif), Defense Attorney

Claimant requests reconsideration of that portion of our December 14, 1990 Order on Review that awarded claimant's counsel an approved fee of 25 percent of the increased compensation created by the order. Specifically, claimant requests, pursuant to OAR 438-15-085(1), that the attorney fee awarded out of compensation be paid in a lump sum upon finality of our December 14, 1990 Order on Review.

In order to allow sufficient time to consider the motion, the above-noted Board order was abated and withdrawn on January 10, 1991. The SAIF Corporation has subsequently filed a response to claimant's motion, stating that it has no objection to the request.

OAR 438-15-085(1) provides:

> "If the claimant consents in the attorney retainer agreement, the referee or the Board may order the payment of approved attorney fees directly to the claimant's attorney in a lump sum when the fee is to be paid out of an award of compensation for permanent disability. The lump sum shall not be due until the award of compensation becomes final."

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. See Ted. G. Dollarhide, 42 Van Natta 1762 (1990); Linda K. Jones, 41 Van Natta 780 (1989). Here, the request for a lump sum payment was not made by claimant or addressed by the Referee before the request for Board review. However, at hearing the Referee did not award additional permanent partial disability; therefore, it was not until the Board increased claimant's permanent disability award that a request for lump sum payment was initiated.

As a matter of policy, we conclude that if an attorney wishes a lump sum attorney fee paid out of the compensation awarded on Board review, the attorney must submit a written request, while the Board retains subject matter jurisdiction, and there must be the necessary authorization language contained in the retainer agreement. In such cases, we will generally grant the request absent persuasive reason not to do so in the particular case.

Nevertheless, we will generally not direct lump sum payment of attorney fees in permanent total disability cases because it ordinarily cannot be determined in advance whether sufficient permanent total disability payments will be made to substantiate the maximum fee allowable under OAR 438-15-055(1). See Duane G. Taylor, 43 Van Natta 138 (1991).

Accordingly, the request for reconsideration is granted. On reconsideration, as supplemented herein, the Board adheres to and republishes our December 14, 1990 order. The approved attorney fee awarded by our December 14, 1990 order, as reconsidered here, shall be paid by the SAIF Corporation directly to claimant's attorney, in a lump sum, upon finality of this Order on Reconsideration. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ANN F. LOWE, Claimant
WCB Case No. CO-00432
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT
Calvert & Calvert, Attorneys
Nelson, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

On December 10, 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 $10,000 by Liberty Northwest Insurance Corporation, claimant agreed to fully release her right to future workers' compensation benefits, except medical services, for her compensable injury. However, by order dated January 10, 1991, the Board withdrew its acknowledgement and refused to approve the agreement because there was no evidence in the agreement that claimant's permanent disability award had been paid in full. The employer has provided evidence that the permanent disability award was paid in full on August 27, 1990, and requests reconsideration of the Board's order. The motion is granted on reconsideration.

The Board is persuaded that its sole objection to the agreement has been met and that the terms of the agreement are in accordance with all statutory and administrative prerequisites.

Under these circumstances, it is unnecessary to recommence claimant's 30-day right to disapprove the agreement. See ORS 656.236(1)(c). Therefore, the Board shall not require the parties to submit a revised agreement pursuant to the standard procedures. See OAR 438-09-025(1), (2).

On reconsideration, as modified herein, the parties' claim disposition agreement is approved, hereby fully and finally resolving this matter.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD K. MILLER, Claimant
WCB Case Nos. 88-17233 & 89-09039
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Thomas J. Dzieman (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Gruber's order that: (1) upheld the SAIF Corporation's denial (on behalf of the Oregon Department of Transportation) of claimant's occupational disease claim for carpal tunnel syndrome; and (2) set aside SAIF's denial (on behalf of Klamath County) of claimant's aggravation claim for the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable injury to the right hand/wrist in 1983 while working for Klamath County Parks. The claim was closed after one month with only a temporary total disability award.

Claimant began working for the Oregon Department of Transportation (ODOT) in April 1987. In September 1987, claimant suffered a nonwork-related overuse injury to the right wrist diagnosed as tendonitis. His symptoms resolved with the use of a splint. Claimant was laid off work from January to March of 1988. When he returned to work on April 1, 1988, he had a recurrence of right wrist pain. About a month later, claimant also complained of numbness which became worse when he built a fence in his off-work hours. The wrist pain increased with on-the-job activities such as painting.

Claimant currently has a carpal tunnel syndrome which is secondary to the 1983 injury. His employment with ODOT increased his symptoms and worsened the pathology of that earlier injury resulting in increased disability and the need for medical services. (Exs.12, 14-1).

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant initially suffered an injury while working for Klamath County, and that the work exposure with ODOT merely contributed to a worsening of symptoms, and thus responsibility remains with the first employer. Hensel Phelps Const. v. Mirich, 81 Or App 290, 294 (1986). We disagree that there was merely a worsening of symptoms.

Here, we have an accepted compensable injury followed by an increase in disability during a later employment. Responsibility is, therefore, fixed with the employer which accepted the claim (Klamath County). See Linda L. Wise, 42 Van Natta 115, 116-117 (1990). In order to shift responsibility, Klamath County must prove that claimant's employment with ODOT independently contributed to a worsening of the underlying condition resulting in disability or the need for treatment. Columbia County School Dist. #13 v. Thurston, 96 Or App 686 (1989). We conclude that responsibility shifted in this case.

The Western Medical Consultants diagnosed claimant's condition as carpal tunnel syndrome and opined that claimant's current problems are secondary to the 1983 injury. However, they further opined that claimant's increased symptoms are secondary to a worsening of the pathology of that earlier injury and that this worsening was caused by his current job. (Ex. 12).

The treating physician, Dr. Sargent, also diagnosed claimant's condition as carpal tunnel syndrome. His opinion on the "cause" of the carpal tunnel syndrome varied depending on the report. Initially, Dr. Sargent implied that repetitive use of a hammer to build a fence in claimant's off-work hours was the major contributing cause and, thus, the 1983 injury did not contribute to the current condition. (Ex. 7). Subsequently, Dr. Sargent concurred with the Western Medical Consultants that claimant's current condition is secondary to the 1983 injury and that his job with ODOT increased his symptoms and worsened the pathology of that earlier injury. (Ex. 14-1).

We are persuaded that the preponderance of well-reasoned medical evidence supports the conclusion that, while claimant's current condition is secondary to the 1983 industrial injury (Klamath County Parks job), his more recent employment with the Department of Transportation was an independent contributing cause to a pathological worsening of that condition. Therefore, claimant's current disability and need for surgical treatment is the responsibility of ODOT, the second employer. See Thurston, supra; Linda L. Wise, supra;. Accordingly, we reverse.

Attorney Fees

This request for Board review was not initiated by an insurer or employer and, accordingly, attorney fees may not be assessed under ORS 656.382(2). Nor is an assessed fee awardable under ORS 656.386. ORS 656.386(1) provides for an assessed fee for services before the Board if claimant finally prevails from an order denying a claim for compensation. Here, the Referee's order found the claim compensable. Only claimant requested review and only with respect to the issue of responsibility. Greenslitt v. City of Lake Oswego, 305 Or 530 (1988). Further, while the determination of responsibility may affect the amount of claimant's compensation, under subsection (1) of ORS 656.386, whether a claimant is entitled to an attorney fee award does not depend on the amount of compensation that claimant may receive. Howard v. Willamette Poultry, 101 Or App 584, n. 4 (1990).

Claimant has, nevertheless, entirely prevailed on review. Therefore, he is entitled to have attorney fees paid from any increase in temporary total disability compensation that is created by this order. See ORS 656.386(2).

ORDER

The Referee's order dated July 19, 1989 is reversed. The SAIF Corporation's denial on behalf of Klamath County Parks is reinstated and upheld. SAIF's denial on behalf of the Oregon Department of Transportation is set aside and the claim is remanded to SAIF on behalf of ODOT for processing according to law. SAIF, on behalf of ODOT, is ordered to pay the $2,500 assessed attorney fee awarded by the Referee at hearing. In addition, claimant's attorney is awarded 25 percent of the increased temporary disability benefits created by this order, to be paid by the SAIF Corporation on behalf of ODOT in an amount not to exceed $3,800.

In the Matter of the Compensation of
CAROLYN C. SMITH, Claimant
WCB Case No. C0-00551
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Vick & Gutzler, Claimant Attorneys
Hallock & Bennett, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

On December 24, 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 Cigna Insurance Companies, claimant fully releases her right to all future rights and benefits permitted by law. We set aside the proposed disposition.

ORS 656.236(1) permits parties, by agreement, to make "such disposition of any of 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 "claims 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).

Here, the proposed disposition purports to release all benefits and rights permitted by law. It does not identify which specific benefits claimant is releasing. Former OAR 436-60-145(6)(g) [Renumbered OAR 436-60-145(3)(h), December 26, 1990] provides that a proposed disposition will contain a specific identification of all benefits, rights and obligations that are disposed of and released under the agreement. Without such a specification, it is not clear what benefits, rights and obligations an agreement purports to dispose of and release. We conclude that such an agreement is unreasonable as a matter of law. See Louis R. Anaya, 42 Van Natta 1843 (1990). Accordingly, the proposed disposition is set aside on this basis. See ORS 656.236(2).

Following our standard acknowledgement procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
BEVERLY A. BECKLEY-STOKES, Claimant
WCB Case No. C1-00069
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Charles E. Woods, Claimant Attorney
David O. Horne, Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

On January 14, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases her rights to future workers' compensation benefits for the compensable injury. We set aside the proposed disposition.

OAR 436-60-145(4) requires that a claims disposition agreement contain a specified notice in prominent or bold face type. A proposed disposition that

does not contain the required notice will not be approved by the Board. See OAR 436-60-145(5); 438-09-020(1). Such an agreement is deemed unreasonable as a matter of law. ORS 656.236(1)(a); OAR 438-09-020(2).

Here, the proposed disposition does not provide the bold-face notice as required by OAR 436-60-145(4)(g). Under these circumstances, the proposed disposition is unreasonable as a matter of law. See OAR 438-09-020(2). Accordingly, we decline to approve the agreement and return it to the parties.

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) & (6) (e).

We also note that the parties failed to specifically identify the benefits, rights and obligations which are disposed of under the agreement. (See page 2, line 20).

Following our standard procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
LOUIS R. ORMAN, Claimant
WCB Case No. 88-22308
ORDER ON REVIEW
Garlock, Smith & Associates, Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Crider and Speer.

The insurer requests review of Referee Harri's order that set aside its denial of claimant's occupational disease claim for his current psychological condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant began work in the employer's wrapping department in 1967. He sustained a back injury in 1974, and remained off work for several years. During that time, he worked for three other employers and completed a vocational rehabilitation program. Between December 1978 and January 1979, claimant treated with Dr. Maltby, M.D., for psychological problems.

In 1981, claimant underwent open heart surgery. Following his heart surgery, he was unable to obtain reinstatement with the employer until he filed a complaint with the State Labor Commissioner.

In 1983, claimant underwent surgery for the excision of an L4-5 disc.

In 1984, claimant alleged physical and emotional stress arising out of a November 25, 1983 incident in which he was denied a promotion. The parties entered into a disputed claim settlement in July 1984.

Beginning in July 1988, claimant's co-workers subjected him to verbal and other forms of abuse. Several employees had been told to "keep an eye" on

claimant after he returned from leave. Claimant's co-workers nicknamed him "the weasel," and on one occasion, in claimant's presence, the co-workers talked about getting a gun and shooting a weasel.

While claimant was on leave in November 1988, the employer moved his saw and rearranged his work area. After he returned to work, claimant was one of the last three workers to have an exhaust fan hooked up at his work station. He suffered nosebleeds from sawdust at the work site until the new fan was connected.

One day at noon, claimant was eating his lunch in his car when an employee told him to move the car so he could get his own vehicle out. Claimant refused and the employee brought another car from his home in order to block claimant's car. The employee refused to move the car until a supervisor threatened to fire him.

At work, claimant was subjected to "bear hugs" by other employees. On different occasions, co-workers spit tobacco and threw debris into his work area and placed glue on his saw. Claimant's co-workers also drove machinery, such as Hysters, toward him while he was walking.

On more than one occasion, an employee shoved a loaded cart full of wooden rails toward claimant. In November 1988, the same employee again pushed a full cart into claimant's work area. The cart slammed to a stop near him and the incident led to a shouting match in which claimant attempted to strike the other employee. Claimant returned to his work area, but subsequently felt ill and checked out of work.

After leaving work, claimant had difficulty obtaining an 801 form, which he requested from the employer. Claimant's paycheck had been made out, but although his supervisor knew that the check was in the safe, he advised claimant that he was not going to be paid.

On November 14, 1988, claimant filed an occupational disease claim for his psychological condition. He sought medical treatment for his inability to sleep and for his symptoms of depression and anxiety. On December 15, 1988, the insurer denied claimant's claim.

During the time he alleged stress at work, claimant's off-work stressors included the death of a son-in-law, altercations with a neighbor, and financial and marital difficulties.

ULTIMATE FINDINGS

Claimant suffered a mental disorder, a mixed adjustment disorder with symptoms of severe anxiety and depression, the cause or worsening of which arose out of and in the course of his employment. That mental disorder required medical treatment and resulted in disability.

Employment conditions which existed in a real and objective sense, included verbal and physical abuse from co-workers who also threatened claimant and tampered with his work site, and selective treatment by management who asked other workers to keep an eye on claimant. Claimant's employment conditions contributed in material part to his mental disorder.

The conditions which resulted in claimant's disabling mental disorder were not conditions generally inherent in every working situation. The conditions were not disciplinary, corrective or job performance evaluation actions and were not associated with the cessation of employment.

Claimant's condition was diagnosed as an adjustment disorder by Dr. Mead. That condition is a mental disorder generally recognized in the psychological community.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was subjected to real and objective employment conditions which are not conditions generally inherent in every work situation. He further found that those conditions produced claimant's mental disorder. He, therefore, concluded that claimant's occupational disease claim was compensable.

The date of "injury" for purposes of determining the compensability of an occupational disease is the date upon which the claimant was last exposed to the employment conditions that caused the disease. Johnson v. SAIF, 78 Or App 143, 146-48, rev den 301 Or 240 (1986). Here, claimant's occupational disease claim for his current psychological condition alleges exposure to potentially causal employment conditions occurring after January 1, 1988. Accordingly, the occupational disease law which became effective January 1, 1988, is applicable. See Johnson, supra at 146-48; Donna E. Aschbacher, 41 Van Natta 1242 (1989).

ORS 656.802 provides, in part, that an occupational disease arising out of and in the course of employment which requires medical services will not be compensable:

> "(2)(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 the events claimant alleged to cause his work-related stress actually occurred. We agree. Claimant's treating psychiatrist, Dr. Mead, reported that claimant was not out of touch with reality. In addition, claimant's credible testimony, and the testimony of various other employees, support his allegations. We conclude that the employment conditions which claimant complained of did exist in a real and objective sense.

The Referee did not make a specific finding that claimant's mental disorder was generally recognized in the medical or psychological community. Nevertheless, the evidence supports such a finding. Dr. Mead, claimant's treating doctor, diagnosed mixed adjustment disorder with symptoms of severe anxiety and depression. Dr. Colistro, psychologist, and Ms. Brighton, mental health therapist, examined claimant and diagnosed major depression with melancholia and personality disorder. Finally Dr. Davies, psychologist, examined claimant for the insurer and concluded that the most appropriate DSM III-Revised Diagnostic

Impression was dysthmia and personality disorder. Based upon the above diagnoses, we conclude that claimant's mental disorder was one generally recognized in the medical or psychological community.

The Referee found that claimant had shown by clear and convincing evidence that his mental disorder arose out of and in the course of employment. We agree. In the present case, three doctors examined claimant and provided diagnoses. Dr. Davies examined claimant and diagnosed early onset dysthmia characterized by chronic depression and a moderately severe personality disorder. He could not "find clear and convincing evidence that (claimant's) pathology should be compensated as an occupational injury." Dr. Davies based his opinion, in part, upon the conversion reaction earlier diagnosed by Drs. Maltby and Turco.

Claimant was also examined by Dr. Colistro and Ms. Brighton. On February 15, 1989, they reported that claimant was suffering from an acute emotional disturbance characterized by feelings of worthlessness and self-reproach, in addition to suicidal ideation, sleep disturbance, anxiety and agitation. Dr. Colistro and Ms. Brighton diagnosed major depression and dependent personality disorder. In their opinion, claimant's emotional difficulties were a direct result of stress experienced on the job. They did not foresee that claimant could return to his old work setting in the future, given the history of repeated difficulties.

Dr. Mead, claimant's treating psychiatrist, reported that when he initially saw claimant on February 2, 1989, claimant showed the signs and symptoms of severe depression and stress. He noted that, since that time, claimant had been treated with several different medications. Dr. Mead diagnosed mixed adjustment disorder with symptoms of severe anxiety and depression. He reported that the adversities which claimant encountered at work had been going on for several years and had involved a number of individuals and situations.

Dr. Mead enumerated claimant's off-work stressors and concluded that, when compared to nonwork factors, claimant's employment was the major contributing cause of his present psychological condition. Dr. Mead concluded that the "chronicity and the length of time of the events (at work) far outweigh the events which have occurred in the nonwork environment."

We are not persuaded by Dr. Davies' opinion that claimant's current psychological condition was not caused by his employment. Dr. Davies relied upon prior reports by Dr. Turco, M.D. In 1984, however, Dr. Turco reported that, if claimant's interpretation of the events (at work) was correct, Dr. Turco believed that "he certainly has experienced psychological stress, associated with his employment situation." In addition, Dr. Turco diagnosed mixed personality disorder and adult stress reaction, associated with problems with employment.

Finally, Dr. Davies testified that claimant had generally intact reality testing, although he was subject to misinterpreting reality. Dr. Davies agreed that the "backbone" of his opinion was his belief that claimant misinterpreted events at work. He acknowledged that, if the work incidents described by claimant actually existed, those incidents would cause claimant's personality disorder to become more symptomatic. Because we have concluded that the events at work claimant described as causing stress did occur in reality, we are not persuaded by Dr. Davies' opinion.

Under the circumstances, we defer to the opinion of Dr. Mead, claimant's treating doctor. Dr. Mead examined claimant and also interviewed claimant's wife. Dr. Mead obtained a complete and accurate history, which included both incidents of work-related and non-work stressors. In addition, Dr. Mead had the

opportunity to treat and examine claimant on more than one occasion. We conclude that Dr. Mead's opinion, as supported by the opinions of Dr. Colistro and therapist Brighton (and the absence of any persuasive evidence to the contrary), constitutes clear and convincing evidence that claimant experienced a mental disorder which arose, in material part, out of and in the course of, his work with the employer. Former ORS 656.802(d).

The Referee found that the employment conditions producing claimant's mental disorder were not conditions generally inherent in every working situation. We agree.

We have interpreted the phrase "generally inherent in every working situation" to mean conditions that are usually present in all jobs or occupations. See Kathleen M. Payne, 42 Van Natta 1900 (1990). Claimant contends that the incidents of harassment and discrimination described above constitute conditions that are not generally inherent in every working situation.

At the outset, and without deciding the matter in this case, we make the assumption that it is claimant's burden to prove conditions not generally inherent in every work situation. We conclude that claimant has met his burden of proof in this regard.

Claimant has not offered opinion evidence directly addressing the "generally inherent" issue. That is, no witness testified that claimant was subject to conditions that are not generally inherent in every work situation. And no physician so opined in a written report. Nevertheless, persuasive evidence need not be direct; it may be circumstantial. See Austin v. SAIF, 35 Or App 249 (1978).

Both Dr. Mead and Dr. Colistro characterized claimant's working conditions at his employer as involving "harassment". Dr. Mead felt claimant had been subject to "adversities" at work. The medical descriptions of the workplace suggest that the physicians did not believe that conditions in the workplace were typical of workplaces generally.

By report dated February 15, 1989, after considering the events experienced by claimant at work, Dr. Colistro and therapist Brighton indicated that claimant was not able to work at that time due to his stress induced mental condition and would never be able to return to his work with the employer. A month later, Dr. Mead, to whom claimant had transferred his care, agreed that claimant was unable to work--"particularly at [the employer]". At hearing, however, Mead testified that, if it were not for the incidents that took place at work, claimant would be capable of performing his job. This medical evidence, in conjunction with our prior findings concerning the repeated episodes of severe and offensive abuse and harassment that claimant was exposed to at the work place, persuades us that claimant's work at the employer involved exposure to conditions not generally inherent in all work situations.

We conclude that claimant has met his burden of proof in regard to all elements of the occupational disease statute. Accordingly, we affirm the order of the Referee.

In light of our conclusions above, claimant is entitled to an assessed attorney fee on the issue of compensability. 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 Board review concerning the issue of compensability is $3,442.50, 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 June 2, 1989 is affirmed. Claimant's counsel is awarded an assessed attorney fee of $3,442.50 for services on Board review, to be paid by the insurer.

February 4, 1991 Cite as 43 Van Natta 231 (1991)

In the Matter of the Compensation of
ELLIS N. PHILLIPS, Claimant
WCB Case No. 89-08868
ORDER ON REVIEW
Jolles, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Crider, Howell and Cushing.

Claimant requests review of that portion of Referee Myzak's order that upheld the self-insured employer's partial denial of temporary total disability benefits. On review, the issue is temporary total disability. We reverse.

FINDINGS OF FACT

Claimant initially sustained a compensable neck strain on December 28, 1983. The claim was closed by a November 14, 1986 Determination Order.

Claimant experienced an aggravation of the 1983 claim on March 19, 1987. Thereafter, claimant's right carpal tunnel syndrome condition became a compensable consequence of the claim. The aggravation claim was closed by an August 6, 1987 Determination Order.

As the result of a labor dispute at his place of employment, claimant went on strike on January 10, 1989.

On March 6, 1989, claimant sought medical treatment for his bilateral carpal tunnel condition. His treating physician, Dr. Bert, requested authorization for bilateral carpal tunnel surgeries. The need for treatment was materially related to the compensable 1983 injury.

In a partial denial letter, dated March 22, 1989, the insurer accepted responsibility for the bilateral carpal tunnel surgeries, but declined to pay claimant temporary total disability on the basis that claimant had voluntarily removed himself from the work force.

On April 4, 1989, claimant underwent a right carpal tunnel release.

The labor dispute ended on May 15, 1989, and the insurer commenced the payment of temporary total disability as of May 16, 1989.

On June 5, 1989, claimant returned to regular work.

We accept the parties' stipulation to the following facts:

> "1. The workers went on strike at Roseburg Forest Products from January 10, 1989 through mid-May 1989; claimant did not look for work during the strike.

2. Claimant did not intend to retire when he left work due (sic) the strike; he intended to return to work at Roseburg Forest Products after the strike.

3. Claimant was not working prior to having his surgery on April 4, 1989.

4. During the strike, claimant received strike pay from the union.

5. Claimant was required to spend between four to (sic) eight hours per week on the picket line during the strike; claimant's picket duty was flexible and he could schedule his time on the picket line at any time.

6. During the strike claimant received no wages, benefits or any form of remuneration from Roseburg Forest Products.

6. (sic) Claimant would not have crossed the picket line even if work were available at Roseburg Forest Products."

ULTIMATE FINDINGS OF FACT

Claimant became disabled due to a compensable condition on the date of his surgery, April 4, 1989.

Claimant had not withdrawn from the work force prior to his date of disability.

CONCLUSIONS OF LAW AND OPINION

A workers' compensation claimant is not entitled to temporary total disability benefits for aggravation of an original compensable injury, where the claimant had voluntarily removed himself or herself from the labor market. Cutright v. Weyerhaeuser, 299 Or 290 (1985). In Cutright, the Court reasoned that claimants who have removed themselves from the labor market are not "workers" as defined by ORS 656.005(28). The Court held that because the entire scheme of Workers' Compensation Law is to compensate "workers" for lost wages, nonworkers are not entitled to temporary disability benefits. Cutright v. Weyerhaeuser, 299 Or at 296, 297. The Court, relying on the language of ORS 656.325(5), also concluded that claimants who have removed themselves from the labor market cannot qualify for temporary total disability because of their decision to refuse further wage earning employment. Cutright v. Weyerhaeuser, 299 Or at 300.

In a subsequent case, Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989), the Court held that a claimant is in the work force if:

"a. The claimant is engaged in regular gainful employment; or

b. The claimant, although not employed at the time, is willing to work and is making reasonable efforts to obtain employment, Cutright v. Weyerhaeuser, 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)."

Dawkins v. Pacific Motor Trucking, 308 Or at 258. The critical date for determining whether a worker is in, or has withdrawn from, the work force is at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990).

In several recent cases we have addressed the question of entitlement to temporary total disability while a claimant was on strike. In Tracy L. Phillips, 42 Van Natta ____ (October 16, 1990), JoAnne Miller 42 Van Natta (October 9, 1990), and Becky L. Schmidt, 42 Van Natta 2067 (1990), we found that the claimants became disabled prior to the commencement of a strike. Because those claimants were in the work force when they became disabled, we found that the subsequent strike did not alter their status as "workers" for purposes of temporary disability compensation. Since those claimants had not been released to regular work and were not medically stationary at the time of the strike, they were found entitled to temporary disability compensation. See Fazzolari v. United Beer Distributors, 91 Or App 592 (1988).

In Stanley R. Barg, Jr., 42 Van Natta 2073 (1990); James A. Barrett, 42 Van Natta 1988 (1990); and Hal L. Farnworth, 42 Van Natta 1674 (1990), the claimants did not become disabled until after commencement of a strike. In those cases, we found that the claimants had demonstrated, through facts not directly related to the strike, notably work search during the strike, that they remained in the labor force during the strike and at the time they experienced disability. Temporary disability compensation was awarded accordingly.

In this case, claimant became disabled from work after the strike began and when he underwent surgery on his right wrist. We conclude that at that time claimant was a "worker." The fact that he was on strike did not remove him from the work force.

ORS 656.005(25) defines a "worker" as "... any person, ... , who engages to furnish services for a remuneration, subject to the direction and control of an employer ...." In other words, a person who enters into an employment agreement with an employer. Here, claimant had an employment agreement with the employer. That agreement continued during the strike. The mere fact that a worker participates in a strike does not terminate the employment relationship. Indeed, by virtue of federal law a striker continues to be an employer's employee until he or she obtains substantially equivalent employment. 29 U.S. C152(3). [1] The striking worker is entitled to return to work in due course following a strike. NLRB v. Fleetwood Trailer Co., 389 U.S. 375 (1967). It is worth noting, at this point, that the issue is whether claimant was a "worker" and in the work force at the time of disability, not whether claimant was actually working. It should be clear that a worker remains in the work force during certain periods, such as vacations, holidays, leaves of absence and sabaticals, despite not actually working during those periods. That is the case here.

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1 "The term 'employee' shall include any employee, and shall not be limited to the employees of a particular employer, unless this 54 Chapter explicitly states otherwise, and shall include any individual whose work has ceased as a consequence of, or in connection with, any current labor dispute or because of any unfair labor practice, and who has not obtained any other regular and substantially equivalent employment . . . "
29 OSC 152(3).

While claimant was not actually working at the time of his disability, he did satisfy the first Dawkins test for proving that he was in the work force because he was engaged in regular gainful employment.

Under the Dawkins test, claimant was in the work force during the strike because his employment with the employer continued. Unlike the claimant in Cutright, he had not decided to refuse further wage earning employment. See Cutright v. Weyerhaeuser, supra. Claimant did not intend to retire but did intend to return to work. Consequently, he was entitled to temporary disability benefits when he became disabled.

Finally, we observe that it would be ironic indeed if, as the dissent asserts, claimant removed himself from the work force by participating in legally protected, concerted activity to maintain or improve the conditions of his continued employment with his employer.

ORDER

The Referee's order dated October 16, 1989 is reversed in part and affirmed in part. That portion of the Referee's order that upheld the employer's partial denial of temporary disability compensation is reversed. Claimant is awarded temporary total disability for the period April 4, 1989 through May 15, 1989. 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.

Board Member Cushing Dissenting:

I dissent.

The majority finds claimant entitled to temporary disability because claimant is a worker, having never left the work force due to the strike. Inasmuch as I conclude that claimant became a non-worker when he left his employer and declined to seek work, I would hold that claimant is not entitled to temporary disability.

The Supreme Court has stated that a worker remains in the work force at the time of disability if: (1) claimant is engaged in regular gainful employment; or (2) claimant is not employed, but willing to work and is seeking work; or (3) claimant is not working but willing to work, but is not seeking work because a work related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

The medical record does not support a finding of futility. Moreover, claimant stipulated that he did not seek work in that: (1) if work had been offered by the employer he would not have accepted; and (2) that otherwise, he made no effort to seek work. The majority does not suggest that claimant met these tests. Rather, the majority contends that claimant did not leave the work force because he was engaged in regular gainful employment.

Interpretation of "engaged in regular gainful employment" must be considered in the context of the temporary disability statute. The function of temporary disability benefits is to provide for maintenance benefits by replacing lost income during the process of healing and recovery of injured workers. Thus, temporary disability is wage replacement. Cutright v. Weyerhaeuser, 299 Or 290, 296-298, 302 (1985). A worker is defined as one who engages in furnishing services for remuneration. See ORS 656.005(27). According to Black's Law Dictionary, the term "engaged in employment" means, "To be rendering service for employer under terms of employment, and is more than being hired to commence

work." Black's Law Dictionary, 474 (5th ed. 1979). Further, ORS 656.210(2)(c) defines "regularly employed" as actual employment or availability for such employment.

In light of the above, I find that the phrase "engaged in regular and gainful employment" was intended to convey an active participation in the work force as opposed to a passive status. Therefore, I conclude that the relevant Dawkins test under consideration here, requires actual employment for which claimant receives remuneration at the time of disability as a necessary predicate to temporary disability entitlement. Accordingly, one who is not rendering services, and further who is not receiving remuneration, is not "engaged in regular gainful employment." Claimant has not demonstrated this key criteria.

The stipulated facts agreed to by the parties, and adopted by the majority indicate that: (1) claimant left work due to the existence of a strike at his employer's; and (2) claimant received no wages, benefits or any form of remuneration from his employer. Accordingly, as a result of claimant's decision to honor the strike, he was no longer a person engaged to furnish services for a remuneration, and therefore, was not a worker. Consequently, claimant is not entitled to temporary disability benefits.

The majority notes the relevant case law and statutory definition of a worker, but nonetheless rejects it, and instead defines a worker as one who enters into an "employment agreement." The majority then proceeds to find that claimant here entered into an employment agreement. Inasmuch as there is no evidence of an agreement, oral or otherwise, I assume that it is the intention of the majority that such an agreement is to be implied from each and every working relationship between employers and employees. It is doubtful that either the employer or claimant contemplated that an employment agreement existed during the strike.

The majority's "agreement" theory is buttressed by citation to federal labor law. In support, the majority opinion states that evidence of such an agreement is a striking worker's entitlement to return to work following the strike. The majority, however, assumes too much. There is no absolute right to reinstatement by striking workers. In the case of an economic strike, as opposed to an unfair labor practices strike, an employer has not lost the right to protect and continue his business by supplying places left vacant by strikers. An employer is entitled to hire permanent replacements. And furthermore, an employer is not bound to discharge those hired to fill the places of strikers, upon the election of the latter to resume their employment in order to create places for them. NLRB v. Mackay Radio & Telegraph Co., 304 U.S. 333, 345-346 (1938); NLRB v. Powell Elec. Mfg. Co., 906 F.2d 1007, 1016 (5th Cir. 1990).

In this particular case, we know nothing about the nature of the labor dispute. We rely upon stipulated facts. There is simply no evidence that the employer here was guilty of any unfair labor practice as defined by 29 U.S.C. Section 158(a)(1) & (3). Thus, in the case before us now, it cannot be said that claimant was entitled to reinstatement. In any event, federal labor law is not applicable here. Cutright makes clear the intent of the Oregon legislature is controlling in its construction of Oregon's workers' compensation system. Cutright, supra, at 301.

The majority attempts to evade the requirement of actual employment, by stating that the issue is not whether claimant is actually working, but solely whether or not claimant is in the work force. Thus, the majority makes a distinction from those actually working from those not working but in the work force as evidenced by an implied employment agreement. In support of that proposition the majority points to the fact that claimant remains a worker while on vacations, holidays, leaves of absence and sabbaticals.

I do not find this argument persuasive, in that a worker on vacation or holiday gets paid for these periods of time. Moreover, a leave of absence is a prearranged and preapproved absence from work with a date of leaving and return. Here, in accordance with the stipulated facts, there is no evidence that claimant is in any of these circumstances. Nor is there evidence that claimant is accruing vacation pay, being paid for holidays, or otherwise made advance and preapproved arrangements for a specified leave of absence.

It is clear the majority equates employment status with actual employment. I would contend that the mere fact of an employment relationship without more is insufficient. The statutory framework of the workers' compensation act, and case law as developed by both Oregon appellate courts requires actual employment for which claimant was receiving remuneration. The stipulated facts indicate this requirement was not met. As stated in Cutright, "A claim for temporary total disability benefits in the absence of wage loss seeks a remedy where there is no damage. Non-workers can sustain medical expenses. They cannot lose earnings." Cutright, supra at 302.

This interpretation is consistent with other elements of the statutory framework of Oregon law. In order to obtain unemployment compensation, a claimant must establish that he is able, available, actively seeking and unable to obtain employment. ORS 657.155(1)(c). Despite the receipt of unemployment benefits, claimants are entitled to temporary partial disability, although subject to offset by the unemployment benefits received. Wells v. Pete Walker's Auto Body, 86 Or App 739 (1987). Thus, a claimant receiving unemployment benefits is not considered to have left the work force.

But yet, the worker on strike is not treated similarly. If unemployment is due to a labor dispute which is in active progress at the worker's place of employment, the worker is disqualified from receiving unemployment benefits. ORS 657.200. In light of these two statutes, it simply cannot be said that there is an unspoken legislative policy to provide striking workers with lost wages in the form of temporary disability.

Finally, I have a more fundamental objection to the majority opinion, and that is with the broad policy statement ultimately made by this opinion. The statutory framework does not provide for what the majority is granting to injured workers. Therefore, in order to achieve what the majority views as an arguably just result, they reach out to make a policy statement, and in doing so make an unwarranted expansion of the law concerning temporary disability.

The practical effect of this holding is to rewrite the coverage policies of Oregon employers to be the "insurer" for striking workers. It is also a disincentive for workers to seek other work during lengthy and protracted strikes when they are able to work.

I close by specifically declining to address the merits of whether or not striking workers should indeed be entitled to temporary disability, inasmuch as I believe such policy questions are ultimately best left to our elected representatives. And until the legislature speaks to us, the Board should decline to reach out and create a new class of temporary disability benefits. For these reasons I dissent.

In the Matter of the Compensation of
CHRISTINE Y. ZORN, Claimant
WCB Case Nos. 89-03606 & 89-03607
ORDER ON REVIEW
Parker & Bush, Claimant Attorneys
Roy W. Miller (Saif), Defense Attorney
Yager & Ainsworth, Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The SAIF Corporation requests review of Referee Leahy's order that: (1) set aside its denial of claimant's occupational disease claims for a bilateral carpal tunnel syndrome condition and a cervical and shoulder condition; (2) upheld Industrial Indemnity's denial of claimant's occupational disease claims for the same conditions; and (3) assessed an attorney fee for an allegedly unreasonable denial. On review, the issues are compensability, responsibility and attorney fees. We affirm in part, reverse in part and modify in part.

FINDINGS OF FACT

Claimant experienced a compensable injury to both hands and arms in 1982 while working as a production worker for SAIF's insured. She underwent surgery for bilateral carpal tunnel syndrome and was declared medically stationary on May 20, 1983. Her claim was closed by an August 31, 1983 Determination Order with an award of temporary total disability.

Claimant subsequently returned to light duty for SAIF's insured and slowly worked back to heavy metal work. She continued heavy work until 1986, at which time she began working as a sawyer for Industrial Indemnity's insured.

Claimant experienced increased pain following a short period of work as a sawyer. She sought treatment in October 1986 from Dr. Dawson, a chiropractor, who diagnosed an aggravation of her bilateral carpal tunnel syndrome condition.

Industrial Indemnity denied responsibility for claimant's bilateral carpal tunnel syndrome condition in November 1986. Claimant did not challenge the denial. She continued to work for Industrial Indemnity's insured until February 1989, at which time she again underwent surgery for bilateral carpal tunnel syndrome. She later returned to work in April 1989.

On February 23, 1989, Industrial Indemnity issued a denial of responsibility for claimant's carpal tunnel syndrome condition and a denial of both compensability and responsibility for a shoulder and cervical condition. SAIF issued a similar denial on April 27, 1989.

CONCLUSIONS OF LAW AND OPINION

Carpal Tunnel Syndrome Condition

The Referee found that claimant's work activities with Industrial Indemnity's insured did not independently contribute to her carpal tunnel syndrome condition. Therefore, he concluded that SAIF remained responsible for claimant's current condition. We agree.

In cases in which an accepted compensable injury or occupational disease is followed by an increase in disability during employment with a later carrier, responsibility is fixed with the carrier who initially accepted the claim. In order to shift responsibility, the original carrier must prove affirmatively that a later employment independently contributed to a pathological worsening of

the accepted condition. See Spurlock v. International Paper Co., 89 Or App 461 (1988); Linda L. Wise, 42 Van Natta 115 (1990).

After our de novo review of the record, we conclude that the medical evidence establishes a mere symptomatic worsening of claimant's underlying compensable condition. Of the five expert opinions submitted in this matter, all believed that claimant's symptoms had worsened. (Exs. 15, 27-4, 28,). None of the doctors, however, concluded that the work with Industial Indemnity's insured contributed independently to her carpal tunnel syndrome condition. To the contrary, Dr. Melvin, the hand surgeon who performed claimant's 1989 carpal tunnel release, stated that claimant's 1982 and 1988 symptoms were "one and the same," and attributed the continuation of her symptoms to earlier inadequate treatment. (Ex. 30A-2). Without an independent contribution to a worsening of the accepted condition, SAIF remains responsible. See Hensel Phelps Const. v. Mirich, 81 Or App 290 (1986).

SAIF contends that a mere symptomatic worsening of claimant's condition is sufficient to pass on responsibility to Industrial Indemnity. It relies on Donna E. Aschbacher, 41 Van Natta 1242 (1989), in which the Board examined the standard of compensability of a "repetitive trauma" claim filed under subsection (1)(c) of former ORS 656.802. The Board concluded that, in view of the 1987 amendments to the definition of an occupational disease, a claimant was required to prove that her work exposure was a material contributing cause of either increased symptoms or a worsening of an underlying condition. Id. at 1249. Because Aschbacher established a "symptoms only" standard of compensability, SAIF evidently believes that a worsening of symptoms alone should also be sufficient to shift responsibility. We disagree.

The Workers' Compensation Act has long recognized a "symptoms only" standard of compensability in the injury context. For example, in Florence v. SAIF, 55 Or App 467 (1982), the claimant was entitled to compensation for a symptomatic worsening of his preexisting knee condition, despite the fact that he had not shown that his underlying condition was worsened by his work-related injury. See also Barrett v. D & H Drywall, 300 Or 325 (1985). Yet, the courts have consistently required that subsequent injuries contribute not only to the symptoms, but also to the condition in order for responsibility to shift. See Boise Cascade v. Starbuck, 296 Or 238 (1984); Crowe v. Jeld-Wen, 77 Or App 81 (1985).

We adhere to this longstanding analysis concerning the determination of responsibility. In fact, to do otherwise might make subsequent potential employers reluctant to hire injured workers, since only a slight contribution to the symptoms of a previously accepted condition would be adequate to shift responsibility to the new employer. Therefore, to adopt the position/analysis advocated by SAIF could contravene one of the primary goals of the workers' compensation system, i.e., to return injured workers' to work as soon as possible. Thus, we hold that, while a claimant may prove a compensable repetitive trauma claim based solely on symptoms, a carrier may not shift responsibility to a later carrier without showing a subsequent independent contribution to the compensable condition.

SAIF next contends that, under Champion International v. Castilleja, 91 Or App 556 (1988), Industrial Indemnity carries the burden of proving a lack of contribution to a worsening of claimant's carpal tunnel syndrome condition. We disagree.

In Castilleja, the claimant had an accepted low back injury and an accepted groin injury. Because the evidence was inconclusive as to which accepted injury was the cause of a subsequent disc herniation, the court

assigned responsibility to the carrier with the last accepted injury. This fixing of a presumptive responsibility with the last, rather that the first, carrier having a potentially causative accepted injury is known as the Kearns presumption. Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984).

The Kearns presumption is designed to assign presumptive responsibility in "successive injury" cases. However, it is not applicable to this type of a responsibility case, in which there is only one work related injury. Where there is an accepted claim and then a later exposure that could have independently contributed to a pathological worsening of the accepted condition, the burden of proof is on the carrier seeking to shift responsibility, which, in this case, is SAIF. See Linda L. Wise, supra at 115.

Cervical and Shoulder Condition

While the Referee noted that both insurers also had denied the compensability and responsibility of claimant's cervical and shoulder condition, he failed to address those issues in the "Opinion" section of his order. Nonetheless, by setting aside SAIF's denial in its entirety, he evidently found the condition compensable and concluded that SAIF was responsible. We disagree.

When compensability and responsibility are both at issue, as here, the threshold issue is compensability. Runft v. SAIF, 303 Or 493 (1987). In order to prove compensability of her cervical and shoulder condition, claimant must prove by a preponderance of the evidence that her work activity with either SAIF's insured or Industrial Indemnity's insured was a material contributing cause of her condition. Claimant also can establish compensability of her condition against SAIF by proving that any cervical and shoulder treatment or disability is materially caused by her compensable bilateral carpal tunnel syndrome condition.

Claimant relies solely on a medical report submitted by two physicians from the Medical Consultants Northwest, which provides:

> "Her cervical problem appears to be related by history and records to [work for Industrial Indemnity's insured]. * * * It is felt that it is more likely that the chiropractic care for her shoulders and neck are the result of the work activities since 1984 to the present and not related to her December 14, 1982 bilateral carpal tunnel syndrome claim." (Ex. 27-5)

The doctors, however, failed to explain the basis for those conclusions. They did not diagnose the condition, nor did they indicate that claimant was suffering from cervical and/or shoulder pain. In fact, the only reference to claimant's shoulder and cervical condition that we can find in the report is the above quoted passage. Moreover, their conclusions are not supported by claimant, who testified that she could not recall any treatment for her upper back or neck. She also testified that she did not recall mentioning a neck problem when she was examined by the doctors who submitted the report. (Tr. 32). Consequently, we give their opinion little weight. See Somers v. SAIF, 77 Or App 259 (1986).

Therefore, we conclude that claimant has failed to establish a compensable cervical and shoulder condition against either SAIF or Industrial Indemnity. Accordingly, both denials are upheld.

Attorney Fees

SAIF contends that the Referee erred in assessing an attorney fee for its allegedly unreasonable delay in accepting or denying claimant's claim. We agree.

The Referee found that there were no amounts "then due" on which to base a penalty for SAIF's allegedly unreasonable delay. ORS 656.262(10). Accordingly, the Referee was correct in declining to assess a penalty. However, relying on Spivey v. SAIF, 79 Or App 568 (1986), he awarded an attorney fee.

Shortly before the Referee issued his order, the Supreme Court issued its decision in Ellis v. McCall Insulation, 308 Or 74 (1989). In Ellis, the Court held that, before an attorney fee can be assessed under ORS 656.262(10), there must be an "unreasonable resistance to the payment of compensation" under ORS 656.382. Here, as the Referee found, there was no evidence that claimant was due any temporary disability benefits as she continued to work. Because there was no compensation due, the delay in accepting or denying claimant's claim did not delay any compensation. Because there was no unreasonable resistance to the payment of compensation, no attorney fee may be assessed. Lloyd L. Cripe, 41 Van Natta 1774 (1990).

As a final matter, we must address the Referee's combined assessed attorney fee for the denial issue and unreasonable conduct issue. The Referee did not specify what amount he was awarding for each issue, but rather awarded a lump sum of $2,600 to be paid by SAIF. In light of our decision that the Spivey fee was improper and because claimant has not prevailed against the cervical and shoulder portion of SAIF's denial, we reduce that award to $2,000. After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that a reasonable attorney fee for services at hearing concerning the bilateral carpal tunnel syndrome issue is $2,000, to be paid by SAIF. In reaching this conclusion, we have considered the time devoted to the issue, the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 12, 1989 is affirmed in part, reversed in part and modified in part. The SAIF Corporation's denial is reinstated and upheld to the extent that it denied claimant's cervical and shoulder condition. The Referee's assessed attorney fee for SAIF's allegedly unreasonable denial is reversed. In lieu of the Referee's $2,600 assessed attorney fee, claimant's attorney is awarded $2,000 for services at hearing concerning the carpal tunnel syndrome issue. The remaining portions of the Referee's order are affirmed.

February 5, 1991 Cite as 43 Van Natta 240 (1991)

In the Matter of the Compensation of
DAVID L. CISNEROS, Claimant
WCB Case Nos. 89-02733 & 88-20418
ORDER ON REVIEW
Callahan, et al., Claimant Attorneys
Marcus Ward, Defense Attorney
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation, as insurer for King Seeds, requests review of that portion of Referee Foster's order which set aside its denial of claimant's "new injury" claim for his current low back condition, the same condition from which claimant did not timely appeal an aggravation denial issued by SAIF, as insurer for West Salem Christian Church. On review, the issue is responsibility. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant compensably injured his low back on July 17, 1985 while working for SAIF's insured, West Salem Christian Church (the Church). Claimant was treated by Dr. Abrams, chiropractic physician, who diagnosed thoracolumbar sprain. He was seen in independent orthopedic examination on October 4, 1985 by the BBV Medical Consultants who concurred in Dr. Abrams' diagnosis and found claimant capable of performing full work activity. Dr. Abrams provided continuing care through January 1987 and recommended that claimant avoid heavy, manual laboring activities.

A Determination Order issued November 6, 1985 awarding claimant time loss through October 18, 1985 but no permanent partial disability.

By Stipulation agreement dated April 30, 1986, claimant was awarded 10 percent unscheduled permanent disability.

Claimant was off work for about nine months after the July 1985 injury. He continued to experience recurrent low back pain during the three-year period following his 1985 injury and he quit several jobs due to pain.

Claimant began working in March 1988 for King Seeds, also insured by SAIF. The job required constant bending while hoeing weeds. Claimant experienced increased back pain beginning the first day and quit after working a total of seven days over a two and one-half week period. Claimant was seen on April 11, 1988 by chiropractic physician, Dr. Utter, who diagnosed myofascitis of the thoracolumbar paravertebral muscles. The doctor reported that claimant's symptoms and current condition are an aggravation of his July 1985 injury. On May 4, 1988, Dr. Utter declared claimant medically stationary with no permanent impairment and released claimant to return to regular work without restriction.

On January 28, 1989, claimant was again seen in independent orthopedic examination by the BBV Medical Consultants. Claimant reported that he had never completely recovered from his July 1985 injury and attributed his current problems to that incident. The Consultants diagnosed thoracolumbar strain and opined that claimant had temporarily aggravated his preexisting low back condition.

On April 24, 1988, claimant filed an aggravation claim with SAIF/the Church. On June 24, 1988, SAIF denied claimant's aggravation claim. Claimant did not timely request a hearing concerning the aggravation denial.

On August 10, 1988, claimant filed a new injury claim with SAIF/King Seeds. On October 18, 1988, SAIF denied claimant's new injury claim. Claimant timely appealed the new injury denial.

No .307 order issued.

A hearing was held on May 4, 1989. The Referee dismissed claimant's request for hearing on his aggravation claim against SAIF/the Church as untimely, and set aside SAIF/King Seeds' new injury denial.

FINDINGS OF ULTIMATE FACT

Claimant's March 1988 injury caused a symptomatic worsening of his underlying low back condition.

Claimant's March 1988 injury did not independently contribute to a worsening of his underlying condition.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's work activities at King Seeds did not cause a pathological worsening of his underlying back condition, but rather contributed to a symptomatic exacerbation of claimant's previously accepted low back condition. The Referee further concluded that because this symptomatic exacerbation contributed to claimant's inability to work and need for medical care, claimant had sustained a new injury. Therefore, the Referee found SAIF/King Seeds responsible for claimant's current low back condition.

Where a claimant has an accepted compensable injury during the first employment followed by a gradual worsening, the determinative inquiry is whether work activity or exposure at the later employment independently contributed to a pathological worsening of the underlying condition. Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986). If such a contribution did occur, and if disability or a need for medical services results from the worsening, then responsibility for claimant's current condition rests with the second insurer/employer.

After our de novo review of the record, we agree that claimant's repetitive work activity for King Seeds did cause a symptomatic worsening of his underlying condition. Claimant was treated by chiropractic physician Dr. Utter from April 11, 1988 through May 5, 1988. Although Dr. Utter examined and treated claimant closest in time to the March 1988 exposure, he did not take note of, nor take any history of, a new injury. In fact, Dr. Utter initially reported to SAIF that claimant's condition was an aggravation of his 1985 injury--a conclusion that he reiterated in later reports to SAIF. Again, in January 1989, Dr. Utter stated: "[Claimant] did not suffer a new back condition. . . . [H]is previous underlying lower back condition was worsened by the activities in the Spring of 1988, while working for [King Seeds] resulting in further pain which then increased disability."

However, in March 1989, in response to an inquiry from claimant's attorney, Dr. Utter opined that claimant "suffered a materially worsening of his [underlying] condition while working at [King Seeds]. . . ." We do not find Dr. Utter's unexplained reversal of opinion to be persuasive. Raul A. Herrera, 40 Van Natta 1281 (1988). Nor do we find his inconsistent conclusion that the 1988 work exposure contributed to a worsening of claimant's condition to be supported by any medical findings of any new pathology or of any change in claimant's underlying physical condition. Marshall v. Boise Cascade, 82 Or App 130, 133 (1986); Melody M. Schneider, 40 Van Natta 1297 (1988).

Instead, we rely upon Dr. Utter's initial opinion and upon that of the BBV Medical Consultants who examined claimant along with the medical records of the case. Claimant reported to the doctors at BBV that his pain had been ongoing and increased with activity. We find that the BBV Consultants' conclusion that the March 1988 work exposure caused only a symptomatic exacerbation of claimant's chronic underlying problem comports with claimant's reports to Dr. Utter, Dr. Schorb, his later treating chiropractic physician, and his roommate, and further comports with the lack of any new neurological deficits or other loss of function indicating any change to his underlying condition. On this record, then, we find only that claimant sustained a symptomatic worsening of his 1985 low back injury. Without an independent contribution to a worsening of the accepted condition, SAIF/the Church remains the responsible insurer/employer under Hensel Phelps, supra.

Nevertheless, claimant argues that the Referee was correct in assigning responsibility to SAIF/King Seeds because claimant's repetitive work activity at King Seeds materially contributed to his current low back symptoms, requiring

the need for medical services and/or resulting in disability. Claimant contends that under former ORS 656.802(1)(c), as interpreted by this Board in Donna E. Aschbacher, 41 Van Natta 1242 (1989), a symptomatic worsening of a worker's condition is sufficient to shift responsibility to the later insurer/employer.

In Aschbacher, supra, the Board examined the standard of proof required to establish the compensability of a "repetitive trauma" claim under the 1987 amendments to former ORS 656.802(1)(c). The Board concluded that, in light of this definition of a compensable occupational disease, a claimant has experienced a compensable occupational disease if work activity or exposure materially contributes to either increased symptoms or a worsening of an underlying condition. Id. at 1249. Claimant suggests that the new criteria for establishing compensability of an occupational disease claim somehow extends to the issue of allocation of responsibility between the employers. We disagree.

Prior to 1990, responsibility law was entirely a court-created doctrine. Although Aschbacher held that former ORS 656.802(1)(c) established a "symptoms only" standard of compensability for occupational disease claims, it did not purport to modify this judicially adopted responsibility law so as to make a mere worsening of symptoms alone sufficient to shift responsibility for a claim to a later insurer. Were we to adopt a rule which shifts responsibility whenever a new exposure results in additional disability or need for treatment, every symptomatic worsening of a repetitive trauma would be categorized as a new injury rather than an aggravation. The Hensel Phelps court clearly indicated that it very much does not want this result when it noted: "If worsened symptoms alone were enough to place responsibility on the second employer, then the first employer would never be responsible. That is contrary to our holding in [prior cases]. There must be a worsening of the underlying condition." Hensel Phelps, supra at 294. [emphasis supplied].

We decline to depart from this longstanding analysis concerning the determination of responsibility. Thus, we hold that, while a claimant may prove a compensable repetitive trauma claim based solely upon symptoms under former ORS 656.802(1)(c), he may not shift responsibility to a later insurer/employer absent a showing that subsequent work activity or work exposure with the later insured independently contributed to a pathological worsening of his underlying compensable condition. Hensel Phelps, supra.

Accordingly, were SAIF/the Church still a party to this dispute, it would remain the responsible insurer/employer for claimant's compensable aggravation claim. We note, however, that claimant's aggravation claim against SAIF/the Church was dismissed at hearing as claimant failed to timely appeal the aggravation denial. This situation notwithstanding, as claimant has failed to established an independent contribution from his work with King Seeds, he cannot shift responsibility for his current back condition and need for treatment to SAIF/King Seeds.

ORDER

The Referee's order dated May 22, 1989 is affirmed in part and reversed in part. The SAIF Corporation's denial on behalf of King Seeds is reinstated and upheld. The Referee's $1,750 assessed attorney fee for prevailing in setting aside SAIF/King Seeds' denial is reversed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
GARY L. DIRKSEN, Claimant
WCB Case No. C0-00632
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Welch, et al., Claimant Attorneys
Roderick Peters (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

On January 3, 1991, 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 $50,000 by the SAIF Corporation, claimant fully releases his right to future workers' compensation benefits, except medical services, for his compensable injury. In addition, claimant agrees to dismiss with prejudice his hearing request regarding the SAIF Corporation's April 30, 1990 partial denial. 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).

Here, the proposed disposition purports to release claimant's rights and obligations not only under his accepted claim, but it also attempts to resolve an April 30, 1990 partial denial issued by SAIF. The latter portion of this release does not pertain to an accepted claim and, as such, is not a proper matter for disposition under ORS 656.236 and the aforementioned administrative rules. See Victor F. Lambert, 42 Van Natta 2707, 2708 (1990). For this reason, the proposed disposition is not a "claims disposition agreement" as defined by OAR 438-09-001(1).

Inasmuch as the offensive portion of the parties' agreement cannot be excised without substantially altering the bargain underlying the exchange of consideration, we are without authority to approve any portion of the proposed disposition. Karen A. Vearrier, 42 Van Natta 2071 (1990). Consequently, the disposition is set aside. Following our standard procedure, we would be willing to consider a revised agreement which does not contain provisions exceeding our authority under ORS 656.236 and OAR 438-09-001 et seq.

Inasmuch as the proposed disposition has been disapproved, SAIF shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

IT IS SO ORDERED.

In the Matter of the Compensation of
RONDA A. CARLSON, Claimant
WCB Case No. 90-01514
ORDER ON REVIEW (REMANDING)
Charles Robinowitz, Claimant Attorney
Foss, Whitty, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Harri's order which dismissed her request for hearing. On review, the issue is whether the Hearings Division had jurisdiction. We remand.

FINDINGS OF FACT

Claimant filed a claim for a strained left wrist on May 15, 1989. The insurer issued a Notice of Claim Acceptance on May 23, 1989 accepting the claim as nondisabling. The notice also closed the claim. Claimant missed no time from work until June 8, 1989.

On June 20, 1989, claimant wrote the insurer stating that she had been laid-off due to her wrist injury and asking for time loss benefits. On June 26, 1989, her treating doctor noted that claimant was capable of modified work. Dr. Butters, an orthopedist, requested authorization for surgery on November 27, 1989.

On December 15, 1989, claimant's attorney wrote the insurer stating that claimant had not been able to work since June 8, 1989. He requested that the insurer pay time loss benefits. On December 29, 1990, the attorney again wrote the insurer requesting that it pay bills for services in November.

Claimant's attorney requested a hearing on January 18, 1990. He specified the following issues: temporary total disability, medical services and penalties and attorney fees.

The insurer filed a motion to dismiss on April 20, 1990. The motion to dismiss was based on claimant's alleged failure to exhaust her remedies under ORS 656.268(8) "by requesting a determination from the Department of Insurance and Finance as to whether her claim is disabling or non-disabling."

Claimant's attorney wrote the Department of Insurance and Finance (DIF) on May 4, 1990 requesting that the claim be reclassified as disabling. Claimant opposed the motion to dismiss on the grounds that the insurer had an obligation to seek reclassification based on the requests by claimant.

The Referee dismissed the request for hearing without prejudice on May 25, 1990. The order does not explain the basis for the dismissal. No hearing occurred. Claimant requested review.

CONCLUSIONS OF LAW AND OPINION

We note at the outset that the Referee had jurisdiction to decide all the issues raised by claimant's request for hearing. The issues of temporary total disability, medical services, penalties and attorney fees are all matters concerning a claim and are, therefore, within the jurisdiction of the Hearings Division. There are no requirements that administrative remedies be exhausted before jurisdiction vests over any of those issues as they are stated in claimant's specification of issues. Because neither party had an opportunity to present evidence or to argue any of these issues, we conclude that the record has been incompletely developed. Remand is warranted.

We write to clarify the reclassification question. In Linda Warner, 43 Van Natta 159 (1991), we distinguished between claims which were allegedly erroneously classified nondisabling from the outset and claims which were originally correctly classified nondisabling but which allegedly became disabling within one year of the injury. In claims which are allegedly erroneously classified as nondisabling, claimant has the obligation to object to that classification by requesting a determination from the Evaluation Section. Former ORS 656.262 (6)(b); 656.268(8). In such cases, the determination by Evaluation is a jurisdictional prerequisite to a request for hearing. Randy G. Fisher, 42 Van Natta 635 (1990). On the other hand, in cases where, within one year of the injury, claimant contends that the claim has become disabling, the insurer must

immediately report the claim to DIF; Evaluation would then determine whether the claim has become disabling. Warner, supra.

In this case, there is no allegation that the claim was initially erroneously classified as nondisabling. When it was so classified, claimant had lost no time from work. It was only later that claimant alleged that the claim became disabling. At that point, the insurer should have reported to DIF that claimant alleged that the claim had become disabling. There is no indication in this record that the insurer reported the claim to DIF. However, claimant did request that DIF reclassify the claim.

This matter is remanded to the Presiding Referee to assign to a Referee to determine whether the insurer submitted the claim to DIF, to determine what action DIF took on claimant's request for reclassification and to hold a hearing on all matters raised by claimant's request for hearing and specification of issues.

ORDER

The Referee's order dated May 25, 1990 is vacated. The case is remanded to the Presiding Referee for action consistent with this order.

In the Matter of the Compensation of
JOE ANN AGUILAR, Claimant
WCB Case No. 89-11086
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Randolph Harris (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Leahy's order that: (1) dismissed claimant's hearing request as untimely filed; and (2) upheld the SAIF Corporation's denial of her aggravation claim for a left wrist condition. On review, the issues are jurisdiction and aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee proceeded to the merits of the claim, reasoning that the claim was not compensable even if claimant could establish "good cause" for her untimely hearing request. We conclude that claimant has not shown good cause for her untimely hearing request, and thus decide the case on that basis.

A hearing request must be filed within 60 days after claimant is notified of a denial. ORS 656.319(1)(a). A request filed after 60 days but not more than 180 days after notification of denial is valid if the claimant establishes that she had "good cause." The test for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized under ORCP 71B(1) and former ORS 18.160. Anderson v. Publishers Paper Co., 78 Or App 513, 517 rev den 301 Or 666 (1986). See also Brown v. EBI Companies, 289 Or 455 (1980). Claimant has the burden to establish good cause for failure to file timely. Hempel v. SAIF, 100 Or App 68 (1990).

On March 29, 1989, SAIF issued a denial of claimant's aggravation claim, which was received by claimant on March 30, 1989. Claimant testified that on that date she telephoned SAIF to inquire about the status of her claim. Claimant filed her request for hearing on June 12, 1989.

It is uncontroverted that claimant received the denial. That she understood her aggravation claim had been denied is shown by the fact that she called SAIF on the same day she received the denial to complain. Claimant testified the reason she called was that she was upset because SAIF had issued a denial. Claimant further testified that the person to whom she spoke at SAIF said that she was unfamiliar with the claim, but felt that the independent medical examiner found no causal relationship between her current problem and the compensable injury. Claimant then went to see her attorney, but did not tell him about the denial letter.

In Diane T. Lindholm, 42 Van Natta 447 (1990), the claimant argued that her reliance on the oral statements of a SAIF employee constituted good cause for her failure to timely file a hearing request from a denial. The Board held that as the claimant was not told by the SAIF employee that her claim would be accepted after the receipt of additional information or that her claim would remain open after the statutory time for appeal had passed, the claimant's reliance on the SAIF employee's statements did not constitute good cause.

Here, SAIF in no way represented that claimant's aggravation claim would be accepted or remain open after the statutory time for appeal had passed. Therefore, we do not find that this constitutes an excusable mistake. Lindholm, supra. See also Cogswell v. SAIF, 74 Or App 234, 237 (1985).

Claimant argues that her failure to inform her attorney of the denial establishes an excusable mistake. We disagree. Lack of diligence does not constitute good cause. Cogswell v. SAIF, supra.

In light of these facts, we conclude that claimant has not established mistake, inadvertence, surprise or excusable neglect for her late filing of the hearing request. Thus, claimant has failed to establish good cause. Therefore, we lack jurisdiction to reach the issue of compensability of the aggravation claim. Accordingly, the Referee's order is affirmed.

ORDER

The Referee's order dated October 5, 1989 is affirmed.

February 7, 1991 Cite as 43 Van Natta 247 (1991)

In the Matter of the Compensation of
LYN D. CRUZ, Claimant
WCB Case No. 89-22135
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The insurer requests review of those portions of Referee Lipton's order that: (1) set aside its "de facto" denial of claimant's neck injury claim; and (2) assessed a penalty and related attorney fee for its allegedly unreasonable claims processing. On review, the issues are compensability and penalty and related attorney fees. We affirm.

FINDINGS OF FACT

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

The company picnic was a traditional event initiated and sponsored by the employer. All costs were paid by the employer, including food, drink, etc. Management scheduled and planned the event. As an assistant manager, claimant was required to attend the picnic and was paid for her time. She was assigned specific duties, which included monitoring participants, monitoring the alcohol consumption of employees and policing the picnic area. The tug-of-war was an annual event at the picnic.

ULTIMATE FINDING OF FACT

Claimant injured her neck while performing work duties for the employer. This incident caused neck pain for which she received medical services.

CONCLUSIONS OF LAW AND OPINION

Course and Scope of Employment

The Referee concluded that claimant's work duties were sufficiently work-related to support compensability. We agree.

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

Seven factors have been identified to determine whether an injury is work-related: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employee; (3) whether the activity was an ordinary risk of, and incidental to, the employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premise; (6) whether the activity was directed by or acquiesced in by the employer; and (7) whether the employee was on a personal mission of his own. Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571, 575, rev den 300 Or 249 (1985). All of the factors may be considered; no one factor is dispositive. Mellis, supra; Jack K. Kyle, 42 Van Natta 10 (1990), aff'd mem Kyle v. Timberline Lodge, 104 Or App 218 (1990).

The insurer argues that claimant's participation in the tug-of-war provided no direct benefit to the employer. While the tug-of-war, per se, may not have benefitted the employer, the tug-of-war was merely incidental to claimant's presence at the picnic. Her presence at the picnic was for the benefit of the employer. The employer paid claimant to attend the picnic to monitor the participants, to monitor alcohol consumption and to clean up afterwards. These activities were for the employer's benefit.

While it is not clear that the parties specifically contemplated the tug-of-war, the employer entrusted claimant with the duties of helping to plan the picnic, including arranging for door prizes. Consequently, we infer that the employer and claimant contemplated that various activities would occur at the picnic and that employees, including claimant, would participate in those activities.

A tug-of-war is certainly not an ordinary risk of being an assistant manager of a restaurant. However, given claimant's specific assignments at the picnic, an injury in the tug-of-war was incidental to claimant's employment.

The company picnic was a scheduled event which claimant was required to attend, and for which she was paid.

The company picnic was not on the employer's premises.

The employer, through its top executives, directed this "social" activity from the planning stages through its implementation, including claimant's role at the picnic.

Claimant was not on a personal mission of her own. She was at a company function sponsored and funded by her employer which she was required to attend and for which she was paid. See Colvin v. Industrial Indemnity, 83 Or App 73 (1986).

The overwhelming weight of these factors convinces us that there is a significant work-connection between the company picnic and claimant's employment. Consequently, the injury that occurred while engaging in the activities of the party, arose out and in the course of claimant's employment.

Compensability

The Referee concluded claimant had established that her neck injury was related to the September 7, 1988 tug-of-war incident. We agree.

To establish the compensability of claimant's neck injury, claimant has the burden of proving by a preponderance of the evidence that the September 7, 1988 incident was a material contributing cause of her disability or need for medical services. See Harris v. Albertson's, Inc., 65 Or App 254, 256-57 (1983). "Material contributing cause" means a substantial cause, but not necessarily the sole cause or even the most significant cause. Lobato v. SAIF, 75 Or App 4888, 492 (1985).

The uncontradicted evidence establishes that claimant sustained a neck injury while participating in the September 7, 1988 tug-of-war. On September 8, 1988, claimant experienced neck stiffness. Over the next several days, her neck condition worsened. Because of increasing pain, claimant sought emergency room treatment, at which time she was treated with medication. Subsequently, Dr. Flowers became claimant's treating chiropractor. He provided treatment for claimant's neck and right arm pain from September 1988 through July 19, 1989. In July 1989, Dr. Flowers referred claimant to treating surgeon, Dr. Rosenbaum. A subsequent MRI scan revealed a left C6-7 disc herniation. Claimant underwent surgery on August 10, 1989.

Under the circumstances, we find that the record establishes that claimant's September 7, 1988 tug-of-war incident materially contributed to claimant's neck injury and need for medical treatment. Accordingly, we find that claimant has established by a preponderance of the evidence that her neck injury is compensable.[1]

[1] The Referee found that the compensable injury was a material cause of the C6-7 disc herniation. The parties argue over that finding of fact. We do not address those arguments because we conclude that that fact is unnecessary to decide the issue in this case. The sole compensability issue at hearing was whether the tug-of-war caused a compensable injury. Because it occurred in the course and scope of claimant's employment and because it required medical treatment, it was a compensable injury. The Referee did not need to decide whether the C6-7 herniation was related.

Penalty and Related Attorney Fees

We adopt the Referee's reasoning associated with this issue.

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 $1,300, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. Further, inasmuch as penalties and attorney fees are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for successfully defending the Referee's order concerning these issues.

ORDER

The Referee's order dated April 3, 1990 is affirmed. For services on review concerning the compensability issue, claimant's attorney is awarded a reasonable assessed attorney fee of $1,300, payable by the insurer.

February 7, 1991 Cite as 43 Van Natta 250 (1991)

In the Matter of the Compensation of
GAYLA GAGE, Claimant
WCB Case No. 89-11624
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Neal's order that increased her unscheduled permanent disability award for a low back injury from 9 percent (28.8 degrees), as awarded by Determination Order, to 18 percent (57.6 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

Claimant's highest specific vocational preparation (SVP) value during the ten years preceding the date of determination was a 6, for working as a sewing machine salesperson (DOT #270.352-010).

Claimant's usual and customary work required the physical capacity to perform heavy work. She returned to modified work. Claimant is permanently restricted from lifting and carrying over 15 pounds and she is restricted from performing repetitive bending, twisting, stooping, pushing and pulling activities.

Claimant suffers from a chronic condition which limits repetitive use of her back and sustained a permanent loss of range of motion resulting from her compensable injury. Claimant's disc bulges are not causally related to her compensable back injury.

CONCLUSIONS OF LAW AND OPINION

The Referee increased claimant's unscheduled permanent disability award from 9 percent to 18 percent. We modify.

Claimant's condition was medically stationary on January 13, 1989. Her claim was closed by a May 5, 1989 Determination Order. We apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent disability.

The parties do not dispute the values assigned to the categories of age (1) and education (2), for a total age/education value of 3. The parties do dispute, however, the values assigned to adaptability and impairment. We turn to those issues.

Adaptability

The Referee analyzed claimant's adaptability based upon former OAR 436-35-310(4). We disagree.

Claimant testified that she was working as a spiritual development teacher at the time of hearing, working three days per week. This fact has not been contested by either party. Therefore, we find that claimant returned to modified work. Consequently, claimant's adaptability value should be based on an application of former OAR 436-35-310(3).

Claimant's adaptability, therefore, is based on the difference between the physical capacity necessary to perform her usual and customary work and the physical capacity required to perform her modified job. Former OAR 436-35-310(3).

Claimant's usual and customary work as a sewing machine sales person required the physical capacity to lift sewing machines weighing up to 75 pounds. Therefore, we find that claimant's usual and customary work required the physical capacity to perform heavy work. See former OAR 436-35-310(4)(a).

Claimant was released to return to work and did return to work as a teacher. At the time of hearing, claimant had been working satisfactorily for approximately four months. The vocational assessment revealed that claimant was capable of working between the light and sedentary categories of work, relying on claimant's statement of being able to lift up to 15 pounds on an occasional basis. The vocational assessment acknowledged, however, claimant's inability to perform repetitively in certain activities. Claimant testified that she was capable of lifting and carrying up to 5 pounds. Further, the medical evidence establishes that claimant suffers from exacerbations whenever she performs repetitive bending, twisting, stooping, pushing or pulling activities. Given these restrictions, and the record as a whole, we find that claimant is capable of performing sedentary work.

Therefore, the appropriate adaptability value, which is the difference between the sedentary and heavy categories, is 3. Former OAR 436-35-310(3).

Impairment

The Referee found that claimant sustained permanent loss of cervical range of motion (5.5 percent) and that she suffered from a chronic condition which limits repetitive use of her back (5 percent). Neither party contests claimant's lost range of motion or her chronic condition. The Referee found, however, that claimant's disc bulges were not causally related to her compensable back injury.

Claimant contends specifically that she is entitled to values for her two disc bulges. We disagree.

Any injury-related unoperated rupture bulge or other disc derangement is entitled to a value of 4 percent. Former OAR 436-35-350(2). Claimant must establish a causal relationship between her disc bulges and her compensable injury, i.e., she must show that disability resulting from impairment presumed by the "standards" to result from disc bulges is "due to" the compensable injury. ORS 656.214(5).

Claimant's compensable injury occurred in December 1987. It was not until almost one year later, in November 1988, that claimant was diagnosed as having two disc bulges. Further, the record establishes that claimant has a history of back problems stemming from 1985.

The only mention of a causal connection between a disc problem and claimant's compensable injury is a brief, April 1988 report authored by claimant's treating chiropractor, Dr. Anderson, in which Anderson stated that he had examined claimant and concluded that there was "disc involvement resulting from [claimant's] lifting injury . . ." (Ex. 7). This report was authored approximately eight months before the MRI revealed the existence of the two disc bulges. We do find Dr. Anderson's report to be persuasive, however, as it is conclusory and without explanation. Moe v. Ceiling Systems, 44 Or App 429 (1980).

Therefore, we find that claimant has failed to prove that her two disc bulges are causally related to her 1987 compensable injury. Consequently, no value is given for claimant's disc bulges.

After combining the values for claimant's lost range of motion (5.5) and her chronic condition (5), we find that claimant's total impairment is 10.2 percent.

Computation of Unscheduled Permanent Disability

When claimant's age value 1 is added to her 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 10.2, the result is 19.2 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 20 percent.

ORDER

The Referee's order dated February 26, 1990 is modified. In addition to the Referee's increased award, claimant is awarded 2 percent (6.4 degrees) unscheduled permanent disability, for a total of 20 percent (64 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total attorney fee awarded by the Referee and Board order shall not exceed $3,800.

In the Matter of the Compensation of
JAMES L. HINES, Claimant
WCB Case No. C1-00203
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Parker & Bush, Claimant Attorneys
Alice M. Bartelt, Defense Attorney

Reviewed by Board Members Cushing and Myers.

On January 28, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

We will 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, it exceeds the bounds of the 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 of under ORS 656.236 and the rules promulgated thereunder. See OAR 436-60-145(1); 438-09-001(1).

Here, the proposed disposition recites that claimant's compensable injury was to his low back and left thigh. The disposition then provides that the insurer will continue to accept and pay for medical services resulting from claimant's low back strain. This language could reasonably be interpreted to limit claimant's right to medical services under ORS 656.245 for the left thigh injury. In this regard, we note that although the disposition itself has one claim number, the letter accompanying the proposed agreement references two claim numbers.

In addition, the proposed disposition purports to release all workers' compensation benefits, except medical services, but later recites that claimant releases "any and all claims for compensation." (See p. 3, line 14-16). The statuory definition of compensation includes medical services, therefore, this language could also be interpreted as a limit on claimant's right to receive medical services. See ORS 656.005(8).

Finally, OAR 436-60-145(2) requires the insurer or self-insured employer provide claimant with certain information concerning claims disposition agreements. OAR 436-60-145(4)(f) requires that a proposed agreement contain a recital that such information was provided to claimant. Similarly, OAR 436-60-145(4)(g) requires that claimant be provided with a specified notice in prominent or bold face type. OAR 436-60-145(4)(g), however, requires the specified notice to be in the proposed agreement as opposed to merely reciting that claimant has received such notice.

Here, although the notice required pursuant to OAR 436-60-145(4)(g) is in the file, it is not in the actual agreement, nor is it incorporated into the agreement. A proposed disposition that does not contain the required notice will not be approved by the Board. See OAR 436-60-145(5); 438-09-020(1). Such an agreement is deemed unreasonable as a matter of law. ORS 656.236(1)(a); OAR 438-09-020(2).

For the reasons noted above, we are unable to approve the parties' proposed disposition. Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

IT IS SO ORDERED.

In the Matter of the Compensation of
DON L. SILER, Claimant
WCB Case No. 89-06735
ORDER ON REVIEW (REMANDING)
Roger J. Leo, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Schultz's order that dismissed claimant's hearing request concerning Farmers' denial of claimant's medical services claim dated June 8, 1989 and aggravation claim dated August 21, 1989, and related penalties and attorney fees on the aforementioned denials. On review, the issue is jurisdiction. We remand.

FINDINGS OF FACT

On September 13, 1985, claimant sustained a compensable neck and low back injury with Farmers' insured. This claim was accepted as an Oregon workers' compensation claim. The claim was closed by Determination Order in November 1988, with no award of temporary or permanent disability.

On April 11, 1988, claimant sustained a traumatic compensable injury with SAIF's insured. The condition was diagnosed as "acute thoracic lumbar strain." This claim was accepted under the jurisdiction of the Federal Longshore Harbor Workers' Compensation Act (LHWA). The claim was closed in March 1989, with an award of temporary and permanent disability.

In May 1989, claimant sought treatment from Dr. Nelson for a lumbosacral sprain/strain with compensatory thoracic and cervical sprain/strain. On June 8, 1989 Farmers issued a denial of medical services on the procedural basis that claimant had exceeded his authorized number of treating physicians.

By letter dated July 14, 1989, Dr. Nelson reported an aggravation. In an addendum to this letter, Dr. Nelson indicated that claimant's condition was a result of work activities at his present employment as an apartment manager. Farmers denied the aggravation claim by letter dated August 21, 1989.

Claimant requested a hearing. The issues were the November 1988 Determination Order, the medical services denial of June 8, 1989, and the aggravation denial of August 21, 1989.

At hearing on October 27, 1989, Farmers' moved to dismiss claimant's request for hearing on the June 8, 1989 and August 21, 1989 denials based on Olson v. EBI Companies, 78 Or App 261 (1986) and Miville v. SAIF, 76 Or App 603 (1985). Although oral argument was presented on the motion, the Referee requested trial memoranda from the parties. Consequently, the hearing did not go forward, and no testimony was taken.

By Opinion and Order (Partial Dismissal) dated November 21, 1989, the Referee granted the Farmers' motion to dismiss claimant's request for hearing on the June 1989 and August 1989 denials, but claimant's request for hearing on the November 1988 Determination order was preserved.

The hearing was reset to December 7, 1989. However, prior to hearing claimant's motion for postponement was granted, and the hearing did not go forward.

On December 18, 1989, claimant requested review of the Opinion and Order (Partial Dismissal).

On January 3, 1990, the hearing was reconvened on the sole issue of extent of permanent partial disability.

CONCLUSIONS OF LAW AND OPINION

The Referee dismissed claimant's request for hearing on Farmers' denial of medical services and aggravation denial. In so holding, the Referee relied on Olson v. EBI Companies, 78 Or App 261 (1986) and Miville v. SAIF, 76 Or App 603 (1985). The Referee held that, because claimant's LHWA claim independently contributed to the current condition for which compensation was sought, the SAIF Corporation as the insurer for the LHWA claim would be liable for his condition. Inasmuch as the LHWA claim was "extra-jurisdictional," the Referee concluded that he did not have jurisdiction and dismissed the claim. We disagree with this analysis, and conclude that dismissal was improper.

In a situation in which subsequent out of state employment independently contributes to a condition for which workers' compensation benefits are sought in Oregon, the original Oregon employer will remain responsible if the initial Oregon employment continues to materially contribute to that condition. However, this rule only applies if: (1) the claimant had filed a claim in the foreign jurisdiction where the second injury occurred; (2) that claim had been rejected; and (3) the earlier Oregon injury was a material contributing cause of the present disability. See Olson v. EBI Companies, 78 Or App 261 (1986); Miville v. SAIF, 76 Or App 603 (1985). We agree that the Olson and Miville cases are applicable here.

However, even though the Referee did not have jurisdiction over SAIF's insured, it does not follow that the forum likewise did not have jurisdiction over the issues before it. The compensability of claimant's medical services and aggravation claim were matters concerning a claim. ORS 656.704(3). The Referee should have proceeded to the merits.

At the October 27, 1989 hearing, no testimony was taken. Although we note the record contains the transcripts of the hearing held on January 3, 1990, we decline to rely on claimant's testimony. First, the issue at that hearing was confined to the permanent partial disability issue. The issue of compensability was not addressed at that hearing. Second, the Referee's Opinion and Order (Partial Dismissal) was issued November 21, 1989, prior to the convening of the second hearing. Thus, inasmuch as the Referee did not have the benefit of claimant's testimony at the time he rendered his opinion, we cannot rely on this material in our deliberations. Finally, we also note the Opinion and Order (Partial Dismissal) had been appealed on December 18, 1989, again, prior to the January 3, 1990 hearing.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Here, we find that the record has been inadequately developed in

order for us to proceed to the merits inasmuch as the parties did not have the benefit of presenting their case as they would have on October 27, 1989. Accordingly, we remand the case for hearing on the merits.

ORDER

The Referee's order dated November 21, 1989 is reversed. Claimant's hearing request with respect to Farmers' denial of claimant's medical services claim dated June 8, 1989 and aggravation claim dated August 21, 1989 is reinstated, and the case is remanded to Referee Schultz for hearing, consistent with the instructions in our opinion.

In the Matter of the Compensation of
MARTY A. SPENCER, Claimant
WCB Case No. 89-23618
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Brown's order that increased his scheduled permanent disability award for the loss of use or function of his left hand from 59 percent (88.5 degrees), as awarded by Determination Order, to 65 percent (97.5 degrees). On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's "Findings" as our own.

CONCLUSIONS OF LAW AND OPINION

We adopt that portion of the Referee's "Opinion" which found claimant entitled to 65 percent scheduled permanent disability under an application of the "standards." We conclude that claimant is entitled to a greater award of scheduled permanent disability, and modify the Referee's award.

The Referee found that there was no clear and convincing evidence that claimant's disability was greater than that calculated under the standards. We disagree.

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).

The record establishes that claimant is prevented from performing grasping activities, i.e., functional gross, cylinder or hook type grasping. Inadequate soft tissue surrounds claimant's distal portion of the proximal phalanx of the little finger and there are at least two neuromas on the little finger which cause mechanical trauma. (Ex. 17). Claimant also suffers from a vibratory intolerance and impairment from "dynamic function in terms of being able to hold objects such as a running chain saw, in a safe manner." (Ex. 35). Further,

claimant has "atrophy of his forearm" which relates to the "non-use of the flexor digitorum sublimus and flexor digitorum profundus musculature." (Ex. 35). Dr. Jewell explained that claimant's eight tendons were cut and have retracted back into the forearm and are literally useless, as they do not attach to any bony structure. Finally, claimant credibly testified that he sustained a loss of strength in his left arm due to his injury. None of these types of impairment are ratable under the "standards."

After our review of the record, and after considering claimant's testimony and his problems associated with grasping, mechanical trauma, vibratory intolerance, and his general loss of left arm strength due to atrophy and non-use, we are convinced that the record, as a whole, establishes by clear and convincing evidence that claimant suffers permanent disability in excess of that amount awarded by an application of the standards. Therefore, we find that claimant is entitled to a total of 75 percent scheduled permanent disability for the loss of use or function of his left hand.

ORDER

The Referee's order dated April 30, 1990 is modified. In addition to the Referee's award, claimant is awarded 10 percent (15 degrees) scheduled permanent disability, for a total of 75 percent (112.5 degrees) scheduled permanent disability for the loss of use or function of his left hand. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total attorney fee awarded by this order and the Referee's order shall not exceed $3,800.

February 7, 1991 Cite as 43 Van Natta 257 (1991)

In the Matter of the Compensation of
DENNIS P. UNDERWOOD, Claimant
WCB Case No. 90-05925
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
C. Douglas Oliver (Saif), Defense Attorney

Reviewed by Board Members Myers and Cushing.

The SAIF Corporation requests review of Referee Otto's order that set aside its denial of claimant's head injury claim. With its appellant's brief, SAIF has enclosed a report not otherwise included in the record. We treat such a submission as a motion to remand for the taking of additional evidence. On review, the issues are remand and whether claimant's injury arose out of and in the course of his employment. We reverse.

FINDINGS OF FACT

Claimant worked as a tire salesman in eastern Oregon. His employer had two stores, one in Pendleton and one in Milton-Freewater. Although he lived in Milton-Freewater, he worked at the Pendleton store, which had four salesmen including himself. His duties included repairing, selling and, on occasion, transporting tires.

In April 1989, the employer devised sales routes for its employees. Claimant was given the territory between Pendleton and Milton-Freewater and, as with all the salesmen, was granted wide discretion as to where and when to contact customers. At times, he was called away from home on service calls during nonworking hours. When that occurred, he was allowed to use his personal truck

or one of the employer's large service trucks. The employer had no written policy regarding the payment for sales route mileage; however, it would occasionally reimburse the salesmen.

On occasion, the Milton-Freewater store requested tires from the Pendleton store. Because claimant's pickup was equipped to carry tires, the employer frequently asked claimant to take the requested tires home with him and deliver them to the Milton-Freewater store. If the tires were not needed that evening, claimant was allowed to take them to his residence and deliver them the following morning.

In July 1989, the employer implemented a drug and alcohol policy that prohibited employees from reporting for duty or performing work while under the influence of any drug, alcoholic beverage or intoxicant. Employees who failed to comply with the policy were subject to discipline, including termination. On a few occasions during 1989, claimant's supervisor detected alcohol on claimant's breath when he arrived for work in the morning. He confronted claimant and asked if it was going to be a problem. Claimant, an admitted alcoholic, stated that it would not and thereafter did not arrive at work with alcohol on his breath. Claimant later received a copy of the policy and believed that he could be fired if he called upon a customer under the influence.

Jeff Snook worked for the employer at the Milton-Freewater store. When business was slow, he occasionally accompanied claimant to the Pendleton store in an attempt to work some additional hours. Such was the case on January 22, 1990. Claimant picked up Snook in Milton-Freewater that morning and drove to Pendleton. However, business was slow in Pendleton as well and a manager told Snook to leave at noon. Because claimant was Snook's ride home, the manager told claimant to take Snook home, deliver some tires to the Milton-Freewater store and call on customers on his sales route.

Claimant and Snook left Pendleton at approximately 12:15 p.m. Before leaving town, however, they stopped at a store and bought a six-pack of beer, which they drank while claimant drove. Before arriving at Milton-Freewater, they also took a detour to Weston, where they arrived at approximately 1:20 p.m. In Weston, they stopped at the Blue Mountain Tavern and each had an eight-ounce glass of beer. The tavern was too busy, however, and they soon left for the Longhorn Tavern, where they played pool and consumed between eight and ten glasses of beer.

Claimant and Snook left the Longhorn at approximately 4 p.m. Snook asked if he could drive claimant's truck, and drove them to his home in Milton-Freewater. Claimant then resumed the wheel and proceeded to his house. Shortly after he had passed his employer's Milton-Freewater store, claimant suddenly veered across four lanes of traffic and collided head-on with another truck.

Claimant was not wearing a seatbelt at the time of the collision and suffered a severe closed head injury with left temporal skull fracture. He immediately was taken to a hospital, where a neurological examination found him to be in a Scale VI Glasgow coma. Blood tests revealed an elevated alcohol level and the presence of barbiturates.

CONCLUSIONS OF LAW AND OPINION

Preliminary issues

Before we reach the central issue on review, that is, whether claimant's injury arose out of and in the course of his employment, we must address two preliminary issues. First, in his brief, claimant has moved to strike a docu

ment that was attached and submitted with SAIF's appellant brief. The document, which was not admitted in the evidentiary record, is a letter from the assistant director of medical records at St. Mary Medical Center. The letter explains how a measurement of milligrams of ethanol per deciliter translates into a measurement of percent blood alcohol.

The Board's review is limited to the record developed by the Referee. We may remand to the Referee for the taking of additional evidence if we determine that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). To merit remand, however, it must be shown that the evidence was not obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986). SAIF has made no such showing. Moreover, we consider the record completely and sufficiently developed. Consequently, remand is not warranted. Accordingly, we exclude the document contained in the insurer's brief and do not consider it on review.

Second, in its brief, SAIF contends that it was prejudiced by the Referee's acceptance of claimant's unsolicited written closing brief. The record reveals that, two days after hearing, claimant's attorney sent a letter to the Referee correcting a legal citation mentioned at the hearing. The attorney then proceeded with a five-page closing argument, incorporating a 20-page memorandum of law. The Referee evidently considered the unsolicited brief and issued his order 10 days later, before receiving SAIF's reply.

We recognize that it is within the Referee's discretion whether to receive closing arguments, as well as whether they will be considered. We note, however, that under ORS 656.283(7), a Referee is to conduct a hearing in a "manner that will achieve substantial justice." Therefore, we recommend that, if an unsolicited written argument is considered, a Referee should permit a timely response before issuing an order.

In any event, this matter is now before the Board and both parties have had an opportunity to submit written arguments for consideration. Thus, we decline to grant SAIF's request that this case be remanded to the Referee. Rather, having reviewed the arguments, we proceed with our analysis.

Compensability

The Referee concluded that claimant's head injury was compensable and set aside SAIF's denial. We disagree.

To establish compensability, claimant must prove that his injury arose out of and in the course of his employment, that is, that the relationship between his injury and his employment is sufficient to allow compensation. See ORS 656.005(8)(a); Rogers v. SAIF, 289 Or 633 (1980). Generally, under the "going and coming" rule, injuries sustained while travelling to and from work are not compensable. SAIF v. Reel, 303 Or 210 (1987). However, an injury may become compensable if such travel is essentially part of the employment. Gwin v. Liberty Northwest, 105 Or App 171 (1991).

Here, on the date of the accident, claimant had been instructed to travel to the Milton-Freewater store, deliver some tires, drop off an employee and call on customers in the area. Had claimant proceeded to Milton-Freewater and done as instructed, his injury would likely be compensable as being within the course and scope of employment. However, the question arises whether claimant's personal activities removed himself from the scope of employment.

Professor Larson offers the following:

> "An employee who has the right to have his homeward journey covered cannot, so to speak, put that right in the bank indefinitely and cash it at whatever future time suits his convenience. The sheer amount of time elapsed is bound to influence the courts in these cases. * * * Other factors in addition to time that might influence the result would include the amount of risk added by the personal activities, such as drinking, the nature of the job, and the extent to which there may be found an identifiable moment in time at which the work duties end and the clock begins to run on the deviation." (Emphasis supplied.) 1 Larsons, Workermen's Compensation Law 294.69-294.71, 19.29 (1972)

The court addressed this issue in Fowers v. SAIF, 17 Or App 189 (1974). There, the claimant was a general manager for the employer and was authorized to use his own vehicle for business purposes. While his employer did not condone drinking alcohol on the job, they assumed and expected that the nature of the work was such that, on occasion, the claimant would do business over drinks.

On the day in question, the claimant arrived at his office in Vale, Oregon and drove to Ontario, Oregon to see a customer. At about 2 p.m., he went to a restaurant where he had lunch and some alcoholic drinks. Shortly after he had left the restaurant, on a direct route from Ontario to his home in Vale, the claimant was killed in a motor vehicle accident. Claimant's blood alcohol content was .18 percent at the time of his death.

The insurer in Fowers denied a claim for compensation, arguing that, prior to his accident, the claimant had abandoned his employment, both by virtue of his deliberate intent to do so and by virtue of his intoxication at the time of the accident. The court rejected the argument, holding that, if the claimant "had been an employee with specific, well-defined duties and without the wide latitude of a general manager, we might well hold that under the circumstances in this case there had been such an abandonment as to defeat coverage, that is not the case here." Fowers v. SAIF, supra at 192.

Like the claimant in Fowers, claimant here was not an employee with specific, well defined duties. Although he was given specific instructions on the day in question, he enjoyed wide discretion in conducting business. Consequently, a mere delay in commencing his business activities would likely not have been enough to remove him from coverage.

Unlike the employer in Fowers, however, the employer here did not assume or expect that claimant would do business over drinks. To the contrary, it expressly prohibited employees from performing work while under the influence of any drug, alcoholic beverage or intoxicant. Claimant was aware of that policy and knew that he could be fired if he called upon a customer while under the influence. Consequently, when claimant spent the entire afternoon drinking, he not only departed from the course of his employment, he necessarily abandoned it.

Claimant argues that, although the employer had a drug and alcohol policy, there is no evidence that the policy was enforced. We disagree. The record reveals that, on a few occasions during 1989, a supervisor detected alcohol on claimant's breath when he arrived for work in the morning. While claimant was not formally disciplined for his actions, his supervisor did confront him and asked if it was going to be a problem. Claimant indicated that it would not and thereafter did not arrive at work with alcohol on his breath. Moreover, claimant later received a written copy of the employer's drug and alcohol policy and

acknowledged that he was aware that he could be terminated if he violated that policy. Accordingly, contrary to claimant's assertion, we find that the policy was, in fact, enforced.

As a final matter, we note that it is unnecessary to determine whether claimant was intoxicated at the time of injury, or whether the motor vehicle accident was, in fact, a result of claimant's consumption of alcohol. Rather, for purposes of this analysis, our inquiry has been focused on whether claimant's admitted consumption of alcohol violated his supervisor's enforced drug and alcohol policy.

In short, claimant's injury occurred after a nonbusiness delay of at least four and a half hours, during which time he consumed a substantial amount of alcohol. We find that those actions, coupled with the employer's enforced policy that specifically prohibited the consumption of alcohol while working, removed him from the course of employment. Consequently, we conclude that claimant's injury did not arise "out of and in the course of employment." See ORS 656.005(8)(a); O'Connell v. SAIF, 19 Or App 735 (1974).

ORDER

The Referee's order dated August 17, 1990 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's assessed attorney fee of $5,040 is reversed.

February 7, 1991 Cite as 43 Van Natta 261 (1991)

In the Matter of the Compensation of
OLLIE D. WIGGER, Claimant
WCB Case Nos. 88-12473 & 88-09689
ORDER ON RECONSIDERATION
Starr & Vinson, Claimant Attorney
Beers, et al., Defense Attorneys
Brian L. Pocock, Defense Attorney

On November 21, 1990, we abated our October 23, 1990 Order on Review in which we affirmed a Referee's order that upheld EBI Companies' denial of claimant's aggravation claim for a left knee condition and set aside St. Paul Fire and Marine's (St. Paul) denial of claimant's aggravation claim for the same condition. We took this action to consider claimant's contention that his attorney is entitled to an assessed fee for his services on review. On reconsideration, we agree.

St. Paul and EBI each denied claimant's aggravation claim on compensability and responsibility grounds. As a result, a ".307 order" did not issue prior to hearing. Nevertheless, at hearing, no party raised the issue of compensability. Since only responsibility was litigated, the Referee's order addressed only the issue of responsibility.

Under ORS 656.295(6), we may only affirm, reverse, modify or supplement the order of a Referee. Therefore, compensability was not an issue which could be reviewed at the Board level, at least not without remand for further proceedings at the hearing level. Riley E. Lott, Jr. 43 Van Natta 209 (1991).

However, claimant's wage rate is greater under his St. Paul claim ($8.67 per hour) than it is under his EBI claim ($8.50 per hour). Thus, his rate of compensation could have been reduced had St. Paul's appeal proved successful. Inasmuch as there was a risk that claimant's compensation would be reduced had

we reversed the Referee's order and found EBI responsible, we conclude that claimant is entitled to an insurer-paid attorney fee for services on review, to be paid by St. Paul Fire & Marine. See Ray Schulten's Ford v. Vijan, 105 Or App 294 (1991).

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 is $800, to be paid by St. Paul Fire & Marine. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

Accordingly, as modified herein, we adhere to and republish our October 23, 1990 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DARILYN DAUGHERTY, Claimant
WCB Case No. C1-00267
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Bischoff & Strooband, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

On February 4, 1991, the Board recieved the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $5,000 by Roseburg Forest Products, claimant fully releases her right to future workers' compensation benefits, except medical services, for her compensable injury. In addition, claimant agrees that any violation of the agreement which causes the assessment of increased claims cost to the employer will vest in the employer certain contractual rights and civil remedies for the return of the $5,000 consideration. 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 medical services, in an accepted claim." OAR 436-60-005(9). See also OAR 438-09-001. The underscored portion of the rule makes it clear that only rights and/or obligations under ORS Chapter 656 may be released by a claim disposition agreement. See Karen A. Vearrier, 42 Van Natta 2071 (1990).

Here, the proposed disposition releases rights and obligations under ORS Chapter 656, but also purports to vest certain contractual rights and civil remedies for the return of the $5,000 consideration in the event of any violation of the agreement which results in increased claims costs. The latter portion, 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 return of consideration in the event of any violation of the agreement. We are also unaware of any

circumstance in which claimant's "violation" of an agreement, wherein she is releasing rights to future workers' compensation benefits, could result in increased claims costs to the employer. For these reasons, the proposed disposition is not a "claims disposition agreement" as defined by OAR 438-09-001(1). Vearrier, supra.

Inasmuch as the offensive portion of the parties' agreement cannot be excised without substantially altering the bargain underlying the exchange of consideration, we are without authority to approve any portion of the proposed disposition. Vearrier, supra. Consequently, the disposition is set aside.

We also note that the parties have failed to provide an order clause as required by OAR 438-09-020(1)(c).

Following our standard procedure, we would be willing to consider a revised agreement which does not contain provisions exceeding our authority under ORS 656.236 and OAR 438-09-001 et seq.

As the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

IT IS SO ORDERED.

February 8, 1991 Cite as 43 Van Natta 263 (1991)

In the Matter of the Compensation of
CHARLES J. FIELDS, Claimant
WCB Case No. 89-10353
ORDER ON REVIEW
Philip G. Cobb, Claimant Attorney
C. Douglas Oliver (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Podnar's order that upheld the SAIF Corporation's denial of claimant's injury claim because claimant was not a "subject worker" and was not injured in the course and scope of employment. On review, the issue is compensability (subjectivity). We affirm.

FINDINGS OF FACT

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

In a January 1989 letter, claimant described himself as a "commissioned sales person," and a "self-employed person" who was not an employee of Ebelmesser Construction. (Exs. 8, 15).

The alleged employer (Mr.Ebelmesser) had no right to control claimant's daily activities.

Claimant did not receive a payroll check for his services.

Ebelmesser did not have the right to fire claimant "at will."

ULTIMATE FINDINGS OF FACT

Claimant was an independent sales person/contractor who worked on commission and did not furnish services for a remuneration, subject to the direction and control of an employer.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Conclusions" with the following supplementation.

The Referee first determined that claimant was not a "subject worker" because he had not proven he was a partner who was engaged in work directly connected "with the construction, alteration, repair, improvement, moving or demolition of an improvement on real property . . . ." ORS 656.027(8). While we agree that claimant did not prove he was a "subject worker," we observe that the threshold question is whether claimant was a "worker" at all under ORS 656.005(27). Only if claimant is a "worker" within the meaning of the statute do we proceed to a discussion of the nonsubject worker exceptions contained in ORS 656.027.[1]

Here, claimant never alleged in the first instance that he was a "worker." Rather, he contended from the outset that he was a "partner" at the time of injury, and, because he was physically engaged in the improvement of real property at the time, he was not excluded as a nonsubject worker by ORS 656.027(8). He therefore argues that he was a "subject worker." We disagree with that reasoning. Claimant must first establish that he is a "worker" within the meaning of the statute. Only then are the specific exclusions of ORS 656.027 relevant. Accordingly, we proceed with a determination of whether claimant was a worker under Workers' Compensation Law.

Claimant's Status as Worker

Pursuant to ORS 656.005(13), an "employer" is any person who contracts to pay a remuneration for and secures the right to direct and control the services of any person. A "worker" is any person who engages to furnish services for a remuneration, subject to the direction and control of an employer. ORS 656.027(28) [formerly ORS 656.027(27)]. Thus, the right of an employer to direct and control the activities of a person is an essential ingredient of the test for an employer/employee relationship and for whether the person was a "worker." The test requires an application of the traditional "right to control" analysis. See Woody v. Waibel, 276 Or 189, 196 (1976); Castle Homes, Inc. v. Whaite, 95 Or App 269, 271 (1989).

Under the traditional test of the right to control, the factors to be considered include: (1) evidence of the right to, or the exercise of, control; (2) the method of payment; (3) the furnishing of equipment by the employee; and (4) the right to fire at will, without liability. Castle Homes, Inc. v. Whaite, supra.

Right to Control

Prior to claimant's business affiliation with the alleged "employer," Mr. Ebelmesser, claimant was in the business of selling homes. In 1985 claimant and Mr. Ebelmesser, agreed to do business. Pursuant to their agreement, claimant was to obtain building contracts in advance of construction. Mr. Ebelmesser was to pay claimant a commission equal to one-half the profits from each contract,

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[1]ORS 656.027 provides: "All workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections: . . ." (emphasis added).

payable upon completion of the construction by Ebelmesser's construction company. There was no written agreement. (Tr. 42).

In a January 23, 1989 letter to SAIF, claimant admitted that he was not an "employee" of the Ebelmesser Construction company: "Dr. Schader thought I was an employee of Ebelmesser Construction rather than a commissioned sales person. I am taking care of this injury through my personal resources as is normal for a self employed person." (Exs. 8, 15).

Claimant also referred to himself as a "partner" who had an equal voice in the construction company's business decisions. This oral "partnership" was allegedly terminated by Mr. Ebelmesser in either December 1988 or January 1989. By claimant's own admissions, Mr. Ebelmesser had no right to control claimant's daily activities, where he went during the day, or what jobs he solicited. (Tr. 68). Mr. Ebelmesser was never seen giving claimant directions. (Tr. 17).

At the construction site where claimant allegedly hurt his knee, claimant actively participated in the management decision-making and was in no respect supervised by Mr. Ebelmesser. In fact, based on claimant's version of events, he (claimant) supervised the entire operation. (Tr. 52-57). Based on this record, we find no evidence that Mr. Ebelmesser retained the right to control the services of claimant on a day-to-day basis or at the time of the alleged injury.

Method of Payment

Both Mr. Ebelmesser and claimant were paid weekly "draws." There was no withholding for income taxes or any other purpose. Claimant testified that Mr. Ebelmesser's accountant filed his tax return for him and that as far as he knew, he paid taxes as a "partner." (Tr. 44-46). We conclude that this method of payment does not suggest an employee-employer relationship.

Furnishing the Equipment

The record is silent as to what, if any, equipment was furnished by claimant or Mr. Ebelmesser.

Right to Fire at Will

Claimant's last land sale contract was in October 1988. The "arrangement" between Mr. Ebelmesser and claimant ended on either December 1, 1988, or January 14, 1989, when Mr. Ebelmesser told claimant that sales were too low to keep his construction company operational. Consequently, Mr. Ebelmesser was winding-down his business. This account of how claimant and Mr. Ebelmesser severed their business relationship is not descriptive of an employment dismissal.

In sum, the relevant factors regarding the traditional "right-to-control" test support the conclusion that claimant was an independent sales person/contractor who was not subject to control by an employer. There is no evidence of actual control to support a finding of an employer-employee relationship. Furthermore, we agree with the Referee that the evidence as a whole does not persuasively describe a "partnership" because claimant was not subject to the usual risks or investments of a partnership.

ORDER

The Referee' order dated February 21, 1990 is affirmed.

In the Matter of the Compensation of
TIMOTHY D. HERRMANN, Claimant
WCB Case Nos. 88-19723 & 88-19935
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

Argonaut Insurance requests review of Referee Lipton's order that granted the SAIF Corporation's Motion to Dismiss Argonaut's hearing request. On review, the issues are standing and res judicata.

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

Claimant suffered an injury to his left arm on September 2, 1983. Argonaut accepted the claim and processed it to closure on December 15, 1983.

Claimant subsequently commenced work for SAIF's insured. In early March 1988, he was taken off work by his doctor because of continuing left arm problems. On March 14, 1988, claimant filed a claim for aggravation with Argonaut. On March 28, 1988, Argonaut denied the claim on compensability and responsibility grounds.

Claimant requested a hearing on the denial. The case was assigned WCB number 88-05369. Hearing commenced on June 7, 1988. Argonaut stated that it intended to argue that claimant was not worse and that, if worse, Argonaut was not responsible. SAIF, the subsequent insurer, had not been joined. After taking testimony, the hearing was continued to August 4, 1988. On July 29, 1988, Argonaut moved to join SAIF.

On August 2, 1988, the Referee denied Argonaut's motion on the ground that Argonaut did not act expeditiously to join SAIF as a party. In a September 30, 1988 Opinion and Order, the Referee set aside Argonaut's denial. On review, the Board affirmed. The Board's order was not appealed.

Meanwhile, in response to notice of a claim submitted by Argonaut to SAIF pursuant to former OAR 436-60-180(5), SAIF issued a denial of the same worsened condition on September 20, 1988. On November 10, 1988, Argonaut requested a hearing protesting SAIF's denial of the claim for occupational exposure. The Referee dismissed Argonaut's hearing request because he concluded further litigation of responsibility for claimant's condition was barred by res judicata. We agree that the dismissal was proper, but for different reasons.

With the exception of certain vocational assistance matters, any party or the director may at any time request a hearing on any question concerning a claim. ORS 656.283(1). Under ORS 656.005(19), "party" is defined as "a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer." As an insurer, Argonaut would be a party to a claim stemming from an injury at Argonaut's insured. ORS 656.005(19). Here, the claim concerns an "injury" with another employer insured by SAIF. Therefore, Argonaut is not a "party" to this proceeding within the meaning of ORS 656.005(19). We conclude that Argonaut has no standing to request a hearing pursuant to ORS 656.283(1) in this matter.

As we have found that Argonaut is not a party to this proceeding, we do not reach the issue of res judicata. Accordingly, the Referee's order is affirmed.

ORDER

The Referee's order dated February 1, 1989 is affirmed.

In the Matter of the Compensation of
ALAN G. HERRON, Claimant
WCB Case No. 90-13623
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Nancy C. Marque (Saif), Defense Attorney

Reviewed by Board Members Howell, Crider and Speer.

The SAIF Corporation requests review of Referee Livesley's order that directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree. On review, the issue is rate of scheduled permanent disability. We affirm.

FINDINGS OF FACT

The Board adopts the facts stipulated to by both parties, as follows:

> "1. On June 21, 1989, Claimant suffered an injury to his right foot while working for a SAIF employer, Carlin Construction. On July 5, 1989, SAIF Corporation accepted a fracture of the right calcaneous. Claimant's claim was first closed by January 1, 1990 Determination Order awarding him 8.10 degrees for a 6 percent loss of his right foot (ankle).
>
> "2. On June 4, 1990, Referee Brazeau signed a Stipulation awarding Claimant an additional 5 percent equal to 6.75 degrees for a total award of scheduled permanent partial disability of 11 percent equal to 14.85 degrees.
>
> "3. On June 21, 1990, SAIF Corporation paid to Claimant $734.07 and to Claimant's attorney, $244.68 based on the additional permanent partial disability which was paid at $145.00 per degree for scheduled permanent partial disability."

CONCLUSIONS OF LAW AND OPINION

ORS 656.214(2) was amended by 1990 Oregon Laws, Ch. 2, 7, to increase the value per degree of scheduled permanent disability from $145 to $305. The Referee concluded that 7 and 54 provide that, regardless of the date of injury, all scheduled permanent disability awards made on or after May 7, 1990, must be paid at the rate of $305 per degree. We agree.

Former ORS 656.214(2) provided that each degree of scheduled disability would be paid at the rate of $145. Under the amendment enacted pursuant to Senate Bill 1197, that amount was increased to $305 per degree. SAIF argues that the amendment to ORS 656.214(2) does not apply in this case, as claimant was injured before May 7, 1990, and the claim was closed and a disability award made after that date.

Senate Bill 1197, now 1990 Oregon Laws, Ch. 2, 54, provides that:

> "(1) Except for amendments to ORS 656.027, 656.211, 656.214(2) and 656.790, this 1990 Act becomes operative July 1, 1990, and notwithstanding ORS 656.202, this 1990 Act applies to all claims existing or arising on and after July 1, 1990, regard-

> less of date of injury, except as specifically provided in this section.
>
> "(2) Any matter regarding a claim which is in litigation before the Hearings Division, the Board, the Court of Appeals or the Supreme Court under this chapter, 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.
>
> "(3) Amendments by this 1990 Act to ORS 656.214(5), the amendments to ORS 656.268(4), (5), (6), (7) and (8), ORS 656.283(7), 656.295, 656.319, 656.325, 656.382 and 656.726 shall apply to all claims which become medically stationary after July 1, 1990." (Emphasis supplied).

In addition, 1990 Oregon Laws, Ch. 2, 55 provides:

> "This Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this Act takes effect on its passage."

The first clause of Section 54 provides that the Act, except for specified provisions, becomes operative July 1, 1990. The amendment at issue in the present case, ORS 656.214(2), is one provision excepted from the July 1, 1990 operative date. Because neither subsection (2) nor (3) of Section 54 pertain to the operative date of ORS 656.214(2), we conclude that the amendment became operative on its effective date. The effective date of ORS 656.214(2), as amended, is controlled by the emergency clause of Section 55 of the Act. We note that the Act was passed by the Legislature and signed by the Governor on May 7, 1990. Accordingly, ORS 656.214(2) became operative on the Act's effective date, May 7, 1990.

Although we have determined that the amendment providing for a rate of $305 per degree became operative on May 7, 1990, we must also determine which claimants will be affected by the amendment. In the present case, SAIF contends that claimant is not entitled to be paid at a rate of $305 per degree, as his injury occurred on June 21, 1989. SAIF asserts that former ORS 656.214(2) was in effect at the time of claimant's injury and, therefore, any award of scheduled disability should be paid at the rate of $145. SAIF argues that the amendment to ORS 656.214(2) applies only to injuries occurring after the May 7, 1990 effective date.

ORS 656.202(2) provides that payment of benefits, including the amounts thereof, shall be determined by the law in force at the time the injury giving rise to the right to compensation occurred. The second clause of Section 54(1) provides that, "...notwithstanding ORS 656.202, this 1990 Act applies to all claims existing or arising on and after July 1, 1990, regardless of date of injury, except as specifically provided in this section." (emphasis added).

SAIF acknowledges that subsection (1) of Section 54 provides an exception to the rule of ORS 656.202(2) and makes the 1990 amendments generally applicable to all claims existing on or arising after July 1, 1990. However, SAIF argues that subsection (1) also excludes certain portions of the 1990 law from the exception. SAIF contends that the exception does not apply to ORS 656.214(2) and, therefore, the general rule of ORS 656.202(2) is applicable. We disagree.

We conclude that ORS 656.214(2) is not excluded from the second clause of Section 54(1). Rather, we interpret the first clause of the provision [excepting the amendment to ORS 656.214(2)] as pertaining only to the immediately subsequent language providing for a July 1, 1990 operative date. We do not agree that the first independent clause applies to the remainder of the provision which states that, "...notwithstanding ORS 656.202, this 1990 Act applies to all claims existing or arising on and after July 1, 1990, regardless of date of injury, except as specifically provided in this section."

In arriving at our conclusion, we note that neither subsection (2) nor subsection (3) of Section 54 provides an operative date for ORS 656.214(2). Taken as a whole, we read Section 54 to require application of ORS 656.214(2), as amended May 7, 1990, to all claims existing or arising on and after July 1, 1990, regardless of the date of injury.

The legislative history of Senate Bill 1197 provides further support for our conclusion that the date of injury does not determine which claimants are entitled to receive $305 per degree for scheduled injuries. On May 4, 1990, during a meeting of the Special Committee on Workers' Compensation, Representative Mannix, who authored section 54, addressed the issue of an operative date for claims in litigation before the bill became effective. He stated that;

> "...in terms of scheduled disability awards, it didn't matter whether the date of the injury was before or after July 1; the new schedule would lock in for anyone with a scheduled disability after July."

Representative Edmunson agreed with Representative Mannix as to the intent of the Committee. No member of the Committee disagreed with Representative Mannix. Accordingly, the legislative history of the bill lends support to our conclusion that the date of injury does not determine which law shall be applied in arriving at the amount to be paid per degree of scheduled disability.

ORS 656.214(2), as amended in 1990, applies to all claims "existing . . . on and after July 1, 1990." Because a compensable claim would have continued once it came into existance, all compensable claims in existence on May 7, 1990 would have continued in existence on July 1, 1990. [Amendments to ORS 656.236 could not have affected the existence of claims prior to that section's July 1, 1990 operative date. See 1990 Oregon Laws, Ch. 2, 54(1).]

We conclude that, because all awards of scheduled disability made on or after the May 7, 1990 effective date of the bill are awards paid for compensable "claims existing or arising on and after July 1, 1990", such awards are payable at a rate of $305 per degree, regardless of the date of injury. In the present case, a June 4, 1990 Stipulation awarded claimant an additional 5 percent scheduled permanent disability. Claimant's compensable injury claim remained a "claim(s) existing or arising on or after July 1, 1990." Because the award was made after May 7, 1990, claimant is entitled to be paid at the rate of $305 per degree, as provided by ORS 656.214(2).

Finally, we are aware that the Director of the Department of Insurance and Finance has adopted an administrative rule which conflicts with our reading of 1990 Oregon Laws, Ch. 2, 54 & 55. OAR 436-35-010(5) (Temp.) provides:

> "ORS 656.214 provides the maximum values to be given for a complete loss of use or function of a body part. A percentage of that figure shall be given for less than complete loss. A value of $305 per degree shall be allowed only for injuries sustained on or after May 1, 1990." (emphasis added) See WCD Admin. Order 15-1990.

We give no effect to that rule.

That portion of 1990 Oregon Laws, Ch. 2 which is here under consideration is a provision written in precise terms and which was clearly meant to be a complete expression of legislative intent with regard to when the law became operative and to which claims the various provisions of the law apply. With respect to such legislation, an administrative agency has no authority to interpret or complete the stated legislative policy. Springfield Ed. Assn. v. School District, 290 Or 217 (1980); Employment Division v. Ring, 104 Or App 713 (1990). "An agency may not amend, alter, enlarge or limit the terms of a legislative enactment by rule. U. of O. Co-oper. v. Dept. of Rev., 273 Or 539, 550, 542 P2d 900 (1975)." Miller v. Employment Division, 290 Or 285, 289 (1980). Thus, to the extent that OAR 436-35-010(5) (Temp.) purports to interpret or limit the application of ORS 656.214(2), it is ineffective.

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 is $500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated August 27, 1990 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $500.

February 8, 1991 Cite as 43 Van Natta 270 (1991)

In the Matter of the Compensation of
JACQUELINE I. JOHNSON, Claimant
WCB Case No. 90-09879
ORDER ON REVIEW
Daniel Snyder, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Speer and Howell.

The insurer requests review of that portion of Referee McGeorge's order that granted permanent total disability, whereas a Determination Order awarded 43 percent (137.6 degrees) unscheduled permanent disability for a left shoulder injury. On review, the issues are extent of scheduled and unscheduled disability, including permanent total disability. We affirm.

FINDINGS OF FACT

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

Just prior to hearing, claimant accepted a job as a cafeteria helper with the insured. This position was specially created for claimant and she will start at two hours per day. There will be no increase in hours without her doctor's approval. (Tr. 40). Thereafter, if the hours are increased and claimant becomes tired or sore, she is entitled to cut her hours back. Claimant will be expected to clean and replenish a salad bar, clean tables, receive food orders and greet customers. She may sit down and rest if she feels like it. (Tr. 58). Although the position would normally include pushing a bus cart to clear tables, this duty has been deleted to accommodate claimant. (Ex. 19).

Claimant is permanently restricted from lifting over 10 pounds, reaching overhead and performing repetitive motions with her left arm.

The sheltered job which claimant accepted is not available in a hypothetically normal labor market.

FINDINGS OF ULTIMATE FACT

Due to claimant's preexisting physical and mental characteristics, lack of transferable skills, and injury-related disability, she is permanently incapacitated from regularly performing work at a gainful and suitable occupation.

Claimant is willing to work and has made reasonable efforts to find employment.

CONCLUSIONS OF LAW AND OPINION

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

Claimant's vocational counselor contacted over a hundred potential employers. Of these, twelve accepted applications and five granted interviews. Claimant received no job offers, other than the one which she accepted. Based on claimant's participation and cooperation in the job search, we conclude that she is willing to work and has made reasonable efforts toward that end.

The determination of permanent total disability status turns on whether claimant is employable or able to sell her services on a regular basis in a hypothetically normal labor market. Harris v. SAIF, 292 Or 683, 695 (1982); Wiley v. SAIF, 77 Or App 486 (1986).

The insurer contends that claimant is not precluded from regularly performing gainful and suitable work, because she accepted a job which had been approved by her treating physician. We disagree.

The job which claimant accepted was created specially for her, in order to accommodate her physical limitations. Therefore, we agree with the Referee's determination that this position does not exist in a "normal" labor market. See Edna R. Ford, 42 Van Natta 45 (1990). Inasmuch as claimant's only job offer resulted from something other than her ability to compete in the labor market, there is no evidence that she is, in fact, able to sell her services. See 2 Larson, Workmen's Compensation Law, 57.35 (1987).

Moreover, even if this position had not been specially created, we are unwilling to find that working two hours per day, qualifies as "regular" and "gainful" employment under ORS 656.206(1) or (4). Peggy S. Charpilloz, 42 Van Natta 125 (1990). Even if claimant successfully performs as a sheltered cafeteria helper, we are not persuaded, on this record, that she is capable of regularly performing gainful and suitable employment.

Finally, we note that the mere fact that claimant has accepted a job is not proof that she is capable of performing it. For the above reasons, as well as those stated by the Referee, we conclude that claimant is permanently and totally disabled.

Claimant's attorney is entitled to a reasonable assessed fee for his services on review in defense of claimant's award of permanent disability compensation. 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 extent issue is $1,250, to be paid by the employer. In reaching this conclusion, we have particularly considered the efforts devoted to the case, the complexity of the issue, the risk to claimant's attorney of not being compensated, and the value of the interest involved and benefit secured.

ORDER

The Referee's order dated August 3, 1990 is affirmed. For his services on review, claimant's attorney is awarded a reasonable assessed fee of $1,250.

In the Matter of the Compensation of
ERNESTO MAGANA, Claimant
WCB Case No. 88-10463
ORDER ON REVIEW
Ronald A. Fontana, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Podnar's order that upheld the self-insured employer's denial of claimant's occupational disease claim for end stage renal disease (ESRD). On review, the issue is compensability.

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

In Phil A. Livesley v. Russ, 296 Or 25 (1983), the claimant was walking from his work station to the time-clock to punch out when he unaccountably fell and broke his hip. Because the medical evidence showed that the fall was not idiopathic, i.e., caused by a condition personal to the claimant, and because it was undisputed that the fall occurred on the employer's premises, during working hours while the claimant was performing regular duties, the Court held that a finding of compensability was consistent with the work-connection approach articulated in Rogers v. SAIF, 289 Or 633 (1980):

> "Because the 'course of employment' elements are strong, because personal risks are eliminated, and because the 'arising' elements are incapable of direct determination, we hold that the administrative agency and the Court of Appeals could find that claimant has carried his burden of proof and that the unitary work-connection test is sufficiently satisfied to allow compensation for this unexplained fall." Livesley, supra, 296 Or at 32.

On review, claimant contends that the same reasoning applies here. Because he has eliminated the most probable idiopathic causes, claimant contends that his End Stage Renal Disease (ESRD) is "unexplained" and, therefore, compensable under Livesley. We disagree.

Livesley involved an injury claim where the "course of employment" test was easily met. As noted above, it was undisputed that the injury occurred at work while the claimant was engaged in a work-related activity. Because that portion of the unitary work-connection test was so fully met, the Court allowed the inference that the unexplained fall "arose out of" the claimant's employment. 289 Or at 32; See also 1A Larson, Workmen's Compensation Law 29.10 at 5-355.

However, in this occupational disease claim, the "course of employment" test is not easily met. While an injury is generally unexpected and sudden in onset, an occupational disease is of gradual onset and cannot be said to be an unanticipated result of an inherently hazardous work environment. James v. SAIF,

290 Or 343 (1981). As here, it is often difficult to determine whether the disease "occurred" while claimant was at work engaged in work-related activities, or whether it was the result of other unrelated causes. Thus, while claimant has eliminated most idiopathic causes for his ESRD, we cannot allow a Livesley-type inference that the disease "arose out of" his employment.

Claimant next contends that he has established a compensable claim under Collins v. Hygenic Corporation of Oregon, 86 Or App 484 (1987). In that case, the claimant suffered respiratory irritation after his employer changed the aerosol lubricant that he had used on the job. The treating physician could not definitely identify the cause of the condition, but reported that it was "conceivable" that 3TCE, a chemical contained in the new lubricant, was the cause of claimant's symptoms. The court found the claim compensable: "Accordingly, in the absence of any other reasonable explanation, we hold that claimant has carried his burden to establish that his exposure to 3TCE on the job was the major contributing cause of the symptoms[.]" 86 Or App at 491.

As in Collins, the medical experts here could not positively identify the cause of claimant's ESRD. The medical evidence in this case, however, does not eliminate other reasonable explanations independent from claimant's employment. To the contrary, most, if not all the medical experts agree that 50 to 70 percent of all ESRD's have no known cause. Because claimant has not eliminated all other explanations, we conclude that claimant has failed to establish a compensable occupational disease claim.

As a final matter, we note that the 1987 Legislative Assembly added ORS 656.266 to the Oregon Workers' Compensation Law. That statute provides that a claimant cannot meet his burden of proof "merely by disproving other explanations of how the injury or disease occurred." It is unclear whether that provision applies retrospectively to this case. However, given the fact that we have concluded that claimant has failed to establish a compensable claim, we need not and do not address that issue.

ORDER

The Referee's order dated February 1, 1990 is affirmed.

February 8, 1991 Cite as 43 Van Natta 273 (1991)

In the Matter of the Compensation of
KAREN S. McKILLOP, Claimant
WCB Case Nos. 89-08897, 89-00905 & 89-00906
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
James L. Edmundson, Attorney
Darrell Bewley, Defense Attorney
Employers Defense Counsel, Defense Attorneys
Robert J. Jackson (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Liberty Northwest Insurance Corporation (Liberty), on behalf of Bohemia Inc., requests review of those portions of Referee McWilliams' order which: (1) found that claimant had timely filed her occupational disease claim for bilateral upper extremity overuse syndrome; and (2) directed Liberty to pay interim compensation from April 13, 1988 through December 19, 1988. In her brief, claimant requests review of that portion of the Referee's order which declined to assess a penalty and attorney fee for Bohemia's allegedly unreasonable

failure to pay interim compensation. On review, the issues are timeliness of claim filing, interim compensation and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Timeliness of Claim Filing

Liberty argues that claimant's occupational disease claim was barred by the time limitations contained in ORS 656.807. The Referee found that the claim was not untimely. We agree with the Referee.

Pursuant to ORS 656.807(1), a claim for an occupational disease must be filed with the insurer one year from the date the worker discovered (or should have discovered) the disease or one year from the date the claimant became disabled or is informed by a physician that she is suffering from an occupational disease, whichever is later.

The insurer argues that, because claimant was informed of an occupation-related upper extremity condition in June 1987, her filing of a claim in November 1988 was untimely pursuant to ORS 656.807(1)(b). We do not agree. In this case, the key date in determining whether claimant timely filed her claim is the date she became disabled. ORS 656.807(1)(b).

Here, claimant first became disabled from her job at Bohemia Lumber in February 1988 when Dr. Tandonnet authorized time loss in connection with claimant's bilateral tennis elbow syndrome. (Ex. 17). In March 1988, Dr. Harris also recommended that claimant not work, at least until after nerve conduction studies were completed.

Accordingly, because we find that claimant first became disabled in February or March 1988, and filed her occupational disease claim against Bohemia in November 1988, we conclude that claimant's claim was not untimely.

Interim Compensation

The Referee found that the greater weight of the evidence established that the employer was aware of a claim on April 13, 1988. We agree with the Referee.

The record contains a health insurance claim form which was acknowledged by the employer's representative on April 13, 1988. Charles Owens, Bohemia supervisor, testified that he signed the form marked Exhibit 18 on that date, and he also stated that claimant's portion and the physician's portion were filled out before he received the form. (Tr. 76-77).

Liberty argues that the form was not sufficient to place the employer on notice of a work-related claim because claimant's portion of the form indicates that her injury was not caused by her work and that she did not intend to file a workers' compensation claim. We disagree, and note that the lower portion of the form, signed by claimant's physician, states that the injury was caused and aggravated by claimant's employment. Her constant elbow flexion and extension was reported to be the cause of her condition and it was recommended that she not then return to work (she had been disabled for over a month at that time).

Former ORS 656.262(4) requires the payment of interim compensation within 14 days of the employer's notice or knowledge of a claim. ORS 656.005(6) provides: "'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."

Here, on April 13, 1988, the employer received claimant's physician's written report documenting a work-related injury or disease and claimant's inability to work as a result. That report provided the employer with notice or knowledge of a compensable injury/disease and constitutes a written request for compensation on claimant's behalf. Therefore, we conclude that the employer's receipt of exhibit 18 did provide it with notice or knowledge of a claim under former ORS 656.262(4).

Because the employer's representative testified that he had signed the form after the physician had signed, that form was sufficient to establish that the employer had notice of an injury claim on April 13, 1988. Accordingly, we agree with the Referee that the employer was obligated to commence payment of interim compensation within 14 days of April 13, 1988 and to continue payment until the claim was denied, in this case on December 19, 1988.

Penalty and Attorney Fee for Unreasonable Resistance to the Payment of Interim Compensation.

The Board adopts the Referee's "Conclusions of Law and Opinion" with regard to this issue.

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 issues of timeliness of claim filing and interim compensation is $800, 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 respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated January 4, 1990 is affirmed. For services on review, claimant is awarded an assessed attorney fee of $800, payable by Liberty Northwest Insurance Company.

February 8, 1991 Cite as 43 Van Natta 275 (1991)

In the Matter of the Compensation of
JULIA PATÉ-HARPER, Claimant
WCB Case No. 89-18249
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Pamela Schultz, Defense Attorney

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Quillinan's order which: (1) upheld the insurer's denial of claimant's low back injury claim; and (2) declined to assess penalties and related attorney fees for an allegedly unreasonable denial. On review, the issues are compensability and penalties and related attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant was employed by the insured as a cannery worker. On August 28, 1989, claimant operated a "filler" machine on the beet line. Claimant's duties

including pulling every tenth can off the line and weighing it. She would then place the can back on the conveyor belt. These duties required twisting and turning. The floor around claimant was wet and slippery with beet particles and juice. Claimant fell striking her coccyx. After falling claimant exhibited jerky body movements, fluttering eyelids and a blank non-focused gaze. Claimant exhibited no respiratory distress. Claimant received emergency room treatment.

On the injury date, claimant was in good health. She had no physical problems. Claimant was taking antibiotics for an acne condition and Triavil, an anti-depressant medication. She had never experienced faintness or dizziness related to these medications.

On August 28, 1989, claimant filed an injury claim for back contusions resulting from the fall.

On September 8, 1989, claimant experienced low back pain, numbness in both legs and tingling in the left leg.

On September 11, 1989, the insurer denied the injury claim, contending that claimant's injury was due to an idiopathic fall.

ULTIMATE FINDING OF FACT

Claimant slipped and fell while performing her work duties for the insured. This incident caused numbness in both legs, tingling in the left leg, and low back pain for which she received medical services.

CONCLUSIONS OF LAW AND OPINION

The Referee found claimant credible based on her demeanor. We defer to that finding.

The Referee found claimant's low back injury not compensable, because the evidence was in equipose as to whether claimant's fall was caused by work conditions or an idiopathic seizure. We disagree.

Claimant has the burden of proving by a preponderance of the evidence that the injury arose out of and in the course of her employment. ORS 656.005(8); ORS 656.266. The Supreme Court has adopted the unitary work-connection approach: "If the injury has sufficient work relationship, then it arises 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 which the Court adopted the "quantum" approach in regard to "arising out of" and "in the course." There are two prongs to the "quantum" approach; the "course of employment" prong and "arising out of employment" prong.

There is no question that claimant's injury occurred "in the course" of claimant's employment. The issue is whether claimant has established that her injury "arose out of" her employment. The "arising out of" employment prong of the analysis requires that claimant show a causal link between occurrence of the injury and a risk connected with her employment. In analyzing this risk factor, we 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.

Claimant contends that the fall was caused by a slippery floor. We agree. The floor where claimant worked was slippery due to beet particles and juice.

At the time of the incident claimant was at her work station. She credibly testified that she twisted around and fell to the floor, landing on her coccyx.

On the other hand, the insurer offers speculative medical evidence that idiopathic causes caused claimant's slip and fall. Dr. Woolpert, an independent medical examiner and orthopedic surgeon, suggested that some medications could have caused claimant to faint or have a seizure. He also ventured that hyperventilation could cause claimant to faint. Woolpert also noted that pelvic inflammatory disease or a urinary tract infection could have caused claimant to faint. However, there is no persuasive medical evidence that claimant suffers from a pelvic inflammatory disease or has exhibited symptoms of a urinary infection. (Ex. 6). In sum, Dr. Woolpert's speculative opinion is insufficient to establish an idiopathic cause for claimant's slip and fall. See Gormley v. SAIF, 52 Or App 1055 (1981). Consequently, we accord Dr. Woolpert's medical opinion little weight.

Finally, the insurer contends that claimant could have suffered a seizure prior to the fall. Ms. Jones, the company nurse, indicated that when she reached the incident site it appeared claimant was suffering from a seizure. However, Jones acknowledged that such a seizure could have been the result of claimant realizing she was in severe pain from the fall. (Tr. 100). Consequently, we do not find her opinion persuasive.

Based on the circumstances surrounding claimant's fall, we conclude that claimant has proven that the fall occurred because of a risk connected with the work place. See Phil A. Livesley, supra. The insurer's speculative evidence does not overcome that proof. Therefore, claimant has met the burden of establishing that her injury arose out of the course of her employment.

Penalty and related attorney fees

The Referee found that the insurer's denial was not unreasonable, because it had reasonable and legitimate doubt as to the causation of the fall. We agree.

Penalties and attorney fees may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10); 656.382(1). The reasonableness of a carrier's action must be decided based upon the information available to the carrier at the time of its action.

At the time that the insurer issued its denial, it had eyewitness accounts of claimant's physical appearance immediately after the fall. These accounts could have raised legitimate doubt as to the causation of the fall. In light of these accounts, we do not find the insurer's denial unreasonable. Therefore, we decline to assess a penalty or attorney fee on this basis.

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 $4,000, 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 March 7, 1990, as reconsidered March 28, 1990, is reversed in part and affirmed in part. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. The remainder of the Referee's order is affirmed. For services at hearing and on review, claimant's counsel is awarded an assessed fee of $4,000, to be paid by the insurer.

In the Matter of the Compensation of
GLEN D. ROLES, Claimant
WCB Case Nos. 90-02445 & 89-14455
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Dennis S. Martin (Saif), Defense Attorney

Reviewed by Board Members Howell, Speer and Crider.

This is a consolidated review of WCB Case Nos. 89-14455 and 90-02445. In WCB Case No. 89-14455, claimant requests review of Referee Podnar's order that dismissed his hearing request and thereby declined to assess additional penalties and related attorney fees for the SAIF Corporation's failure to comply with Referee Harri's February 27, 1989 Order. In WCB Case No. 90-02445, claimant requests review of Referee Peterson's order that dismissed his hearing request and thereby declined to assess a penalty and related attorney fee for the SAIF Corporation's failure to pay time loss benefits awarded by the Board's January 10, 1990 Order on Review. In both cases, the sole issue on review is penalties and related attorney fees. We reinstate claimant's request for hearing and affirm.

FINDINGS OF FACT

On or about February 23, 1988, claimant requested a hearing contesting a February 17, 1988 Determination Order. At the hearing, claimant requested that Referee Michael Johnson set aside four prior Determination Orders, which issued February 8, 1984, February 16, 1984, April 26, 1985, and November 18, 1986. Johnson did so, and, as a consequence of having done so, ordered payment of over $10,000 in what he characterized as temporary total disability compensation. SAIF did not pay. Claimant requested a hearing, seeking enforcement of Johnson's order. After a February 1989 hearing, Referee Harri ordered SAIF to pay the monies ordered by Johnson and assessed a 25 percent penalty and related attorney fee for SAIF's failure to comply.

SAIF did not pay. Claimant requested another hearing, seeking only penalties and related attorney fees. Referee Emerson awarded an additional 25 percent penalty and a related attorney fee for SAIF's failure to comply with Harri's enforcement order.

SAIF still did not pay. Claimant requested a fourth hearing, seeking penalties and attorney fees for SAIF's continued failure to comply with Harri's order. Referee Podnar, in WCB Case No. 89-14455, noted that Emerson had already penalized SAIF for refusing to comply with Harri's order. Podnar also noted that the most recent order requiring payment of anything other than penalties and associated attorney fees was Harri's. Podnar dismissed claimant's request for a hearing, because he found no basis to award an additional or continuing penalty.

SAIF requested Board review of the orders issued by Johnson, Harri and Emerson. In a January 10, 1990 Order on Review, we reversed the portions of Johnson's order that gave rise to the enforcement actions heard by Harri and Emerson. The Order also reinstated the four Determinations Orders that Johnson had set aside. Glen D. Roles, 42 Van Natta 68 (1990) (hereafter, Roles I). In a second Order, issued the same date, we reversed those portions of the Harri and Emerson orders that awarded penalties, but otherwise affirmed the Harri enforcement order. Glen D. Roles, 42 Van Natta 73 (1990) (hereafter, Roles II). The latter order was pending review by the Court of Appeals until January 22, 1991, when we withdrew it.

SAIF did not pay the amounts previously ordered by Harri and by our order in Roles II. Claimant requested a hearing, seeking penalties and related attorney fees for SAIF's failure to comply with our order in Roles II. Referee Peterson, in WCB Case No. 90-02445, dismissed claimant's hearing request, finding no basis to award an additional or continuing penalty.

CONCLUSIONS OF LAW AND OPINION

We first note that both Referees dismissed claimant's requests for hearing. Neither party requested dismissal and we are aware of no authority for dismissing those requests for hearing. We, therefore, reinstate the requests for hearing but affirm on the merits.

In WCB Case No. 89-14455, claimant seeks penalties and related attorney fees for SAIF's failure to comply with its alleged "continuing obligation" to pay the monies ordered paid by Harri. In WCB Case No. 90-02445, claimant seeks penalties and related attorney fees for SAIF's failure to comply with our order, Roles II, which affirmed Harri's order and ordered SAIF to pay the monies Harri had previously ordered paid.

In Roles I, which has now become final, we found that the two 1984, the 1985 and the 1986 Determination Orders had become final by operation of law, before they were challenged. We now conclude that, because Johnson lacked jurisdiction and statutory authority to set aside the Determination Orders, his order was, in that regard, void. Moreover, inasmuch as a void order is unenforceable, Harri's and our (Roles II) enforcement orders were also void and unenforceable.1 Because those orders were void, SAIF was not required to comply with them and penalties and attorney fees may not be assessed.

JOHNSON'S ORDER

Whether a time limitation for the bringing of an action is jurisdictional depends on the intent of the legislature. Roque Valley Memorial Hospital v. Salem Insurance Agency, 265 Or 603, 612-615 (1973). Here, we conclude that the time limitation in ORS 656.319(4) is jurisdictional. We base our conclusion on judicial interpretations of statutory time limits in prior Workers' Compensation cases.

The Supreme Court has stated,

> "The whole scheme of Workmen's Compensation Law is purely statutory, and not according to the common law. It is elementary that in acquiring jurisdiction in pursuit of a statutory remedy, the requirements of the enactment must be complied with strictly."

Demitro v. State Industrial Acc. Com., 110 Or 110, 112 (1924) (rev'd on other grounds) (quoted with approval in Southwest Forest Industries v. Anders, 299 Or 205, 216 (1985); See Gerber v. State Ind. Acc. Com., 104 Or 313 (1940)).

1We note that ORS 656.313(1) provides that payment of "compensation" is not stayed by a request for review or court appeal (sic). ORS 656.313(4) defines "compensation" for purposes of the statute as "benefits payable pursuant to the provisions of ORS 656.204 to 656.208, 656.210 and 656.214 and does not include the payment of medical services." Those portions of Harri's order and our Roles II order here under discussion were made without authority under Workers' Compensation Law because the orders attempted to require payment of monies which were not due or authorized under law. See Wacker Siltronic v. Satcher, infra. Therefore, those monies were not "compensation" as that term is used in ORS 656.313 and SAIF was not obligated under that statute to pay those monies pending review by the Board or Court.

The Supreme Court has also noted that "[t]he word 'jurisdiction' has not appeared in the legislative scheme for judicial review of administrative agency action since 1925." Southwest Forest Industries, supra at 216-17. Nevertheless, in Anders, the Court found "nothing to indicate that the legislature meant that filing within the time limit was no longer essential to the court's jurisdiction." Id. at 218. In that Workers' Compensation case, the Court held that the Court of Appeals correctly determined that it lacked jurisdiction over the merits, due to claimant's failure to file notice of appeal within the statutory period.

The Court of Appeals has held that, pursuant to ORS 656.319, an untimely challenge to a denial is fatal to the Referee's jurisdiction. Sweeden v. City of Eugene, 95 Or App 577, 578 (1989). See also Naught v. Gamble, Inc., 87 Or App 145 (1987). Applying Sweeden, supra, we have held that a Referee lacked jurisdiction to address the merits of a challenge to a denial when the hearing request was not timely. Duane Fresh, 42 Van Natta 864, 865 (1990). And we have previously determined that propriety of a denial may not be litigated unless a hearing is timely requested on the denial. Robert E. Derby, 41 Van Natta 405, 406-7 (1989).

This case involves Determination Orders issued under former ORS 656.268(4) and set aside by Referee Johnson. At that time, former ORS 656.268(6) provided: "Any * * * party may request a hearing under ORS 656.283 on the determination made under subsection (4) of this section within one year after copies of the determination are mailed." Former ORS 656.319(4) added: "With respect to objections to a determination under ORS 656.268(3) [sic], a hearing on such objections shall not be granted unless a request for hearing is filed within one year after the copies of the determination were mailed to the parties." (Emphasis added).

In Weyerhaueser v. Roller, 85 Or App 500, 504 (1987), the court affirmed our holding that a referee lacked jurisdiction because there was no timely request for hearing from a Determination Order before him. See Charles W. Roller, 38 Van Natta 50 (1986). And, in Shaw v. SAIF, 63 Or App 239 (1983), the court discussed the time limits for challenging Determination Orders set out in ORS 656.319 in terms of "jurisdiction." We, therefore, conclude that timeliness is as critical to the vesting of jurisdiction to decide a challenge to a Determination Order, as it is to jurisdiction regarding a challenge to a denial. If the statutory time limitation is not met, jurisdiction does not vest in the Referee. See Anton V. Mortensen, 42 Van Natta 1183 (1990); David L. Mallette, 38 Van Natta 843 (1986).

In the Johnson case, the requests for hearing were made more than a year after the Determination Orders issued. Thus, the requests were not timely. See former ORS 656.319(4); Roles I. Jurisdiction never vested in Johnson, although he purportedly "exercised" it. See SAIF v. Johnson, 99 Or App 64, 71 (1989).

Finally, even if the issue were not "jurisdiction," per se, Johnson lacked statutory authority to act. It is fundamental that an administrative agency does not have substantive authority beyond that delegated by the legislature. Former ORS 656.319(4) provides that a hearing "shall not be held" if the request for hearing is not timely filed. Clearly, the legislature withheld the authority which Johnson purported to exercise. McGinnis v. Tigard School District #23J, 87 Or App 363 (1987). See also Reine R. Webb, 42 Van Natta 477 (1990).

The Court of Appeals has instructed that:

> "The benefits awarded under the workers' compensation law are purely statutory, and a claimant must

> strictly follow the prescribed procedures in order to recover under the law. * * * Time limitations prescribed by the law are limitations upon the right to obtain compensation and are not subject to exceptions contained within the general statute of limitations. * * * Neither the Board nor the courts may waive these requirements."

Nelson v. SAIF, 43 Or App, rev den 288 Or 173, cert den 446 US 980 (1980) (citations omitted). We conclude that ORS 656.319 precluded Johnson from requiring SAIF to pay the more than $10,000 of what he characterized as temporary disability compensation.

When a judicial decisionmaker acts without authority, his order is void. See Deering v. Quivey, 26 Or 556, 558 (1894) ("If the court had no power to make the order at the time it was made, the judgment rendered would be void. . . .") Accordingly, as we have concluded that Johnson acted without jurisdiction or authority, we also conclude that his order was void.

HARRI'S ORDER

Our January 1990 Orders did not address the fundamental issue surrounding Johnson's exercise of jurisdiction. We simply reversed that order and found that the four Determination Orders had become final as a matter of law. Roles I reversed the portion of Johnson's order that set the Determination Orders aside. Roles II reversed Referee Harri's penalty assessment for SAIF's nonpayment, because we determined that the amounts ordered paid were "never due." Consequently, there was no compensation "then due" upon which to base a penalty. Former ORS 656.262(10).

We affirmed, without discussion, the remainder of Harri's order. Inasmuch as Harri had also ordered the payment of the amount Johnson had ordered paid (i.e., enforced Johnson's order), we effectively ordered SAIF to pay those amounts and simultaneously found that "compensation" was "never due." At this time, we conclude that Harri's enforcement order was invalid.

Where, as here, the first Referee exceeded his statutory authority, a second Referee lacks authority to enforce the first Referee's order. See James L. Guyton, 41 Van Natta 2010 (1989); Rudolfo Chavez, 41 Van Natta 2127 (1989).

We, therefore, conclude that Harri lacked authority to enforce Johnson's invalid order and that, as a consequence, Harri's order was also invalid. SAIF was not required to comply with that invalid order.

THE ROLES II ORDER

Just as Harri's order attempting to enforce Johnson's invalid order was itself invalid, our de novo enforcement of Johnson's order (by affirming Harri's) was equally invalid. Compliance with that legally invalid order was not required.

PENALTIES AND ATTORNEY FEES IN THESE CASES

In the present cases, claimant requests penalties and attorney fees for SAIF's failure to pay monies ordered paid by Harri's order and our order in Roles II. Because we have concluded that both of those orders were invalid, SAIF was not required to comply with them and pay the award which was never due. Georgia-Pacific v. Hughes, 305 Or 286 (1988). SAIF's failure to do so was not unreasonable and penalties and attorney fees may not be assessed.

We conclude that we cannot assess penalties and attorney fees for another reason, as well. In Roles I we reversed Johnson's award (with the exception of a stipulated amount). In Roles II we reversed penalty assessments, for SAIF's failure to comply with Johnson's order, because "compensation" was "never due." Here, the same reasoning applies. Johnson's award was reversed. Harri required SAIF to pay the monies ordered paid by Johnson. However, Harri's order did not award "compensation" because: as we held in Roles I, claimant was not entitled to "compensation"; and as we held in Roles II, "compensation" was never due. Harri's order simply ordered SAIF to pay certain monies, not because "compensation" was due under Workers' Compensation Law, but only because Johnson had ordered those monies paid. It follows that if Harri's order did not require the payment of "compensation," then a penalty may not be assessed for nonpayment under ORS 656.262(10) and an attorney fee may not be awarded for resistance to the payment of "compensation" under ORS 656.382(1).

In a very similar situation in Wacker Siltronic v. Satcher, 103 Or App 513 (1990), a referee held that a claim was compensable. The employer sought Board review of that order. While that review was pending, the employer denied payment of medical services. A second referee set aside the employer's denial of those medical services. The employer did not seek review of the second Referee's order and did not comply with it. A third referee issued an order enforcing the second referee's order and requiring the employer to pay the medical services plus a penalty and attorney fee. In that case, we held that, even though the second referee's order was contrary to ORS 656.313, because it became final, the employer was required to comply. We affirmed the third referee's enforcement order. Elmira K. Satcher, 41 Van Natta 1737 (1989). The Court reversed. It held that the second referee's order could not create an obligation for the employer to pay "compensation" because ORS 656.313 provides that, "compensation" does not include medical services during the period an employer's request for review is pending. Thus, the Court held that there was no basis to assess penalties or attorney fees for the employer's failure to comply with the second referee's order, because that order did not award "compensation."

ORDER

Claimant's requests for hearing are reinstated. In WCB Case # 89-14455, the Referee's order dated September 13, 1989 is affirmed. In WCB Case # 90-02445, the Referee's order dated March 16, 1990 is affirmed.

Board Member Crider dissenting.

I do not share my colleague's view that disability benefits are not compensation because a referee should not have conducted the hearing which gave rise to the award of benefits. The disability benefits awarded by Referee Johnson were compensation. The only question is whether compensation awarded under these circumstances must be paid under former ORS 656.313.

I would reverse for the reasons stated in our original order in WCB Case No. 88-19267 and 89-06314.

In the Matter of the Compensation of
SUSANNA L. STAEHLY, Claimant
WCB Case No. 89-16655
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Ray Miller (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Lipton's order which awarded 5 percent (16 degrees) unscheduled permanent disability for a psychological condition, whereas a Determination Order had awarded no permanent disability. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

FINDING OF ULTIMATE FACT

Claimant sustained no permanent psychological impairment as a result of work-related stressors during April 1988.

CONCLUSIONS OF LAW AND OPINION

The Referee awarded claimant 5 percent unscheduled permanent impairment for a Class 1 anxiety reaction under former OAR 436-35-400(4)(a)(A). He did not include any values for claimant's age, education and adaptability factors. Claimant contends that she is entitled to a greater impairment value for symptoms of a Class 3 psychoneurosis. She further contends that she is entitled to ratings under the social/vocational categories because she has not returned to work. We affirm the Referee's award. However, we base our analysis on the following reasoning.

For purposes of determining work-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's condition became medically stationary on June 6, 1989, and her claim was closed by Determination Order on August 28, 1989. Therefore, we apply the "standards" in effect January 1, 1989 in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled 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 impairment, age, education, and adaptability. If the injury did not result in measurable impairment, no award of unscheduled permanent partial disability is given. Former OAR 436-35-280(1); former OAR 436-35-320(1).

Impairment

On de novo review, we find that claimant has no ratable permanent psychological impairment.

With the exception of the last report from claimant's treating psychologist, Dr. Lazere, all of the medical reports from him as well as from four examining psychiatrists have consistently noted that claimant has no residual impairment. Dr. Lazere treated claimant for her compensable condition in 1988. Initially, he diagnosed an anxiety reaction to stressors occurring at work. Claimant's symptoms included anxiety, mild depression, and lack of self-confidence. She exhibited no thinking disorder or difficulties with the activities of daily living.

Dr. Klein, independent examining psychiatrist, examined claimant on three separate occasions in July 1988. She found that claimant had no psychiatric diagnosis and opined that claimant could return to her usual office work job.

On October 14, 1988, Dr. Colbach, examining psychiatrist, stated that claimant's condition had worsened while she was not working and that she had lost confidence in herself. He reported that claimant did not want to return to work because she anticipated that it would be stressful. He further found that claimant was not motivated to return to work.

Claimant was not treated or seen by anyone after her examination by Dr. Colbach until she was evaluated by examining psychiatrist, Dr. Turco, on June 9, 1989. She was not receiving psychological care at that time and was on no medications for her anxiety condition. Although the doctor noted claimant's continuing lack of self-confidence, claimant's mental status examination was entirely normal. Dr. Turco opined that claimant was psychiatrically stationary at that time and could return to full-time work. Dr. Lazere concurred with Dr. Turco's assessment.

In November 1989, claimant was evaluated by independent examining psychiatrist, Dr. Parvaresh. Claimant still was not receiving ongoing psychological care and was on no medications for her anxiety condition. Dr. Parvaresh similarly noted claimant's lack of self-confidence. However, claimant's mental status examination continued to be entirely normal. Claimant reported that she lived by herself in her own apartment, socialized with friends and family members, and was attending school and receiving excellent grades. Dr. Parvaresh opined that claimant did not need current psychiatric treatment and could perform any work she chose. He further opined that claimant had no impairment as a consequence of her compensable April 1988 event.

Then, in December 1989, Dr. Lazere reported that claimant had minimal permanent residuals of her work-induced anxiety reaction. He offered no basis for his opinion. Although Dr. Lazere has followed claimant for an extended period of time and has observed her emotional state before this work incident as well as her response to treatment, we do not find Dr. Lazere's unexplained reversal of opinion to be persuasive. Raul A. Herrera, 40 Van Natta 1281 (1988). Nor do we find his inconsistent conclusion that the 1988 work exposure produced permanent, albeit minimal, residuals to comport with the lack of objective psychological findings as noted by Dr. Lazere in his earlier reports or as reported by Drs. Klein, Parvaresh, Turco and Colbach.

On this record, then, claimant has not established that she has sustained permanent impairment as a result of her compensable psychological condition. Since claimant has no ratable value for impairment under former OAR 436-35-270 through 436-35-440, she has no calculable disability under the "standards." Former OAR 436-35-280(1); former OAR 436-35-320(1).

Because we have found that claimant sustained no permanent impairment as a result of her compensable injury, we need not address her argument that she is entitled to values for the age, education and adaptability categories under former OAR 436-35-290, 436-35-300 and 436-35-310.

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". Former 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 Corporation, 303 Or 390, 402 (1987).

Claimant contends that because the limiting factor in her adaptability for other employment is stress, the adaptability values of former OAR 356-35-310 are not applicable in assessing her emotional disability under the standards. Instead, claimant asserts that her emotional impairment correlates to a loss of ability to perform the approximate percentage of jobs as would a light residual physical capacity. Therefore, given her exclusion from a substantial portion of the job market, claimant urges us to award her 62 percent permanent partial disability.

However, because claimant has not established that she has any permanent psychological impairment, we find that claimant's compensable psychological condition does not preclude her from performing any job in the labor market. Consequently, claimant has failed to prove by clear and convincing evidence that she is entitled to a greater award of disability than that indicated by the "standards."

Nevertheless, as the insurer has not requested a reduction in claimant's 5 percent permanent disability award, on review, we affirm that award. See Daniel M. Alire, 41 Van Natta 752 (1989).

ORDER

The Referee's order dated February 9, 1990 is affirmed.

February 8, 1991 Cite as 43 Van Natta 285 (1991)

In the Matter of the Compensation of
CAROL A. WEAVER, Claimant
WCB Case No. 89-04118
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Crider and Myers.

Claimant requests review of Referee Mongrain's order that upheld the self-insured employer's denial of temporary disability benefits from February 8, 1989 through May 31, 1989. On review, the issue is temporary total disability. We reverse.

FINDINGS OF FACT

Claimant filed an occupational disease claim for bilateral carpal tunnel syndrome (CTS) in December 1985. That claim was accepted as nondisabling. Claimant received conservative treatment for her bilateral CTS, but missed no time from her regular work duties due to the bilateral CTS until 1989.

On January 6, 1989, claimant's treating physician, Dr. Young, recommended nerve conduction studies and surgery.

On January 11, 1989, claimant's union began a labor dispute and claimant left work incident to the strike.

On February 8, 1989, after nerve conduction studies, Dr. Young performed bilateral carpal tunnel release surgery. On March 27, 1989, Young tentatively released claimant to return to work on April 10, 1989. The employer offered claimant work beginning on April 21, 1989, but claimant did not respond due to the strike.

Claimant returned to regular work on May 31, 1989.

ULTIMATE FINDINGS OF FACT

Claimant became disabled due to a compensable condition on the date of her surgery, February 8, 1989.

Claimant, by leaving work incident to a labor dispute, had not withdrawn from the work force prior to her date of disability. Claimant did not lose her status as a "worker" due to her participation in a labor dispute.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was not a "worker" at the time her disability commenced, and concluded that she was not entitled to temporary total disability from February 8, 1989 to May 31, 1989. We disagree.

A claimant is not entitled to temporary total disability benefits for aggravation of an original compensable injury, where the claimant had voluntarily removed himself or herself from the labor market. Cutright v. Weyerhaeuser, 299 Or 290 (1985).

In Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989), the Court held that a claimant is in the work force if he/she met certain criteria. The critical date for determining whether a worker is in, or has withdrawn from, the work force is at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990).

Recently, in Ellis N. Phillips, 43 Van Natta 231 (1991), we concluded that a claimant's participation in a labor dispute was not a voluntary removal from the work force. We held that in such a situation the claimant remained a "worker," and entitled to temporary total disability.

Here, we find that claimant became disabled due to her compensable bilateral carpal tunnel syndrome on February 8, 1989, the date of her surgery. Thus, claimant became disabled from work after the strike began and on the date she underwent bilateral CTS surgery. Pursuant to the analysis followed in Phillips, supra, we also find that claimant was a "worker" when she became disabled and that she had not removed herself from the work force by participating in the labor dispute. Therefore, we conclude that claimant is entitled to temporary total disability beginning on February 8, 1989.

However, the employer contends that pursuant to former OAR 436-60-030(5), an injured worker's refusal of wage earning employment permits the employer to reduce benefits from temporary total disability compensation to temporary disability partial compensation (which may equal zero). We note that before an employer can unilaterally reduce temporary total disability to partial disability, strict compliance with former OAR 436-60-030(5) is necessary. Eastman v. Georgia-Pacific Corp., 79 Or App 610 (1986).

Former OAR 436-60-030(5) provides as follows:

> "(5) An insurer shall cease paying temporary total disability compensation and start making payment of such temporary partial disability compensation as would be due in section (1) when an injured worker refuses wage earning employment prior to claim determination under the following circumstances:
>
> (a) the attending physician has been notified by the employer or insurer of the specific duties to be performed by the injured worker and the physical requirements thereof;
>
> (b) the attending physician agrees that the offered employment appears to be within the worker's capabilities; and
>
> (c) the employer has provided the injured worker with a written offer of the employment which states the beginning time, date and place; the duration of the job if known; the wage rate payable; 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."

Here, we find that the employer failed to satisfy the requisites of former OAR 436-60-030. First, we note that Dr. Jones' March 27, 1989 report indicates that claimant was released only tentatively to return to work on April 10, 1989. Subsequently, the employer offered claimant work beginning on April 21, 1989. However, there is nothing in the record to indicate that claimant's attending physician actually released her to regular work on either date. Further, there is nothing in the record to establish that claimant's attending physician had found the offered job to be within claimant's capabilities.

We find that the employer failed to satisfy the requisites of former OAR 436-60-030. Consequently, claimant did not refuse to begin wage earning employment. Therefore, it would be inappropriate to reduce claimant's temporary total disability to zero. Given these findings, we conclude that claimant is entitled to temporary total disability from February 8, 1989 to May 31, 1989, the day she returned to her regular work.

ORDER

The Referee's order dated November 28, 1989 is reversed. The employer's January 26, 1989 denial is hereby set aside. Claimant is awarded temporary total disability from February 8, 1989 through May 31, 1989. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

In the Matter of the Compensation of
WILLIAM J. WILSON, Claimant
WCB Case No. 89-09198
ORDER ON REVIEW
Jim L. Scavera, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Myers and Crider.

Claimant requests review of Referee Baker's order that: (1) declined to award temporary disability benefits from March 23, 1989 to June 1, 1989; and (2) declined to assess penalties and related attorney fees for allegedly unreasonable claims processing. On review, the issues are temporary disability and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" as supplemented in our "Conclusions of Law and Opinion."

CONCLUSIONS OF LAW AND OPINION

Temporary Disability

The Referee concluded that claimant was not entitled to temporary partial disability from March 23, 1989, the date claimant was offered modified work, through June 1, 1989, the date claimant returned to regular work. We disagree.

A carrier 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. Former ORS 656.268(3); Fazzolari v. United Beer Distributors, 91 Or App 592 (1988). Here, claimant had neither been released to regular work nor was he medically stationary. Thus, he was entitled to temporary total disability benefits.

The employer contends that pursuant to former OAR 436-60-030(5), an injured worker's refusal of wage earning employment permits the employer to reduce benefits from temporary total disability compensation to temporary disability partial compensation (which may equal zero). However, we note that before an employer can unilaterally reduce temporary total disability to partial disability, strict compliance with former OAR 436-60-030(5) is necessary. Eastman v. Georgia-Pacific Corp., 79 Or App 610 (1986).

Former OAR 436-60-030(5) provides as follows:

> "(5) An insurer shall cease paying temporary total disability compensation and start making payment of such temporary partial disability compensation as would be due in section (1) when an injured worker refuses wage earning employment prior to claim determination under the following circumstances:
>
> (a) the attending physician has been notified by the employer or insurer of the specific duties to be performed by the injured worker and the physical requirements thereof;

(b) the attending physician agrees that the offered employment appears to be within the worker's capabilities; and

(c) the employer has provided the injured worker with a written offer of the employment which states the beginning time, date and place; the duration of the job if known; the wage rate payable; 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."

On February 24, 1989, claimant's treating physician, Dr. Adams, approved four light duty job descriptions claimant was capable of performing. Those jobs included dryer feeder, sorter of nuts and bolts, time and motion monitor, and clean up and sweep person. The job descriptions included physical requirements and indicated that claimant was capable of performing them. On March 20, the employer wrote to claimant and indicated "per the enclosed" that light duty was available at claimant's regular wage rate, and he was to report to the Coquille Mill at 7:00 a.m. on March 23, 1989. The duration of the modified job offer was not indicated. When claimant did not report for light duty work, the employer terminated paying temporary total disability effective March 23, 1989.

Although we find that the employer complied with the strict procedural requirements of the administrative rule, we do not find that claimant's failure to report to work was a "refusal" of employment within the meaning of former OAR 436-60-030(5) and ORS 656.325(5). Claimant testified that on March 23, 1989 he drove to the Coquille Mill at 6:45 a.m., noted the picket line, and decided he would not cross it in order to report for modified work. Claimant further testified that his decision not to cross the picket line was based on a concern for the safety of his person and property, his position as a union member and union steward, and future working relationships with fellow employers who honored the picket line and did not report for work.

Recently, in Ellis N. Phillips, 43 Van Natta 231 (1991), we concluded that claimant's participation in a labor dispute was not a voluntary removal from the work force. We held that in such a situation claimant remained a "worker," and entitled to temporary total disability. We find it would be inconsistent for us to hold on the one hand that claimant remains a worker during a labor dispute entitled to continuing temporary disability, but on the other hand hold that claimant's action in declining to cross a picket line to be a refusal of modified work, and thus, to deny claimant those same benefits.

Additionally, we note that the legislature has indicated an intention that where there is a labor dispute in progress at the place of employment, the injured worker may refuse to return to that employment without loss of reemployment rights or vocational services. See ORS 656.268(9). Although that section does not control here, by interpreting former OAR 436-60-030(5) and ORS 656.325(5) as we do, we are consistent with the policy articulated in ORS 656.268(9).

Accordingly, we conclude that claimant did not refuse employment under the terms of former OAR 436-60-030(5). Therefore, it was improper to terminate claimant's temporary total disability. Claimant is entitled to temporary total disability benefits from March 23, 1989, until his return to regular work on June 1, 1989.

Penalties and attorney fees

A penalty is assessed if the employer unreasonably refuses to pay compensation or unreasonably delays acceptance or denial of a claim. Former ORS 656.262(10); 656.382(1).

Here, we have found the employer's termination of temporary total disability benefits to have been improper. However, inasmuch as the law was unclear at the time the employer terminated claimant's temporary total disability benefits, we find the employer had a legitimate doubt as to its legal obligation to pay temporary total disability to a worker who participates in a labor dispute and declines to cross a picket line when modified work is approved by the claimant's treating physician, and offered by the employer. Under the circumstances, we do not find the employer's failure to pay temporary total disability benefits from March 23, 1989 to June 1, 1989 to have been an unreasonable refusal to pay compensation. Norgard v. Rawlinson, 30 Or App 999 (1977). Accordingly, claimant is not entitled to penalties and related attorney fees.

ORDER

The Referee's order dated September 20, 1989 is reversed in part and affirmed in part. Claimant is awarded temporary total disability compensation from March 23, 1989 to June 1, 1989. Claimant's attorney is awarded an approved fee of 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. The remainder of the order is affirmed.

Board Member Crider concurring:

I join in the order. I specifically join those portions of the lead opinion that hold that an employer may not reduce a worker's temporary total disability benefits pursuant to ORS 656.325(5) and former OAR 436-60-030(5) simply because the worker refuses to cross a picket line to perform modified work and that the claimant was entitled to continued compensation in this case. I further agree that the employer's conduct in this case was not unreasonable.

Nevertheless, I do not believe it was necessary to decide whether refusal to cross a picket line to accept modified work justifies a reduction in temporary disability benefits because I do not agree that procedural requirements of the rule were met in this case. The record establishes that the Coquille mill was not operating at all when the offer of work was made. Those members of the bargaining unit who in fact crossed the picket line to work were not put to work at the mill. Rather, they were offered work at a Weed, California mill. I am satisfied, therefore, that the offer of modified work at Coquille was not bona fide. For that reason, as well as the reasons stated in the lead opinion, the Referee's order must be reversed. See Jaclene I. Johnson, 42 Van Natta 1802 (1990) (dissenting opinion).

In the Matter of the Compensation of
EDWIN A. STEINBORN, Claimant
WCB Case No. 87-03249
ORDER ON RECONSIDERATION
Emmons, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

On December 20, 1990, we issued an Order of Abatement in this matter stating that we had decided to reconsider our Order on Review, issued December 12, 1990. In our initial order, we set aside the self-insured employer's denial of claimant's claim for coronary artery disease, peptic ulcer disease, gastritis, diabetes and obesity. We based our ruling on the finding that these conditions were caused in material part by drug treatment for claimant's accepted, longstanding asthma condition. On reconsideration, the employer contends that the Board erred in concluding that it accepted claimant's longstanding asthma condition. Claimant has responded to the motion and the employer has replied.

We conclude that the employer's argument was adequately considered in our initial Order On Review. Accordingly, the Board adheres to and republishes its December 12, 1990 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

February 12, 1991 Cite as 43 Van Natta 291 (1991)

In the Matter of the Compensation of
MARIA CAMPOS, Claimant
WCB Case No. 87-08331
SECOND ORDER ON REMAND (REMANDING)
Ginsburg, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

The insurer requests reconsideration of our January 31, 1991 order which remanded this case to the Referee for further proceedings. Specifically, the insurer objects to our instructions that "seemingly commands" the Referee to consider claimant's affidavit as admissible evidence.

To begin, we note that, in objecting to the Referee's consideration of claimant's affidavit, the insurer relies upon an administrative rule (OAR 438-07-022) which was not in existence at the time of the 1987 scheduled hearing. Thus, although testimony by means of personal appearance at hearing was and remains the recommended procedure, no Board rule requiring testimony in such a manner had been adopted at the time this case arose.

Moreover, in dismissing claimant's hearing request, the Referee expressly stated that his order could be reconsidered if claimant's counsel filed a document establishing good cause for claimant's failure to appear at the scheduled hearing. Since claimant's affidavit is in direct response to the Referee's statements, we conclude that it should be considered for the purpose of determining whether good cause for claimant's failure to appear has been established. Of course, the evidenciary weight to accord such a document is a matter for the Referee's determination, after consideration of the other evidence presented by the parties.

Our instructions on remand do not deny the insurer the opportunity to cross-examine claimant. To the contrary, we expressly provided that "the Referee shall consider evidence from the insurer in rebuttal and/or evidence concerning any prejudice to the insurer caused by claimant's failure to appear." Such a pronouncement was never intended, nor should it be interpreted, to prohibit the insurer from cross-examining claimant regarding the statements offered in her affidavit. Rather, our instructions were and are designed to give the Referee sufficient latitude to conduct the remand proceedings in any manner that would afford substantial justice to the parties and insure a complete and accurate record of all examination and/or testimony. After further consideration, we remain confident that our instructions achieve that goal.

Accordingly, our January 31, 1991 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our January 31, 1991 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

February 12, 1991 Cite as 43 Van Natta 292 (1991)

In the Matter of the Compensation of
JOHN T. SEIBER, Claimant
WCB Case No. 89-14515
ORDER OF ABATEMENT
Michael B. Dye, Claimant Attorney
Roberts, et al., Defense Attorneys

The Board has received claimant's motion for abatement and reconsideration of our Order on Review dated January 24, 1991.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and withdrawn. The self-insured employer is requested to file a response to the motion within 10 days from the date of this order. Thereafter, the Board shall take this matter under advisement.

IT IS SO ORDERED.

February 13, 1991 Cite as 43 Van Natta 292 (1991)

In the Matter of the Compensation of
LAMARR H. BARBER, Claimant
WCB Case No. 89-22820
ORDER ON REVIEW (REMANDING)
Philip Schuster, II, Claimant Attorney
C. Douglas Oliver (Saif), Defense Attorney

Reviewed by Board Members Crider, Howell and Speer.

Claimant requests review of Referee Podnar's order that upheld the SAIF Corporation's denial of reimbursement for home care. Claimant argues in part that SAIF is estopped from denying reimbursement. On review, claimant requests remand for the taking of evidence concerning the estoppel issue. The issues are estoppel, remand, compensability, and penalties and related attorney fees for an allegedly unreasonable denial. We remand.

FINDINGS OF FACT

We are unable to determine the facts relevant to the issues raised on review, except for the following:

Dr. Grewe did not prescribe home care for claimant.

SAIF paid $53.90 for one hour per day of home care for two weeks.

Claimant offered to prove that he reasonably and detrimentally relied on SAIF's assurances that it would pay for two weeks of full time home care.

The Referee refused to allow testimony following claimant's offer of proof.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that the Referee dismissed claimant's hearing request, although no party requested dismissal. Inasmuch as we are aware of no authority for dismissal absent such a request, we conclude that the Referee should not have dismissed claimant's request in this case. Therefore, we reinstate claimant's hearing request and proceed with our review.

We agree with the Referee's conclusion that claimant's home care is not reimbursable under former OAR 436-10-050(2), because it was not prescribed by claimant's attending physician, Dr. Grewe. We also agree that SAIF did not "waive" application of the aforementioned rule by paying for $53.90 worth of home care. See ORS 656.262(9); Richmond v. SAIF, 87 Or App 401 (1987). However, it remains for us to address claimant's estoppel argument.

At hearing, claimant argued that SAIF should be estopped to deny reimbursement for two weeks of full time home care because it had promised to pay, and claimant relied upon that promise to engage a professional to care for him for two weeks. (Tr. 22). The Referee did not address this argument. Claimant raises estoppel again on review.

"To constitute an equitable estoppel, or estoppel by conduct, (1) there must be a false representation; (2) it must be made with knowledge of the facts; (3) the other party must have been ignorant of the truth; (4) it must have been made with the intention that it should be acted upon by the other party; and (5) the other party must have been induced to act upon it." Bennett v. City of Salem, 192 Or 531, 541 (1951).

We are not aware that the Oregon courts have considered the issue of estoppel asserted by a claimant against an insurer, in the Workers' Compensation context.[1] However, the Court of Appeals has determined that the doctrine is

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[1]In Stovall v. Sally Salmon Seafood, 306 Or 25 (1988), the Court concluded that false representations by a worker to obtain employment would not bar a subsequent claim for benefits resulting from an otherwise compensable injury incurred during such employment. In reaching its conclusion, the Court relied upon public policy expressions including the prohibition against releases set forth in former ORS 656.236, as well as the judicial doctrine that the statutory workers' compensation scheme be construed liberally in favor of the worker. Here, such policy considerations are not invoked. Accordingly, we do not find that Stovall is determinative.

applicable even against the government. Employment Div. v. Western Graphics Corp., 76 Or App 608, 612-13 (1985) (citation omitted, emphasis added).

Professor Davis writes that estoppel should apply "where justice and right require it." Davis, 2 Administrative Law Treatise 542, quoting Sawyer v. City of San Diego, 138 Cal App 2d 652, 662 (1956).[2] We see no reason why application of the doctrine to preclude the insurer from refusing to reimburse claimant for medical costs incurred in this case would be inconsistent with the purpose of the workers' compensation law.

Here, claimant offered to prove that he relied on assurances, made by SAIF's representative, that two weeks' worth of full time home care would be reimbursed by SAIF. Claimant contends that he relied on those representations in hiring two caregivers and that SAIF should be estopped to deny its assurances and required to pay for the care, the cost of which it reasonably caused claimant to incur.

Based on claimant's offer of proof, we conclude that estoppel may apply in this case. However, because the Referee refused to allow testimony which may have been relevant, we are unable, on this record, to determine whether the circumstances necessary for application exist. Compare Bruce D. Craig, 37 Van Natta 1143 (1985). We are unable to determine whether SAIF's denial was reasonable, for the same reason.

Accordingly, we conclude that the record is insufficiently developed, and the case must be remanded for the taking of additional evidence on the estoppel issue. See Bernard L. Osborn, 37 Van Natta 1054 (1985), aff'd mem 80 Or App 152 (1986).

ORDER

The Referee's order dated February 1, 1990 is vacated. Claimant's request for hearing is reinstated and the case is remanded to Referee Podnar for further proceedings consistent with this order.

[2]We note Davis' description of estoppel as a "principle of fairness that has been developed to guide the determination of issues between private parties." Davis, supra at 491.

February 13, 1991 Cite as 43 Van Natta 294 (1991)

In the Matter of the Compensation of
JAMES G. CANNON, Claimant
WCB Case No. C1-00200
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
S. David Eves, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

On January 28, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

A proposed disposition must be set aside 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 a fact-finder could only conclude that the agreement is unreasonable as a matter of fact. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990).

Here, the proposed disposition provides that if claimant dies prior to October 5, 1993, the consideration will be paid to his spouse or other beneficiary. However, the attached addendum provides that if claimant dies prior to September 5, 2023, the consideration will be paid to his estate. These two provisions are inconsistent. Inasmuch as we are unable to discern the parties intent with regard to the payment of consideration in the event of claimant's death, we are persuaded that a reasonable fact-finder could only conclude that the proposed disposition is unreasonable as a matter of fact. Accordingly, we find that the agreement is unreasonable as a matter of law and set it aside. Anaya, supra.

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

We note that, as a result of our order, any new disposition submitted by the parties will be subject to the current rules which became effective December 26, 1990. See OAR 436-60-003(4). Such dispositions must include the bold face notice required by current OAR 436-60-145(4)(g).

Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

February 13, 1991 Cite as 43 Van Natta 295 (1991)

In the Matter of the Compensation of
FLOYD A. CROUCH, Claimant
WCB Case No. 89-20831
ORDER ON REVIEW
James Edmunson, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Crider and Myers.

Claimant requests review of that portion of Referee Peterson's order that declined to grant an award of permanent total disability. In its respondent's brief, the insurer cross-requests review of that portion of the Referee's order that increased claimant's unscheduled permanent disability award for his low back and left shoulder injury from 24 percent (76.8 degrees), as awarded by a Determination Order, to 57 percent (182.4 degrees). On review, the issues are permanent total disability and extent of unscheduled permanent disability. We reverse and grant permanent total disability.

FINDINGS OF FACT

Claimant, a 63 year old electrician, sustained a compensable shoulder injury when he slipped from a ladder in November 1985. He tried to break his fall by holding on to the ladder with his left arm and, in the process, dislocated his left shoulder. He was taken to a hospital where his shoulder dislocation

was reduced and his arm was put in a sling. He continued to experience shoulder pain and, after a period of time, began to notice low back pain. His claim for compensation was accepted.

Claimant's low back pain gradually increased and, in March 1986, he began receiving chiropractic treatment for a lumbar sprain. In February 1987, he had an arthroscopic debridement of the shoulder joint. Later, in June 1988, he had an anterior inferior capsular shift performed on his left shoulder.

Claimant has constant left shoulder pain that increases with arm movement. He has very limited use due to pain of his left arm and is unable to lift it higher than his shoulder. He has intermittent low back pain that increases with activity. Sitting, bending, stooping, lifting and standing are limited. Repeated bending causes pain. He does some stretching and weight-lifting exercises with his left arm, but receives no medical treatment for it. He occasionally wears a low back support. He receives one chiropractic treatment every two weeks for his low back.

Claimant has no prior low back injuries. In 1978, he slipped and fell while fishing and injured his left shoulder requiring surgery to repair a joint separation. He made a full recovery, however. He suffers from a heart condition and had open heart surgery in 1987. His heart condition limits him to light or sedentary work.

Claimant has an eighth grade education and received his GED. He has worked as an electrician since 1945 and has worked as foreman on some jobs. He has few clerical skills.

Claimant became medically stationary on May 8, 1989. At the time of hearing, he was receiving $800 a month in Social Security disability and $1,000 a month from his retirement pension. After his compensable injury, claimant looked for work in the electrical business and even tried one job, but was unable to perform at a competitive pace.

ULTIMATE FINDINGS OF FACT

Claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation. His physical incapacity, in conjunction with his age, limited education, lack of clerical skills and narrow work history renders a work search futile. But for his compensable shoulder and back condition, claimant would be willing to seek regular gainful employment.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

To establish permanent total disability, claimant must prove by a preponderance of the evidence that he is unable to perform any work at a gainful and suitable occupation. Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Claimant acknowledges that he is not permanently and totally disabled by his physical incapacity alone. The question, therefore, is whether, under the "odd-lot" doctrine, the combination of his physical incapacity plus nonmedical factors, such as age, education, work experience, training and mental capacity, effectively forecloses him from gainful employment. Welch v. Bannister Pipeline, 70 Or App 699 (1984).

The Referee concluded that claimant was not permanently and totally disabled. He based his conclusion on a vocational counselor's testimony that claimant "would be employable had he the benefit of some specific training."

(Tr. 120). However, as the Court held in Gettman v. SAIF, 289 Or 609 (1980), whether a claimant is permanently and totally disabled must be decided on occupational abilities existing at the time of hearing. While claimant may become employable in the future with training, our inquiry is limited to circumstances as they now exist, without regard to how his employability may change at some point in the future. See also Clark v. Boise Cascade Corp., 72 Or App 397 (1985).

After our de novo review of the record, we are persuaded by the testimony of Mr. Ross, claimant's vocational expert, who expressed the opinion that, "given his age, education, narrow work history, his current limitations on functioning, his lack of clerical skills," claimant would not be able to sell his services in the competitive labor market. Accordingly, we conclude that claimant is permanently disabled due to a combination of medical and nonmedical disabilities that effectively foreclose him from gainful employment. The inquiry whether he is entitled to permanent total disability, however, does not end here.

Generally, in order to prove permanent total disability status, a claimant also must prove that he made a reasonable effort to seek gainful employment. ORS 656.206(3). The Referee found that claimant made no such effort. However, there are instances where that effort is not required. As the Court held in SAIF v. Stephen, 308 Or 41 (1989), a claimant who is so incapacitated that he cannot perform regular gainful employment need not establish that he has made "reasonable efforts to obtain such employment," because seeking work would be futile. Such a claimant need only establish that, but for the compensable injury, he is or would be willing to seek regular gainful employment. Id.

We find that exception applicable here. Claimant is able to only perform light or sedentary work. We conclude that, with that limitation, a 63 year old claimant with an eighth grade education, limited work history and lack of clerical skills would have little reasonable expectation of being able to sell his services to an employer. That finding is supported by both vocational experts. Thus, under the circumstances, we conclude that it would have been futile for claimant to have attempted to find employment. See Looper v. SAIF, 56 Or App 437 (1982).

Furthermore, considering the evidence in the record, we conclude that claimant has established that, but for his compensable injury, he is willing to work. Claimant testified that he looked for work in the electrical business and even tried one job, but was unable to perform at a competitive pace. He further testified that he tried to do physical tasks to see if he could perform certain jobs, such as climbing a pole, but was unsuccessful. Accordingly, we conclude that claimant has proved entitlement to permanent total disability benefits.

The effective date of a permanent total disability award is the earliest date when a claimant proves that all elements necessary to his claim existed. Adams v. Edwards Heavy Equipment, Inc., 90 Or App 365 (1988); Arva M. Perkins, 42 Van Natta 2384 (1990). In this case, claimant became medically stationary on May 8, 1989. All vocational and social factors relevant to his permanent and total disability existed at that time. Accordingly, we conclude that the award of compensation for permanent and total disability shall commence as of May 8, 1989. The insurer is authorized to offset any permanent partial disability compensation paid after May 8, 1989 as a prepayment of claimant's permanent total disability compensation. See Pacific Motor Trucking Co. v. Yeager, 64 Or App 28 (1983).

ORDER

The Referee's order dated February 28, 1990 is reversed. In lieu of the Referee's increased award of permanent disability, claimant is granted permanent total disability, effective May 8, 1989. The insurer is entitled 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 compensation created by this order, payable by the insurer, except that total out-of-compensation fees awarded by the Referee and the Board shall not exceed $6,000.

February 13, 1991 Cite as 43 Van Natta 298 (1991)

In the Matter of the Compensation of
KATHERINE V. HASENYAGER, Claimant
WCB Case No. C1-00045
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Francesconi & Associates, Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Howell and Speer.

On January 10, 1991, 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 a stated sum, claimant fully releases certain rights to future workers' compensation benefits, except medical services, for her compensable injury. We set aside the proposed disposition.

We shall not approve a proposed claim disposition agreement 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 it exceeds the bounds of existing statutes or rules. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990).

Here, the proposed agreement provides that claimant shall be paid consideration in the amount of $10,725 and her attorney shall be paid a fee of $3,275. However, those amounts are inconsistent with the total amount of consideration, $12,500, which is also specified in the proposed agreement. Further, the dollar amounts of consideration and attorney fees are inconsistent with those enumerated in the summary sheet. See OAR 436-60-145(3)(i) and (j). Because we are unable to ascertain, with certainty, the specific amount of consideration to be paid claimant, we find that the agreement is unreasonable as a matter of law. Accordingly, the proposed disposition is set aside and returned to the parties.

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
HOMAR S. LOPEZ, Claimant
WCB Case No. C1-00150
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Bottini, et al., Claimant Attorneys
Gray, et al., Attorneys
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Cushing and Myers.

On January 22, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $25,000 by Peter King, claimant fully releases his right to future workers' compensation benefits, except medical services, for his compensable injury. In addition, claimant agrees to submit all future claims for medical services for his compensable condition first to his personal and/or group insurance carrier. 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 the 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).

Here, the proposed agreement purports to release claimant's further rights to workers' compensation benefits of any type, except medical services payable under her workers' compensation claim. The disposition then provides that claimant will submit any and all future claims for medical expenses for the compensable injury first to his own personal and/or group insurance carrier. This language directly limits claimant's right to medical services. See ORS 656.245(1); 656.245(3). Any limitation on that right exceeds the bounds of ORS 656.236 and OAR 436-60-145(1). Accordingly, the agreement is unreasonable as a matter of law and is set aside. See ORS 656.236(2).

We also note that the proposed disposition does not contain information concerning the extent of claimant's vocational training, if any, as required by OAR 436-60-145(4)(e). Additionally, it does not contain a bold-face notice as required by OAR 436-60-145(4)(g). Finally, the parties have also failed to provide an order clause as required by OAR 438-09-020(1)(c).

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

Following our standard procedure, we would be willing to consider a revised agreement which does not contain provisions exceeding the bounds of the statutes and rules.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARY L. POTTER, Claimant
WCB Case Nos. 89-14844 & 89-14843
ORDER ON REVIEW
Charles D. Beshears, Claimant Attorney
Roberts, et al., Defense Attorneys
Daniel J. DeNorch (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of those portions of Referee Quillinan's order that: (1) upheld the SAIF Corporation's denial, on behalf of Servicemaster, of claimant's aggravation claim for a right shoulder condition; and (2) upheld SAIF's denial, on behalf of Daily Linen, of claimant's "new injury" claim for the same condition. Claimant also seeks remand, alleging that the record is incompletely developed. The issues on review are remand, compensability and, if compensable, responsibility. We affirm.

FINDINGS OF FACT

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

SAIF denied an aggravation claim on behalf of Servicemaster on June 16, 1989. In the SAIF/Servicemaster denial, only "responsibility" was denied on the ground that claimant's new employment activities at Daily Linen "independently contributed to a worsening" of her condition. (Ex. 39). Thereafter, claimant filed a new injury claim against Daily Linen. On July 27, 1989, SAIF/Daily Linen denied compensability of and responsibility for this claim. (Ex. 42).

At the hearing, SAIF/Servicemaster verbally amended their June 16, 1989 denial by also contesting the compensability of the aggravation claim. (Tr. 3). When claimant subsequently sought clarification of the issues, SAIF/Servicemaster stated: "Our first argument is that there has been no worsening. Should the Referee find there was a worsening, it is our contention it's not our responsibility." (Ex. 4). Claimant did not request a continuance or postponement of the hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee's "Opinion" is adopted with the following supplementation.

Remand

The SAIF/Servicemaster denial on June 16, 1989 was a denial of responsibility for the claim. At the hearing, SAIF/Servicemaster verbally amended the denial by also contesting the compensability of the aggravation claim (e.g., denying a "worsening" of the 1987 compensable condition). Claimant contends that SAIF's attempt to raise compensability as a defense for the first time at hearing was an impermissible backup denial under Bauman v. SAIF, 295 Or 788 (1983). We find this argument without merit.

After the Referee's order issued, claimant requested reconsideration and reopening of the record because the Referee upheld both the Servicemaster and Daily Linen denials with reference to "compensability" of both claims. Claimant contends that if she had known at hearing that "compensability" as to Servicemaster was being denied, she would have requested a continuance to adequately prepare. The Referee denied the reconsideration. We agree.

We disagree with claimant that the compensability of the aggravation claim against SAIF/Servicemaster was improperly placed at issue during the preliminary phase of the hearing. In cases where at least one carrier has denied compensability (here, SAIF/Daily Linen), the Board has concluded the issuance of an order pursuant to ORS 656.307 precludes changing a responsibility denial to one of compensability at hearing. No ".307" was issued in this case and, therefore, the subsequent denial of compensability was not improper. See James P. Bowers, 41 Van Natta 1967, 1972 (1989); Judy Witham, 40 Van Natta 1982 (1988).

If, as claimant's counsel contends, he was "surprised" by SAIF/Servicemaster's amended denial and the admission of "final hour" medical reports, counsel could have requested a postponement or continuance pursuant to OAR 438-06-081 or OAR 438-06-091. In the absence of such a request, the Referee's denial of reconsideration was not an abuse of discretion and it is accordingly upheld. Sue Bellucci, 41 Van Natta 1890 (1989).

The Board may remand only if the record was "improperly, incompletely or otherwise insufficiently" developed or heard. Former ORS 656.295(5). Other than claimant's contention that counsel was not adequately prepared to litigate SAIF/Servicemaster's amendment which denied a "worsening" of the 1987 condition, she presents no argument that the record is improperly, incompletely or otherwise insufficiently developed. We conclude the record is properly and sufficiently developed for our de novo review on the merits. Accordingly, the motion for remand is denied.

"New Injury"/Aggravation

We have concluded that SAIF has raised compensability of the claim on behalf of both Servicemaster and Daily Linen. In a compensability/responsibility case such as this, the threshold issue is compensability. Joseph L. Woodward, 39 Van Natta 1163, 1164 (1987). If the claim is compensable, then the trier of fact must address the issue of responsibility. See Runft v. SAIF, 303 Or 493, 499 (1987).

In order to prove a compensable "new injury" during her second period of employment with SAIF/Daily Linen, claimant must establish that she experienced an accidental injury arising out of and in the course of her employment requiring medical services or resulting in disability or death. ORS 656.005(7)(a). To establish a compensable aggravation of her prior claim with SAIF/Servicemaster, claimant must show a worsening of her compensable right shoulder condition since her last arrangement of compensation. Smith v. SAIF, 302 Or 296 (1986). "Worsening" within this context means increased symptoms, or a worsened underlying condition, resulting in a diminishment of earning capacity. Id. Here, no persuasive evidence has been presented that establishes claimant's 1989 complaints and "symptoms" are materially related to her 1987 compensable shoulder injury. Furthermore, there is no showing of a material worsening of claimant's compensable condition. Nor does the evidence establish that claimant experienced a compensable "new injury."

In March 1989, claimant's treating chiropractor diagnosed an acute right shoulder strain/sprain with associated cervical strain and concluded claimant's current condition was related to the 1987 compensable injury (SAIF/Servicemaster). However, Dr. Finley's opinion is based entirely on claimant's subjective complaints; he reported no objective tests or findings on physical examination. Claimant provided conflicting medical histories concerning the onset of her shoulder pain in March 1989. Accordingly, the Referee found claimant's testimony and self-histories too inconsistent and unreliable to be credible. We concur. Therefore, Dr. Finley's opinion is not persuasive as to either the occurrence of a "new injury" or an aggravation of claimant's prior injury.

In August 1989, two physicians with Western Medical Consultants initially concluded that claimant's complaints after March 1989 (pain down the arm, headaches, ringing ears and numbness) were more than just a continuation of the symptoms associated with her July 1987 compensable injury. They accordingly opined that the second employment with Daily Linen independently contributed to a worsening of claimant's condition.

However, Dr. Fuller, also of Western Medical Consultants, concluded that a nonwork incident was the actual cause of claimant's current symptoms and that there was no new injury or a worsening of the 1987 compensable injury. Moreover, in October 1989, claimant underwent a reevaluation by Western Medical Consultants which resulted in a changed medical opinion. All physicians now agreed that claimant experienced neither a worsening of her old injury nor a new injury.

We conclude that there is no persuasive evidence that claimant experienced a "new injury" at Daily Linen or an aggravation of her 1987 compensable shoulder injury with SAIF/Servicemaster. Accordingly, the Referee properly upheld both denials.

While claimant has not proven an aggravation of her compensable right shoulder condition, SAIF/Servicemaster remains responsible for all reasonable and necessary medical services required by the 1987 compensable right shoulder injury. Former ORS 656.245(1).

ORDER

The Referee's order dated November 30, 1989 is affirmed.

In the Matter of the Compensation of
GARY M. STEPHENS, Claimant
WCB Case No. 89-24688
ORDER ON REVIEW
Ainsworth, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Mongrain's order that: (1) affirmed the self-insured employer's Notice of Closure which did not award unscheduled permanent partial disability for a cervical spine injury; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable closure. The issues on review are extent of unscheduled permanent disability, if any, and penalties and attorney fees. We reverse.

FINDINGS OF FACT

Claimant is a 38-year-old medical technologist. In July 1986, claimant sustained a compensable injury to his cervical spine when a chair he was sitting on collapsed. Claimant did not miss a significant amount of work due to his injury and he is under no medical restrictions.

Since the work incident, claimant has had injury-related severe headaches concurrent with severe neck pain. Although slight, there is also reduced range of motion of the cervical spine. Claimant has had ongoing conservative medical

treatment to ease the pain and prevent further loss of motion of the spine so that he can perform his work activities and remain physically active.

Claimant is a college graduate and has been employed as a laboratory technician for about fifteen years. His prior work experiences were in shipping and receiving.

The claim was closed by Notice of Closure on October 10, 1989. No permanent disability was awarded. The last medical evidence revealed that claimant had some permanent impairment and reduced range of cervical motion.

ULTIMATE FINDINGS OF FACT

Claimant has sustained a loss of earning capacity as a result of his compensable injury.

The self-insured employer unreasonably closed claimant's claim with no award of permanent disability.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled 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 Notice of Closure from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010(1).

Because claimant's condition became medically stationary on August 24, 1989, and his claim was closed by Notice of Closure on October 10, 1989, we apply the "standards" effective at the time of the Notice in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent disability.

Age, Education, and Adaptability

Where the claimant has returned to his or her usual and customary work, no value is assigned to the age, education and adaptability categories under former OAR 436-35-290(2)(a), 436-35-300(2)(a) and 436-35-310(2)(a). Neither party challenges the application of those rules.

Here, claimant has returned to his usual and customary work as a laboratory technician. Therefore, no values will be assigned to the categories of age, education and adaptability. Former OAR 436-35-290(2)(a), 436-35-300(2)(a) and 436-35-310(2)(a).

Impairment

Claimant has cervical spine instability secondary to a work injury which is manifested by reduced range of motion of the cervical spine, together with intermittent variably severe headaches and neck pain. Claimant responds to physical therapy and other conservative treatment programs and accordingly his symptoms wax and wane.

Two recent medical reports measure claimant's cervical range of motion. Independent medical examiner, Dr. Versteeg, reported in February 1990 that

claimant's cervical extension was minimally restricted at 40 degrees. Flexion and rotation were in the normal ranges and lateral extension and flexion were not reported. At the time of Dr. Versteeg's evaluation, claimant had just undergone two weeks (2-3 times per week) of mobilization and stretching exercises of the cervical spine for myofacial pain. (Ex. 26).

On the other hand, Dr. Kelty reported complete range of motion findings based on an August 1989 physical examination conducted while claimant was having an exacerbation of symptoms. (Ex. 16). Although minimal, claimant had reduced range of motion and Dr. Kelty reported that claimant had some permanent impairment of the cervical spine that responds well to periodic treatments. Although permanent disability is ultimately evaluated at the time of hearing, Dr. Versteeg's report is not as persuasive because it has incomplete range of motion findings. Accordingly, we rely on Dr. Kelty's report which we conclude is a more accurate reflection of the degree of permanent disability. Claimant's impairment rating, due to loss of cervical range of motion, pursuant to former OAR 436-35-360(1)-(5), is as follows:

	degrees	percent
Flexion	63/60	0
Extension	43/50	.5
Left Rotation	45/60	1.5
Right Rotation	49/60	1.5
Left lateral flexion	33/45	.5
Right lateral flexion	35/45	.5

Total: 4.5 percent permanent impairment. See former OAR 436-35-360(10).

Computation of Unscheduled Permanent Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 0, is added to his education value, 0, the sum is 0. When that value is multiplied by claimant's adaptability value, 0, the product is 0. When that value is added to claimant's impairment value, 4.5, the result is 4.5 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, 5 percent.

Clear and Convincing Evidence

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).

The Referee did not decide whether claimant had suffered injury-related measurable impairment because he concluded there was "clear and convincing evidence" that claimant sustained no loss of earning capacity. Thus, whatever minimal permanent partial disability rating claimant might have was completely eliminated by "clear and convincing evidence." Former ORS 656.283(7); ORS 656.214(5). We disagree.

The Referee was convinced that claimant sustained no loss of earning capacity because:

1. Claimant's job of looking over a microscope places a good deal of stress on his cervical spine and in spite of this:

a. Claimant has never missed time from work;

b. Claimant performs his job duties competently, in spite of any physical discomfort he may experience.

2. Claimant regularly skis, jogs, and rides a "drop handle" bicycle. (The Referee acknowledges that since the accident claimant does not do as much of these activities.)

3. Claimant is under no medical restrictions.

4. Claimant is obviously intelligent.

Loss of earning capacity for purposes of a "clear and convincing" analysis outside the "standards" is measured against the broad field of general occupations, not the claimant's current job. See former ORS 656.214(5). We conclude that claimant's reduced range of motion of the cervical spine, together with intermittent variably severe headaches and neck pain, effects claimant's earning capacity in the broad field of general occupations, regardless of whether his stoic attitude has so far permitted him to perform his current job without missing time from work.

Finally, the fact that claimant is health conscious and engages in athletic pursuits should not deprive him of a permanent disability award (no matter how minimal) to which he is otherwise entitled. Accordingly, we conclude that there is not clear and convincing evidence that claimant's permanent disability is less than the 5 percent value indicated by the "standards."

Penalties and Attorney Fees

Unlike the Referee and Board, the employer was required to determine permanent partial disability pursuant to the "standards" and without consideration of "clear and convincing evidence." See former ORS 656.268(3)(b). Dr. Kelty's report, which was available to the employer at the time of Notice of Closure, indicated that there was a small degree of permanent impairment. (Ex. 16). Under the "standards" claimant had a minimal permanent impairment and no reason was given for failing to apply the "standards" and make an award. We conclude it was unreasonable for the employer not to make a minimal permanent partial disability award. Thus, we assess a penalty of 20 percent of the permanent disability awarded by this order, to be paid by the self-insured employer. See ORS 656.262(10). After considering the factors set forth in OAR 438-15-010(4), for the unreasonable resistance to the payment of compensation an attorney fee of $300 is assessed, to be paid by the self-insured employer. ORS 656.382(1). In so doing, we have particularly considered the time devoted to the issue, the complexity of the issue, and the value of the interest involved. We further note that an attorney fee is not due under former ORS 656.382(4) because the increased award granted by this order was not made by a Referee and did not total at least 20 percent.

ORDER

The Referee's order dated March 28, 1990 is reversed. Claimant is awarded 5 percent (16 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. Claimant is also awarded a penalty of 20 percent of the permanent disability awarded by this order. In addition, claimant's attorney is awarded an assessed attorney fee of $300, to be paid by the self-insured employer.

In the Matter of the Compensation of
GARY L. STILES, Claimant
WCB Case No. 89-18178
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorney
Daryll E. Klein, Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Bethlahmy's order which: (1) declined to grant permanent total disability; and (2) increased claimant's scheduled permanent disability award for a hip and abdomen injury from 10 percent (15 degrees), as awarded by a Determination Order, to 15 percent (22.5 degrees). On review, the issue is extent of permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

The Referee concluded that claimant was capable of working at a gainful occupation, and was not persuaded that claimant had made reasonable efforts to secure employment. We agree.

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

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

Claimant argues that he is not employable because he is functionally illiterate, has marginal math skills and has a general intelligence of low average/inferior. However, claimant testified that, at the encouragement of his vocational counselor, he had enrolled in a course in order to obtain his GED. He also testified that he had enjoyed the course, but quit in order to stay home and take care of his brother's children. In the future, claimant intends to complete his GED and find a job. (Tr. 34). He has not sought work since he was first declared medically stationary by Dr. Krupa, his treating chiropractor in July 1989.

Claimant's vocational counselor, Mr. Moses, testified that claimant was eager to return to work. (Tr. 38-39). In December 1989 the counselor arranged

a job interview at Continental Brass and claimant was offered a job. The employer agreed that claimant could begin work after receiving the conditioning program that Dr. Krupa said was necessary, and obtaining a job release.

However, in January 1990, Dr. Krupa changed his opinion concerning claimant's medically stationary status. He would not release claimant for more than four hours work per day until claimant completed a conditioning program of two to four weeks. (Tr. 40). Furthermore, Dr. Krupa would not do the conditioning until claimant's insurance company paid some past bills which were subject to dispute. The insurance company then offered to prepay the work-hardening program, but the chiropractor continued to refuse to do it. (Tr. 41).

Considering the abovementioned evidence, we conclude that claimant is not permanently totally disabled, that he has not made reasonable efforts to obtain work, and that he has not shown that it would be futile for him to seek regular, gainful employment. See also Ex. V5-1.

Extent of Scheduled Permanent Disability

Claimant's injury was a contusion on his left hip in the area over the left greater trochanter. Because the leg begins with the femoral head, the greater trochanter is considered to be part of the leg. Former ORS 436-35-130(1). Accordingly, the Determination Order and Referee were correct in making an award of scheduled disability.

Although the Board generally gives greater weight to the conclusions of a treating physician, it will not so defer when there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, there are persuasive reasons not to defer to the opinion of Dr. Krupa.

Krupa opined that claimant suffered extensive impairment as a result of his compensable injury. (Ex. 50). However, none of his findings equate to ratable impairment under the standards for rating scheduled disability of the leg. Further, independent medical examinations conducted by the Western Medical Consultants in July and December 1989 established no objective orthopedic or neurological abnormalities. (Ex. 46-3, 49-3). In addition to the lack of objective findings, the independent examiners found that claimant had psychosocial factors that affected his recovery. Moreover, in examinations for injuries in the past, physicians have noted exaggerated symptoms and marked functional overlay. (Exs. 9, 18, 22). We find the well-reasoned opinion of the Consultants, making no objective findings other than leg weakness, more persuasive in determining claimant's injury-related impairment. Somers v. SAIF, 77 Or App 259 (1986).

The Determination Order awarded claimant 10 percent scheduled permanent disability for weakness in his left leg. Former OAR 436-35-230(5)(a) & (b). We agree with that award.

The Western Medical Consultants found giveway weakness on testing the muscles of the entire left lower limb. (Ex. 49-2). Additionally, thermal findings indicated that claimant has causalgia due to the injury to his left leg, a condition that affects the nervous system. Claimant's causalgia was subsequently accepted as a natural consequence flowing from the compensable injury. Williams v. Gates McDonald & Co., 300 Or 278, 281 (1985); Pattitucci v. Boise Cascade Corp., 8 Or App 503, 507-8 (1972). Accordingly, we agree that claimant is entitled to 10 percent impairment for weakness of his left leg.

In addition to the 10 percent impairment award for weakness, the Referee awarded an additional 5 percent for chronic pain. We agree that claimant is entitled to such an award but clarify the award. We find that an additional 5

percent award is appropriate for chronic conditions (i.e., permanent injury-related pain) limiting repetitive use of the left leg. Former OAR 436-35-010(7). For multiple losses in the leg the figures are combined. Former OAR 436-35-240(5). Combining 10 percent for weakness of the leg with 5 percent for chronic conditions limiting repetitive use we arrive at an impairment rating of 14.5 percent. Rounded to the next highest whole number the total is 15 percent. Former OAR 436-35-010(6). Claimant is entitled to 15 percent scheduled permanent disability for loss of use or function of his left leg.

We do not find clear and convincing evidence of greater disability.

Extent of Unscheduled Permanent Disability

The Board adopts the Referee's "Opinion" with respect to this issue.

ORDER

The Referee's order dated March 16, 1990 is affirmed.

February 13, 1991 Cite as 43 Van Natta 308 (1991)

In the Matter of the Compensation of
KAREN M. TULL, Claimant
WCB Case No. 88-17674
ORDER ON RECONSIDERATION
Lucas, et al., Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

The SAIF Corporation has requested 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. We previously abated our order to allow adequate time to consider the motion. We now proceed with our reconsideration.

On reconsideration, SAIF argues that, regardless of whether its February 24, 1988 denial was valid, the Referee and the Board lacked jurisdiction to consider that denial. SAIF's argument is premised on its denial letter having been mailed on February 24, 1988 and claimant having failed to file a request for hearing within 180 days, as required by ORS 656.319(1). If the premise to SAIF's argument were established by the record before us, we would agree. However, the record does not establish if or when, prior to hearing, notice was given claimant of SAIF's February 24, 1988 denial.

Following the February 13, 1989 hearing, the record was held open for the receipt of certain additional evidence. (Tr. 43). By letter dated February 21, 1989, SAIF submitted the documents for which the record had been held open. Those documents were identified by SAIF as Exhibits 23 and 24 and were received into the record by the Referee. At the same time, SAIF asked that the record be reopened for the receipt of additional exhibits identified as Exhibits 22a, 25, 26 and 27. Claimant objected and the Referee refused to continue to hold open, or to reopen, the record for receipt of those additional documents. She held that the exhibits could have been submitted, but were not, at or before hearing, as required by the Board's rules. We agree, and for that reason, refuse SAIF's request to remand for the purpose of reopening the record and receiving those additional documents. Because the exhibits identified by SAIF as 22a, 25, 26 and 27 are not part of the record to which our review is limited, they may not be considered. ORS 656.295(5); Bailey v. SAIF, 296 Or 41 (1983).

As noted above, the record does not indicate if or when claimant was given notice of SAIF's denial. For purposes of ORS 656.319(1), "notified" means deposited in the mails. Norton v. Compensation Department, 252 Or 75 (1968). Actual notice may substitute for notice by mailing. Anderson v. EBI Cos., 79 Or App 345 (1986).

Claimant testified that she did not recall receiving the denial letter. There is no evidence in the record of actual receipt or any other form of actual notice to claimant. Further, contrary to the Referee's finding, there is no evidence as to when the denial letter was mailed. The fact that the letter is dated February 24, 1988 raises no presumption as to if, or when, it was mailed. As the Court of Appeals said in Madewell v. Salvation Army, 49 Or App 713 (1980):

> "While there is a presumption that a writing is truly dated, and that a letter directed and mailed was received in the regular course of the mail, there is no presumption that a letter is mailed on the day it is dated or on the day it was written." (footnotes and citations omitted)

Because SAIF has failed to put on proof that claimant's request for hearing was untimely, we treat it as timely. Madewell v. SAIF, supra. Therefore, our prior finding that SAIF "issued" its denial on February 24, 1988, as well as the Referee's finding, which we adopted, that SAIF mailed the denial on that date, are deleted.

SAIF, in its motion for reconsideration, states: "(T)he Motion for Reconsideration is not based upon the merits of the case, but rather on whether the Board has jurisdiction to even consider the compensability of the carpal tunnel syndrome which SAIF denied on February 24, 1988." Because SAIF requests reconsideration of only the jurisdictional aspect of our Order on Review, we do not reconsider the remainder of that order.

Accordingly, on reconsideration, as supplemented and amended herein, we adhere to and republish our September 13, 1990 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

February 14, 1991 Cite as 43 Van Natta 309 (1991)

In the Matter of the Compensation of
JUDITH H. BYRD, Claimant
WCB Case No. 89-10497
ORDER ON REVIEW
Rick W. Roll, Claimant Attorney
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Cushing and Myers.

The SAIF Corporation requests review of that portion of Referee Podnar's order that granted claimant permanent total disability, whereas she had previously been awarded 25 percent (80 degrees) unscheduled permanent disability for her cervical condition. SAIF also challenges the Referee's ruling denying its motion for a postponement. SAIF moves to remand for the taking of additional evidence. Claimant cross-requests review of that portion of the Referee's order

that granted reimbursement for travel expenses and assessed penalties and related attorney fees associated therewith. On review, the issues are evidence, remand, permanent total disability, travel expenses, and penalties and related attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings" with the exception of paragraphs 3 and 4 on page 2 of the Opinion and Order. We make the following supplementation.

On March 28, 1990, the Board affirmed a Referee's order finding claimant's compensable injury of March 23, 1982 a material contributing cause of her psychological condition.

Claimant is permanently incapacitated, by a combination of her physical and psychological conditions, from regularly performing work at a gainful and suitable occupation. Her current physical limitations, in conjunction with her disabling psychological condition, make it futile for claimant to secure gainful employment.

At hearing, SAIF moved for postponement contending that it had evidence of a new condition, i.e., disc bulges revealed by a September 1989 MRI. SAIF alleged incomplete case preparation due to the newly discovered disc bulges. The Referee denied SAIF's motion.

The Referee did not abuse his discretion by denying SAIF's motion for postponement.

The record was not improperly, incompletely or otherwise insufficiently developed.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Ruling/Remand

The Referee denied SAIF's motion for postponement. We agree.

On December 14, 1989, SAIF received a copy of an MRI which revealed disc bulges at C2-3, C3-4, C4-5, C5-6 and C6-7. During the January 2, 1990 hearing, SAIF moved for postponement, asserting that claimant's impairment rests on the compensability of the disc bulges and that the discovery of the disc bulges was too near to the time of hearing to permit sufficient case preparation. SAIF moves for remand for the taking of additional evidence relating to the compensability of the disc bulges. We affirm the Referee's denial of the postponement motion and deny the remand motion.

OAR 438-06-081 provides that a hearing shall not be postponed except by order of the Referee upon a finding of extraordinary circumstances beyond the control of the party requesting the postponement. More specifically, OAR 438-06-081(4) provides that "incomplete case preparation, unless the referee finds that completion of the record could not be accomplished without due diligence," is not an extraordinary circumstance which justifies postponement.

The record establishes that SAIF received the MRI data on December 14, 1989. The hearing was convened on January 2, 1990. Therefore, SAIF had two weeks in which to respond to its newly discovered evidence. Therefore, we find that, with due diligence, SAIF had adequate time to complete the record.

Further, claimant had back impairment as a matter of law since the April 17, 1985 Determination Order became final. Claimant was diagnosed with cervical disc disease as early as December 14, 1988. (Ex. 65). In fact, SAIF concedes this fact in its brief. Finally, while claimant's disc condition was not specifically diagnosed as disc bulges until the December 1989 MRI, SAIF knew that claimant suffered from degenerative disc disease of the cervical spine and that that disease, without the bulges, caused permanent impairment and resulted in claimant being restricted to light/sedentary work as early as December 1988. Id.

Consequently, on this record, we do not find that the diagnosis of the disc bulges, by itself, is an extraordinary circumstance justifying a postponement. Therefore, postponement of the hearing was not appropriate.

Furthermore, even if we were to allow a postponement and subsequently find that the disc bulges are not compensable, the medical evidence, both physical and psychological, and the opinions of claimant's physicians and vocational counselors, establish that claimant was permanently and totally disabled at the time of hearing, notwithstanding the compensability of the disc bulges.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Osborn, 37 Or App 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986). As we have found that SAIF failed to establish extraordinary circumstances beyond its control, and because there is no evidence to establish that material evidence was not obtainable with due diligence at the time of the hearing, we deny SAIF's motion to remand.

Permanent Total Disability

We adopt the Referee's "Conclusions" which found claimant permanently and totally disabled. We make the following supplementation.

In order to prove entitlement to permanent total disability compensation, claimant must show that she is not "employable or able to sell her services on a regular basis in a hypothetically normal labor market." Harris v. SAIF, 292 Or 683, 695 (1982). Further, claimant must establish that she is willing to seek regular gainful employment and that she has made reasonable efforts to obtain such employment, unless such efforts are shown to be futile. ORS 656.206(3); SAIF v. Stephens, 303 Or 41 (1989); See Thomas A. Engkilterra, 42 Van Natta 2591 (1990).

After our de novo review of the record, we find that claimant was willing to seek work, but that efforts to obtain gainful and suitable employment were futile. Claimant had, in fact, returned to part-time work in early 1988. That work required working two-and-one-half hours, three days a week. Claimant successfully performed that work until July 1988, at which time her treating physician, Dr. Steinmann, M.D., released her from that work due to increasing cervical pain. At no time after that date had claimant been released to return to any kind of work. Moreover, claimant's current treating physician, Dr. Voeller, M.D., who took over Dr. Steinmann's practice, concluded in December 1989 that claimant was unemployable.

We defer to the opinions of treating physicians unless there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find no persuasive reasons not to rely on the opinions of Dr. Steinmann

and Dr. Voeller. Therefore, we conclude that claimant has established that she is permanently and totally disabled.

Travel Expenses and Penalties and Related Attorney Fees

Claimant cross-requested review of a portion of the Referee's order upon which she prevailed at hearing, i.e., reimbursement for mileage and lodging expenses and penalties and related attorney fees associated therewith. Under such circumstances and since SAIF does not contest these issues, we do not address those issues further.

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 permanent total disability issue is $500, to be paid by the SAIF Corporation. 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.

Further, while claimant did officially file a cross-request for review, the request centered on an issue which claimant prevailed at hearing, an issue upon which SAIF did not seek review. Because claimant has not been aggrieved by those portions of the Referee's order, we did not further address the issues on review. Consequently, as claimant did not prevail on a cross-request for review at the Board level, no attorney fee is awarded for services devoted to the cross-request.

ORDER

The Referee's order dated February 27, 1990, as corrected March 21, 1990, is affirmed. For services on Board review concerning the issue of permanent total disability, claimant's attorney is awarded a reasonable assessed fee of $500, payable by the SAIF Corporation.

In the Matter of the Compensation of
KATHRYN E. LUND, Claimant
WCB Case No. 89-02919
ORDER ON RECONSIDERATION
Welch, Bruun & Green, Claimant Attorneys
Williams, et al., Defense Attorneys

The Board, on its own motion, has decided to reconsider its Order on Review, dated January 16, 1991. In our Order on Review, we assessed a penalty and assessed fee for the insurer's January 1989 denial, which we found was prospective and therefore unreasonable. We have previously held, however, that where an insurer issues a prospective denial claimant is not automatically entitled to a penalty and assessed fee. Specifically, we have held that in cases where there are no outstanding bills for the period covered by the denial there are no "amounts due" on which to base a penalty. Kathy J. Richard, 42 Van Natta 2030 (1990), citing to Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (1989). Moreover, in Richard, supra, we held that inasmuch as the prospective denial was not issued in response to a claim for compensation, there was no unreasonable resistance to compensation, and an attorney fee was not assessable.

Similary, in this case, we find that claimant is not entitled to a penalty or attorney fee for the insurer's prospective denial. Here, the January 1989

denial was prospective until amended in March 1989. Dr. Won stated, in a June 2, 1989 letter, that up to that time the insurer had paid for all of claimant's treatment. Therefore, as in Richard, supra, we find that there are no "amounts due" upon which to base a penalty. Moreover, we find that there was no unreasonable resistance to the payment of compensation. Therefore, claimant is not entitled to a penalty and assessed attorney fee for the insurer's prospective January 1989 denial.

Accordingly, our January 16, 1991 order is abated and withdrawn. As corrected herein, we adhere to and republish our January 16, 1991 order in its entirely. 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.

I disagree with that portion of the Order on Reconsideration which denies claimant a carrier-paid fee for unreasonable resistance to compensation.

A denial may be resistance to the payment of compensation within the meaning of ORS 656.382(1), even though there are no amounts due at the time of the denial. Ellis v. McCall Insulation, 308 Or 74 (1989).

In this case, the condition for which claimant receives chiropractic 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 claims for future chiropractic treatment that may well be compensable.

Accordingly, claimant is entitled to an attorney fee for establishing an unreasonable resistance to compensation.

February 14, 1991 Cite as 43 Van Natta 313 (1991)

In the Matter of the Compensation of
JAMES N. McGREW, Claimant
WCB Case No. 89-19782
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Mills' order which affirmed a Determination Order award of 5 percent (16 degrees) unscheduled permanent disability for his neck and back injury. On review, claimant contends that the Referee erred in failing to abate his order and reopen the record to allow claimant to testify. On review, claimant seeks remand to allow him to testify. We deny the motion to remand and affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact and supplement on the remand issue.

Hearing was scheduled for February 17, 1990. Sometime before hearing, claimant's attorney contacted SAIF's attorney and informed her that claimant

would not be present at hearing. The attorneys agreed to proceed without claimant's testimony and presented argument to the Referee by telephone. SAIF also presented a written memorandum. The Referee issued an Opinion and Order on March 6, 1990.

On March 19, 1990, claimant moved the Referee for abatement of the order and to reopen the record for claimant's testimony. Attached to the motion was an affidavit from claimant directed to his attorney which stated:

> "As I understand it, I missed a hearing date because you had trouble locating me. I am sorry that I didn't get ahold of you. I was out of work and got to drinking too much and ended up in de-tox center here in Reno in January and early February. I am better now and attend an alcolic (sic) re-hab group."

The Referee did not rule on claimant's motion and claimant requested review.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's Conclusions and Opinion and supplement on the remand issue.

We conclude that claimant, through his attorney, waived his right to appear at hearing. The attorney had a contractual relationship with claimant which allowed him "to represent my interests under the Oregon Workers' Compensation Law." The attorney apparently considered it in claimant's best interests to proceed without claimant when claimant was out of touch with the attorney. We consider the attorney's waiver binding on claimant. Consequently, the Referee correctly decided the case based on the written record and oral argument.

Even if claimant were not bound by his attorney's waiver, we conclude that claimant has failed to establish that the matter should have been reopened for his testimony. Claimant's motion to abate and reopen the record was, in essence, a motion for a continuance under former OAR 438-06-091. That rule provides several bases for a continuance; however, the only one arguably applicable here is the catchall, section 4, which allows a continuance for any reason which would justify a postponement under former OAR 438-06-081. The latter rule allows a postponement upon a showing of extraordinary circumstances.

We find nothing in claimant's affidavit which establishes extraordinary circumstances. The affidavit merely establishes that claimant had not kept in contact with his attorney. It establishes that claimant had been in a de-tox center, however, it is not apparent from the affidavit that claimant was in the de-tox center at the time of hearing. In fact, the hearing was scheduled for February 17; the affidavit states that claimant was in the de-tox center through early February. We do not find the facts, as recited in the affidavit, sufficient to establish extraordinary circumstances. Accordingly, no continuance was appropriate and we decline to remand.

ORDER

The Referee's order dated March 6, 1990 is affirmed. Claimant's motion to remand is denied.

In the Matter of the Compensation of
MARK G. SMITH, Claimant
WCB Case No. 89-19698
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The insurer requests review of those portions of Referee Davis' order which: (1) allowed a continuance of the hearing for admission of further evidence; and (2) set aside its partial denial of claimant's medical services claim for inner ear surgery. 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 with the following supplementation.

At the hearing, claimant's counsel requested a continuance in order to obtain a further report from Dr. Black. The Referee left the record open for Dr. Black's report and subsequently admitted it into the record.

CONCLUSIONS OF LAW AND OPINION

Admission of Evidence

The insurer contends that the Referee abused his discretion by allowing claimant to submit Exhibit 39, a further report from Dr. Black, into the record. We disagree.

OAR 438-06-091 gives the Referee discretion to continue a hearing under certain circumstances. Incomplete case preparation is not grounds for a continuance unless the Referee finds that the completion of the record could not be accomplished with due diligence. See OAR 438-06-091(4); 438-06-081(4).

Approximately two months prior to hearing, counsel for claimant submitted a letter to claimant's treating ear surgeon, Dr. Black, requesting a written report providing for justification and explanation for the proposed surgery. However, counsel did not receive a report until approximately two weeks prior to the hearing. The received report was not responsive to counsel's request. Counsel then attempted to contact Dr. Black telephonically in order to obtain a response addressing matters pertaining to the original request. These attempted contacts did not meet with success. It was not until the day before the hearing that Dr. Black's office finally informed counsel that a report could not be rendered any earlier than 10 days due to Dr. Black's work schedule.

The Referee concluded that claimant's counsel's actions constituted due diligence in regard to preparing his case. See (Tr. 12, 14). Under these circumstances, we find that the Referee did not abuse his discretion in continuing the hearing for the requested report from Dr. Black. Accordingly, Exhibit 39 was properly admitted.

Compensability

We adopt the "Conclusions of Law and Opinion" as set forth in the Referee's order.

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 is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 10, 1990 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $500, payable by the insurer.

In the Matter of the Compensation of
ALLYSON EELLS AS BENEFICIARY OF LOREN EELLS (DECEASED), Claimant
WCB Case No. 88-18854
ORDER ON REVIEW
Tooze, et al., Claimant Attorneys
Chelsea Mohnike (Saif), Defense Attorney

Reviewed by Board Members Crider and Brittingham.

The SAIF Corporation requests review of that portion of Referee Peterson's order that set aside its denial of survivors' benefits related to the deceased claimant's motor vehicle accident. Claimant's survivors cross-request review of the attorney fees awarded at hearing seeking an increased fee on remand on this issue. On review, the issues are evidence, compensability, remand, and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's "FINDINGS OF FACTS", with the following supplementation.

Since 1981 the employer had been paying Savage, the foreman, $75 a month for the use of Savage's truck for the employer's business.

On February 17, 1989, claimant's attorney timely submitted a statement of services for a total of $21,158.25. SAIF contested the amount of the fee. On March 14, 1989, the Referee set aside SAIF's compensability denial and awarded claimant $2,000 as a reasonable attorney fee. The same day claimant submitted a reply to SAIF's objections. On March 20, 1989, before the Referee could respond, SAIF requested Board review. Claimant sought remand to the Referee, which the Board denied by letter dated March 28, 1989. Claimant thereupon filed a timely cross-request for review on the amount of the fee.

FINDINGS OF ULTIMATE FACT

The foreman's truck was under the control of the employer at the time of the accident.

Claimant was within the course and scope of his employment when he was killed.

CONCLUSIONS OF LAW AND OPINION

The Referee found the claim compensable on two theories. First, because claimant was a passenger in a vehicle under the control of the employer, and because the risks of employment continue throughout a journey in a vehicle under the control of the employer, the Referee found that claimant's death was compensable. Second, the Referee found that claimant was on a special errand for the employer because of the urgency of the work. We affirm and adopt on the first theory, with supplementation.

Evidence

Before addressing the issue of compensability, we turn to SAIF's contention that the Referee abused his discretion by allowing hearsay testimony in violation of the Oregon Evidence Code. Hearsay evidence is generally admissible in workers' compensation proceedings, although such evidence may be excluded when it is in the interest of substantial justice to do so. See former ORS 656.283(7); Armstrong v. SAIF, 67 Or App 498, 501 n.2 (1984); Robert E. Weber, 41 Van Natta 1739, 1742 (1989). Marion R. Webb, 37 Van Natta 750, 751 (1985). It appears to us that there is nothing in the Referee's findings of fact or opinion regarding the issue of the employer's control over the vehicle to indicate that he relied on the hearsay evidence to support his conclusion that claimant's claim was compensable. Nor do we do so on our de novo review. Thus, even if the Referee's ruling permitting hearsay was arguably not in the interest of substantial justice, it was not prejudicial.

Compensability

The employer made the following admissions at hearing: The employer had a confidential arrangement with his foreman, whereby he had been paying the foreman $75 a month for the use of a pickup for the employer's business since 1981. (Tr. 215, 236). The employer had control over the vehicle during working hours and during the times he requested the foreman to carry materials to and from the job site. (Tr. 216, 219). The truck involved in the fatality was identical to the trucks that the employer provided to his supervisors and estimators, including the color and the company logo painted on it. (Tr. 239). The employer assisted the foreman to purchase the truck. (Tr. 210, 236, 238). Unlike the painted company logo on the foreman's truck, the employer on occasion issued magnetic signs to other workers for use on their own vehicles. The employer paid employees for transporting equipment to and from job sites; but his arrangement with the foreman was different, in that it was a standard continuous monthly payment since 1981 and not based on a per trip use of a truck as it was for the others. The employer also identified company painting paraphernalia that was found at the accident site. (Tr. 271).

These admissions by the employer are sufficient to support the Referee's conclusion that the vehicle in which claimant died was under the control of the employer and that claimant's death was incurred in the course of employment because the risks of the employment continued throughout the journey. See I Larson, Worker's Compensation Law, 17.50, 4-239 through 4-250 (1985, rev. 1988).

Remand

In its March 28, 1989 letter denying claimant's request for immediate remand, the Board indicated it was willing to reconsider the attorney fee award, but only on the basis of matters in the record which were submitted to the Referee. See ORS 656.295(5). Any supplemental documents would be treated as a motion for remand. Judy A. Britton, 37 Van Natta 1262 (1985).

On review, claimant submitted several documents generated after SAIF's request for review, contending that the attorney fee award should be remanded to the Referee for reconsideration. Should the Board determine that the record has been improperly, incompletely or otherwise insufficiently developed, we may remand a case to the Referee for further evidence taking, correction, or other necessary action. 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); See Bernard L. Osborn, 35 Van Natta 1054, 1055 (1985), aff'd mem. 80 Or App 152 (1986). Here, we find that the exhibits in the record which were submitted to the Referee were sufficient to completely, properly and adequately develop the record. See ORS 656.295(5). Thus, the motion to remand is denied.

Attorney Fees

In determining an appropriate fee for claimant's counsel's services at hearing, we consider those factors set out in OAR 438-15-010(4). Those factors are: "(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 and standing of the attorneys; (e) the nature of the proceeding; (f) the result 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."

The hearing in this matter took place over much of two days. In addition, claimant's counsel found it necessary to develop lengthy hearsay testimony as a result of the unavailability of the two primary witnesses. Both counsel submitted lengthy, well-reasoned arguments following the hearing. Claimant's attorney devoted slightly over 87 hours to this case at hearing.

This matter involves a death benefits claim. Because the claim was found compensable, claimant's survivors are entitled to all benefits provided for survivors of a deceased worker under ORS Chapter 656.

Both counsel are skilled and each demonstrated that skill during these proceedings. The hearing was strongly adversarial and strenuously and competently litigated by both attorneys.

Claimant's counsel bore a significant risk of his efforts going uncompensated.

Considering the above factors and applying them to this case, we find that the fee awarded by the Referee was inadequate. Consequently, we find that a reasonable fee for claimant's counsel's services at hearing concerning the compensability issue is $14,500, to be paid by SAIF.

Furthermore, after applying the same factors to this case on review, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issue is $3,500. In reaching this conclusion, we have particularly considered the time devoted to the case as represented by claimant's respondent's brief, the moderate complexity of the issue, and the value of the interest involved. We note that claimant's counsel is not entitled to an attorney fee for services devoted to his cross-request on the attorney fee issue.

ORDER

The Referee's order dated March 14, 1989 is affirmed in part and modified in part. That portion of the order which awarded an assessed fee of $2,000 is

modified. For services at hearing, in lieu of the Referee's award, claimant's attorney is awarded $14,500, to be paid by the SAIF Corporation. The remainder of the order is affirmed. For services on review regarding the compensability issue claimant's attorney is awarded an assessed fee of $3,500, also to be paid by SAIF.

February 15, 1991 Cite as 43 Van Natta 319 (1991)

In the Matter of the Compensation of
STEPHEN L. GILCHER, Claimant
WCB Case No. 89-17998
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Nichols, Brittingham, and Crider.

Claimant requests review of those portions of Referee Brown's order which: (1) found that claimant's back injury claim was not prematurely closed; (2) declined to assess penalties and attorney fees for the SAIF Corporation's allegedly unreasonable claim processing; and (3) authorized SAIF to recover overpaid temporary disability compensation. On review, the issues are premature closure, penalties, attorney fees and offset. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's opinion with the following comment.

Premature Closure

A claim may be closed if claimant's compensable condition is medically stationary, i.e., no further material improvement would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17). It is claimant's burden to establish that he was not medically stationary when the claim was closed. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981); Brad T. Gribble, 37 Van Natta 92 (1985). The reasonableness of medical expectations for claimant's condition must be judged in the context of the condition at the time of closure. Scheuning v. J. R. Simplot, 84 Or App 622, rev den 303 Or 590 (1987); Alvarez v. GAB Business Services, 72 Or App 524, 527 (1985). Subsequent testimony, opinions or events may only be considered to the extent they relate to claimant's condition at the time of closure. Wojick v. Weyerhaeuser, 89 Or App 561 (1988); Scheuning, supra.

Dr. Purtzer, claimant's treating physician, recommended that claimant undergo decompressive lumbar laminectomy/diskectomy. (Ex. 1). On April 3, 1989, claimant initially refused surgery (Ex. OC). Dr. Purtzer later opined, on April 11, 1989, that if claimant refused surgery then he may be declared medically stationary. (Ex. 1). Dr. Purtzer's opinion is the only medical opinion in the record.

On April 19, 1989, SAIF sent a letter to claimant and his attorney asking claimant whether he intended to pursue surgical treatment. (Ex. 1A). This letter also informed claimant that, if he did not respond within two weeks, SAIF would assume claimant agreed that his condition was medically stationary without

surgery, and SAIF would submit his claim for closure. (Id.) On April 30, 1989, claimant responded by stating that he would submit his final decision concerning surgery immediately after the week of May 8, 1989, when his bio-feedback evaluation was complete. (Ex. 2). Claimant made no further communication to SAIF. A Determination Order issued on June 28, 1989, finding claimant medically stationary as of June 1, 1989. Claimant did not return to his treating physician until August 15, 1989, at which time claimant informed his physician that he had decided to have surgery. (Ex. 4).

At the time of claim closure, claimant's treating physician had opined that claimant was medically stationary if claimant did not have surgery. Based on the above circumstances, we find it reasonable for SAIF to infer that claimant would continue to refuse surgery since claimant did not notify SAIF of his decision whether he would have surgery, as he said he would. Claimant's subsequent decision to have surgery may not be considered in determining claimant's preclosure medical status. Therefore, we agree with the Referee's ruling that claimant's claim was not prematurely closed by the June 28, 1989 Determination Order.

Penalties and Attorney Fees

The record shows that SAIF was notified in March 1989 that claimant was represented by an attorney. (Ex. OB). Yet SAIF did not send a copy of the May 24, 1989 letter scheduling an independent medical examination (IME) to claimant's attorney, as required by OAR 436-10-100(1)(d). Also, this letter gave claimant less than the required ten days notice about the IME scheduled for June 1, 1989. Former OAR 436-60-090(3).

We find it unreasonable that SAIF would not notify claimant's attorney about the scheduled IME, or give claimant the required minimum ten days notice. ORS 656.262(10) provides for a penalty based upon a percentage of "amounts then due." Here, claimant's back injury claim was not prematurely closed, and SAIF timely paid temporary total disability benefits beyond the June 1, 1989 medically stationary date, to June 25, 1989. Thus, there was no compensation "then due" upon which to base a penalty. Therefore, a penalty is not authorized by law. Ellis v. McCall Insulation, 308 Or 74 (1989).

Further, there was no unreasonable resistance to the payment of compensation. As a result, we do not assess an attorney fee. Lloyd L. Cripe, 41 Van Natta 1774 (1989).

ORDER

The Referee's order dated January 22, 1990 is affirmed.

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

I agree with the majority that claimant was medically stationary and thus his claim was not prematurely closed by the June 28, 1989 Determination Order. However, I think that the failure of SAIF to send a copy of the letter scheduling the IME to claimant's attorney led to claimant's failure to attend the IME and to the subsequent issuance of the June 28, 1989 Determination Order without permanent partial disability compensation. This closure of the claim without a permanent partial disability determination provides the basis for a penalty. See Theresa Skoyen, 41 Van Natta 174 (1989), aff'd mem 104 Or App 744 (1990) (Claimant entitled to penalty and attorney fee for carrier's failure to promptly submit a claim for closure). Consequently, I would award a penalty of a percentage of any permanent partial disability compensation eventually awarded by the Evaluation Division for this injury. In addition, I would award a reasonable attorney fee for SAIF's unreasonable resistance to the payment of compensation.

In the Matter of the Compensation of
CHELLA M. MORTON, Claimant
WCB Case No. 89-06342
ORDER ON REVIEW
Myrick & Seagraves, Claimant Attorneys
Bailey & Associates, Defense Attorneys

Reviewed by Board Members Myers, Cushing and Crider.

The self-insured employer requests review of Referee Mongrain's order that set aside its denial of claimant's "new injury" claim for a left knee condition. On review, the employer contends that claimant's present claim is barred by the doctrine of res judicata. We agree and reverse.

As a preliminary matter, the employer has requested permission to present oral argument. We normally will not entertain oral arguments. OAR 438-11-010(1). Inasmuch as this matter has been fully developed and briefed, we conclude that oral argument is not necessary. Consequently, the employer's request is denied.

FINDINGS OF FACT

Claimant sustained a knee injury in August 1985 and was treated by Dr. Potter. That claim was closed by a January 22, 1986 Determination Order, which awarded temporary total disability and 5 percent permanent partial disability. (Ex. 2).

Claimant sustained a second knee injury on February 10, 1988. She returned to Dr. Potter, who submitted reports indicating the need for further medical treatment. The employer accepted the injury as an aggravation of the 1985 injury and notified claimant via a 1502 form. (Ex. 10). Claimant received temporary total disability and subsequently was accepted for vocational assistance. (Ex. 14B-1).

The aggravation claim was closed by an October 10, 1988 Determination Order, which awarded additional temporary disability but no additional permanent disability. (Ex. 17). Claimant's attorney initially filed a request for hearing; however, he later withdrew the request and added that a "new injury" claim was being pursued. (Ex. 20A).

On January 12, 1989, claimant filed a claim against the employer, alleging that she had sustained a "new injury" during the February 1988 incident. (Ex 20). The employer denied the claim on the ground that "the medical documentation supports the fact that there is no new injury." (Ex. 25). Claimant requested a hearing.

On April 9, 1989, the October 10, 1988 Determination Order became a final order. Shortly thereafter, the employer filed a motion to dismiss, asserting that claimant's "new injury" claim was barred by res judicata.

CONCLUSIONS OF LAW AND OPINION

The sole question is whether claimant's "new injury" claim is barred by principles of res judicata. The Referee concluded that it was not and denied the employer's motion to dismiss. We disagree.

"Preclusion by former adjudication," generally referred to as res judicata, is a "doctrine of rules and principles governing the binding effect on a subsequent proceeding of a final judgment previously entered in a claim." Drews

v. EBI Companies, 310 Or 134 (1990). The term comprises two doctrines, claim preclusion and issue preclusion.

Issue preclusion bars future litigation of a subject issue only if that issue was "actually litigated and determined" in a setting where the determination of that issue was essential to the final decision reached. North Clackamas School Dist. v. White, 305 Or 48, 53 (1988). Claim preclusion, on the other hand, bars future litigation not only of every claim included in the pleadings, but also to every claim that could have been alleged under the same aggregate of operative facts. Million v. SAIF, 45 Or App 1097, 1102 rev den, 289 Or 337 (1980). Claim preclusion does not require actual litigation of an issue; however, it does require the opportunity to litigate, whether or not used. Drews, supra.

Here, claimant first sought compensation for the February 1988 knee injury when her physician submitted reports indicating the need for further medical treatment. See ORS 656.273(3). The employer accepted the claim as an aggravation of an earlier knee injury and began payment of temporary disability benefits. The claim was closed by an October 10, 1988 Determination Order, which awarded only additional temporary disability. Although that decision was initially contested, it became final by operation of law on April 10, 1989, after claimant had withdrawn her request for hearing.

Acting on new medical reports from Dr. Potter, claimant again sought compensation for the February 1988 knee injury in January 1989. This time, she alleged that she had sustained a "new injury," rather than an aggravation. The employer denied the claim and later filed a motion to dismiss, alleging that claimant was precluded by the earlier Determination Order.

The issue whether claimant sustained a "new injury" was not adjudicated by the Determination Order. That decision settled only issues relating to temporary total disability, permanent partial disability and the date claimant became medically stationary. Consequently, issue preclusion does not bar claimant's present claim. However, we conclude that claim preclusion is applicable.

Subsequent to the Referee's order, the Board issued Irene Jensen, 42 Van Natta 2838 (1990). In that case, the claimant developed severe back pain and, in 1985, filed an occupational disease claim. Diagnosed as having preexisting degenerative disc disease of the cervical and lumbar spine, she alleged that a back strain, caused by work stress, had aggravated her arthritic spine. The Referee found the condition compensable. On review, the Board determined that the claimant had failed to prove an occupational disease claim and reversed. The Court of Appeals affirmed. Jensen v. Employment Division, 93 Or App 635 (1988).

Meanwhile, the claimant began treating with a new doctor who diagnosed her condition as fibromyalgia. Acting on the diagnosis, claimant filed a second occupational disease claim in 1988. The Referee concluded that, because the fibromyalgia diagnosis had not been made at the time of the first hearing, the claimant's second claim was not barred by claim preclusion. On review, we reversed. We noted that under Proctor v. SAIF, 68 Or App 333 (1984), the claimant's condition must have been different from her condition at the time of the earlier claim in order for her fibromyalgia to be compensable. Because the claimant was merely contending that her current symptoms were the result of fibromyalgia, rather than the back strain as earlier alleged, we found that, regardless of the new diagnosis, the second claim for relief arose out of the same set of operative facts that had been and determined by a final order. Therefore, we concluded that the second occupational disease claim was barred by claim preclusion.

The same reasoning applies here. Claimant does not contend that her current condition is different, or has changed, from her condition at the time of the earlier final adjudication. Relying on new medical reports from Dr. Potter, she merely contends that the February 1988 knee injury resulted in a "new injury," rather than an aggravation. Therefore, as in Irene Jensen, supra, the present claim for relief arises out of the same set of operative facts that have been previously fully litigated and determined by a final order. The fact that claimant now asserts her claim by another name does not alter the preclusive effect of the prior adjudication. Million v. SAIF, 45 Or App at 1102.

Therefore, we conclude that claimant's "new injury" claim is barred by the principles of preclusion by former adjudication. The employer's motion to dismiss should have been granted.

ORDER

The Referee's order dated August 3, 1989 is reversed. The self-insured employer's motion to dismiss claimant's hearing request is granted.

Board Member Crider specially concurring:

I agree with the panel's conclusion that claimant was not entitled to litigate the question of whether her claim should have been processed as a new injury rather than an aggravation because she failed to request a hearing on the Determination Order before it became final. See Drews v. EBI Companies, 310 Or 134 (1990).

I do not agree, however, with the panel's reliance on Million v. SAIF, 45 Or App 1097, rev den 289 Or 337 (1980) and Irene Jensen, 42 Van Natta 2838 (1990). Those cases, in my view, deal only with the waiver rule. As claimant's right to compensation was never denied, there was no occasion for her to waive the right to contend that she had suffered a new injury. This case is controlled by the substantive workers' compensation rule enunciated in Drews which held that disputes concerning the amount of disability compensation must be resolved before a claim is finally determined by determination order. On the basis of that rule, I agree that the Referee's order must be reversed.

In the Matter of the Compensation of
RICKY J. THOMAS, Claimant
WCB Case Nos. 89-06026 & 89-14916
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Crider and Nichols

The insurer requests review of those portions of Referee Barber's order that: (1) set aside a Determination Order as premature; and (2) assessed a $25 penalty-related attorney fee for failure to accept or deny a claim for psychological services. Claimant cross-requests review, seeking a higher penalty-related fee. On review, the issues are premature closure and penalty-related attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Premature Closure

Although there is no dispute that claimant's physical condition was medically stationary in March 1989, claim closure was nonetheless premature if claimant's compensable psychiatric condition was not yet medically stationary when the Determination Order issued on June 21, 1989. Rogers v. Tri-Met, 75 Or App 470 (1985); Paul E. Voeller, on recon, 42 Van Natta 1962 (1990).

The Referee interpreted Scheuning v. J. R. Simplot & Co., 84 Or App 622 (1987), to hold that all post-closure evidence could be used to determine whether a claim was prematurely closed. On that basis, he unreservedly relied on the post-closure evidence to determine that claimant was not psychologically medically stationary at claim closure. Although we agree that claimant's claim was prematurely closed, we do so for different reasons.

In deciding whether a claim was prematurely closed, we determine whether the claimant's condition was medically stationary on the date of closure, without considering subsequent changes in his condition. Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). However, medical reports authored after closure may be considered if they address claimant's condition at the time of closure. For example, post-closure reports can be considered if there is no post-closure change in claimant's condition and the only question is whether claimant was medically stationary at the time of closure. Scheuning v. J.R. Simplot & Co., supra.

"Medically stationary" means no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). It is claimant's burden to establish that he was not medically stationary when the claim was closed. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981); Brad T. Gribble, 37 Van Natta 92 (1985). An issue concerning a 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).

The insurer argues that claimant was psychologically stationary when the June 21, 1989 Determination Order issued, and that claimant sought out Dr. Hymen again in July 1989 after his psychological condition worsened post-closure due to a lost job opportunity. The insurer contends the Referee erred in considering the post-closure reports of Drs. Hymen and Turco because they were based on claimant's post-closure worsening.

We conclude that, even without these post-closure reports, claimant has established that his claim was prematurely closed. Thus, we need not address whether the Referee properly considered the reports.

On December 20, 1988, Dr. Hymen examined claimant and diagnosed adjustment disorder, with mixed emotional features. (Ex. 25-9). Dr. Hymen found that this condition was related to claimant's work injury and recommended psychotherapy in conjunction with antidepressants. (Ex. 25-10).

On February 14, 1989, Dr. Phipps, M.D., and Dr. DeVour, psychologist, performed independent psychological examinations of claimant on behalf of First Northwest Health. (Ex. 29). Dr. Phipps found claimant's physical condition

medically stationary and deferred to Dr. DeVour in regard to claimant's psychiatric condition. Dr. DeVour diagnosed adjustment disorder, with mixed emotional features, and noted that claimant's current psychological condition was directly related to his work injury. (Ex. 29-2). Although Dr. DeVour did not recommend psychotherapy or medication, he did not opine that claimant was psychologically stationary. Instead, he opined that claimant's condition would improve with employment or vocational retraining. Thus, although First Northwest Health's report indicated that claimant was physically stationary, it did not indicate that he was psychologically stationary.

In March 1989, Dr. Redfield, treating physician, Dr. Jewell, treating surgeon, and Dr. Englander, consulting neurologist, concurred with First Northwest Health's opinion that claimant was medically stationary. (Exs. 31, 32, 33). However, the record is not clear that Dr. DeVour's psychological report was provided for their concurrence. Furthermore, in explaining their concurrences, Drs. Redfield and Jewell later deferred to Dr. Hymen on claimant's psychological condition and Dr. Englander stated that he did not intend his concurrence to speak to the psychological issues as that was not his area of expertise. (Exs. 36, 36B, 36D).

In summary, Dr. Hymen and Dr. DeVour diagnosed a psychological condition that was caused by claimant's work injury and did not declare claimant to be psychologically stationary. Dr. Hymen expected improvement with psychiatric treatment. Dr. DeVour opined that claimant's condition would improve with employment or vocational retraining. In fact, no doctor stated that claimant was psychologically stationary. Claimant's non-medically stationary status is further supported by claimant's wife's testimony that his psychiatric symptoms were basically the same from January 1989, before the examinations occurred, through June 1989, when the claim was closed. (Tr. 32-35). We also note that claimant received no psychiatric treatment that would have improved his condition. Therefore, we find that claimant's psychiatric condition was not stationary at claim closure. Accordingly, we agree with the Referee's ultimate conclusion that the claim was prematurely closed.

Attorney Fees

The Referee awarded a $25 assessed attorney fee for the "de facto" denial of claimant's psychological condition. He reasoned that because there was no treatment, and therefore, no amounts "then due" upon which to base a penalty, a minimal attorney fee award was adequate for reporting a technical violation. Although we agree that there should be an assessed attorney fee, we do so for different reasons.

Even in the absence of any amounts of compensation "then due," ORS 656.262(10) permits assessment of an attorney fee under ORS 656.382(1) if the insurer unreasonably resists the payment of compensation. Ellis v. McCall Insulation, 308 Or 74, 78 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (1989). The insurer's failure in this case to accept or deny the claim for psychological treatment within 60 days is an unreasonable resistance to the payment of compensation. Former ORS 656.262 (6) and (10).

On December 20, 1988, Dr. Hymen examined claimant, diagnosed a work-related psychological condition and recommended treatment. The insurer received Dr. Hymen's report on January 17, 1989. Dr. Hymen repeatedly attempted to get the insurer to authorize this treatment. (Ex. 41-3). On January 30, 1989, the insurer received a letter from claimant's attorney requesting authorization for the psychological treatment recommended by Drs. Hymen, Redfield and Jewell. (Ex. 25A). The record shows no response to these requests for authorization.

The insurer never issued a formal denial. In a June 1989 letter to its attorney, the insurer stated that it had not issued a denial or partial denial of psychiatric services but that counseling with Dr. Hymen was not authorized because the independent medical examiner did not recommend psychotherapy when he examined claimant in February 1989. (Ex. 36). On July 5, 1989, claimant began psychotherapy with Dr. Hymen. (Exs. 36C, 38). This therapy was covered by the insurer.

The insurer's actions resulted in deprivation of medical services to claimant from January through June 1989. We find these actions constitute unreasonable resistance to payment of compensation. These actions also resulted in considerable legal work in getting the insurer to finally authorize the psychological treatment. After considering the factors set forth in OAR 433-15-010(4) and applying them to this case, we find that $2,000 is a reasonable attorney fee for the insurer's unreasonable resistance to payment of compensation.

Finally, claimant's attorney is entitled to a reasonable fee for prevailing against the insurer's request for review on the premature closure issue. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the complexity of the issue, the time devoted to the case as represented by claimant's statement of services, and the value of the interest involved. Claimant is not entitled to an attorney fee for defending against the penalty-related 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 December 14, 1989 is modified in part and affirmed in part. In lieu of the Referee's award of a $25 penalty-related attorney fee, claimant's attorney is awarded a fee of $2,000, to be paid by the insurer. The remainder of the order is affirmed. For services on Board review regarding the premature closure issue, claimant's attorney is awarded an assessed fee of $750, to be paid by the insurer.

In the Matter of the Compensation of
JULIAN H. COMBS, Claimant
WCB Case No. C1-00124
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Michael B. Dye, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

On January 17, 1991, 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 $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 is in accordance with the terms and conditions prescribed by the Director. 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.

Parenthetically, the agreement provides that SAIF shall advance claimant a payment of $2,000 upon submission of the agreement to the Board. The agreement further provides that, if the agreement is disapproved by the Board, SAIF shall be entitled to an offset in the amount of $2,000 against any future disability benefits. That arrangement is contrary to law. Because the advance payment is part of the settlement proceeds, it cannot be considered a prepayment of compensation to be offset against future awards of compensation. See Robert D. Surina, 40 Van Natta 1855, 1857 (1988). Thus, if the Board had disapproved this agreement, SAIF would not be permitted to offset the advance payment against any amount of compensation. However, inasmuch as the Board finds no basis for disapproving the agreement, this objectionable language is harmless and shall not preclude approval of the agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN P. DEROSS, Claimant
WCB Case No. 89-04720
ORDER ON REVIEW
Johnson, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Brazeau's order that declined to award temporary total disability benefits in the form of interim compensation from January 11, 1989 through March 6, 1989. On review, the issue is temporary disability compensation. We reverse.

FINDINGS OF FACT

Claimant injured his low back at work on December 22, 1988. He continued to work at his regular job. In January 1989 he began to have increased pain. He worked until January 11, 1989, when his union called a strike against the employer. On that date, claimant sought medical treatment and was diagnosed

with an acute lumbar strain. The doctor released claimant to work, but did not find him medically stationary. A claim was filed with the employer, which it received January 17, 1989. (Ex. 2).

Claimant returned to the doctor on January 20, 1989, complaining of pain extending into his left hip and radiating down his left leg into his thigh. The doctor excused claimant from work effective January 24, 1989. On February 13, 1989, the employer notified claimant that claimant's claim was in deferred status, and denied "temporary total disability" payments, stating that claimant voluntarily removed himself from the labor market on January 10, 1989, the date the strike began. It is this failure to pay temporary disability benefits that is before us.

Claimant's doctor released him to work without limitation as of March 7, 1989.

Claimant's claim was closed by Determination Order on April 13, 1989, with no medically stationary date specified. The Determination Order stated that claimant was entitled to no temporary or permanent disability compensation. It further stated that "this is not a determination of any denials issued by the insurer." (Ex. 7).

Claimant did not look for work during the strike. Instead, he cut and sold burls, and tended the sheep on his ranch. He did not sell any sheep or sheep products during the period of the strike.

Claimant would not have crossed the picket line had he been offered work at the employer.

Claimant returned to regular work on June 5, 1989.

FINDINGS OF ULTIMATE FACT

Claimant had not withdrawn from the work force prior to January 24, 1989, the date he was released from work as a result of the injury.

CONCLUSIONS OF LAW AND OPINION

An injured worker is entitled to temporary disability compensation after the claim is accepted until the worker is released to regular work and medically stationary or the worker becomes medically stationary and the claim is closed. Fazzolari v. United Beer Distributors, 91 Or App 592 (1988); David L. Smith, 42 Van Natta 499 (1990). However, as a procedural matter, when a claimant's claim is not accepted, the worker's compensation statutes give the employer two choices: to deny the claim or to make payments of interim compensation. ORS 656.262; Jones v. Emanuel Hospital, 280 Or 147, 151 (1977). In this case, as long as the claim remained in deferred status, the employer was required to pay interim compensation until it denied the claim provided, however, claimant left work as a result of the injury. Id. These payments are required to begin within 14 days after the employer had notice of the claim, ORS 656.262(4), and are to be paid whether or not the worker suffered a compensable injury. Bono v. SAIF, 298 Or 405, 407 (1984).

Claimant contends that interim compensation payments should have been made from January 11, 1989, the date claimant sought medical treatment and the strike began, through March 6, 1989, the date claimant was released to work. However, a worker cannot receive interim compensation unless he left work as a result of the disabling injury. Id., at 410. In this case, the doctor did not excuse claimant from work until January 24, 1989. Consequently, the date claimant

became disabled and was unable to work was not January 11, 1989, the date claimant sought medical care, but January 24, 1989.

The Referee concluded that the determination of the temporary disability compensation issue was dependent on the status of the worker at the time of the onset of his disability and the concept of wage replacement. The Referee found that claimant was ineligible for interim compensation payments because he had voluntarily left the workforce because of a labor dispute and not as the result of his injury alone. He further found that because claimant was not actively seeking work at the time of his disability, he was not losing wages, and therefore had no wages to replace. We disagree.

Here, claimant filed a claim for an industrial injury the same day the strike began and became disabled because of his back injury on January 24, 1989, the date he was taken off work. He had been working until the strike was called. He was entitled to and did return to work in due course following the strike. The fact that he was on strike did not remove him from the work force. Ellis N. Phillips, 43 Van Natta 231 (1991). Consequently, he was entitled to interim compensation when he became disabled.

ORDER

The Referee's order dated June 13, 1989, as amended July 5, 1989, is reversed. The self-insured employer is instructed to pay claimant temporary total disability compensation for the period January 24, 1989 through March 6, 1989. Claimant's attorney is allowed an approved fee in the amount of 25 percent of the temporary disability compensation awarded under this order, not to exceed #3,800, payable directly to claimant's attorney.

February 19, 1991 Cite as 43 Van Natta 329 (1991)

In the Matter of the Compensation of
GORDON G. GAGO, Claimant
WCB Case No. 89-16878
ORDER ON REVIEW
Rieke, et al., Claimant Attorneys
Ronald Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Shebley's order that upheld the SAIF Corporation's denial of claimant's claim for multiple injuries sustained in a motor vehicle accident. On review, the issue is whether claimant's injuries arose out of and in the course and scope of his employment. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee adopted page 8 through 16 of SAIF's closing argument as his "Conclusion of Law and Opinion." The Referee further concluded that it was at least as probable that claimant was on a personal errand as on his way home at the time of the accident and ultimately concluded that claimant failed to prove that he was within the course and scope of employment when the accident occurred.

Claimant argues that the portions of SAIF's brief adopted by the Referee contain misstatements of fact and that the Referee does not apply the correct legal test. Claimant asserts that his injuries occurred within the course and scope of his employment under one of the following exceptions to the coming and going rule: (1) the dual purpose exception; (2) the employer conveyance exception stated in Jenkins v. Tandy Corp., 86 Or App 133 (1987); or (3) the special errand exception.

We agree with the Referee's ultimate ruling that the injury is not compensable. However, we base our conclusion on the following reasoning.

Dual Purpose Exception

A compensable injury is one "arising out of and in the course of employment." ORS 656.005(7)(a). Generally, injuries sustained by employees when going to and coming from work are not considered to arise out of and occur in the course of employment. Philpott v. SIAC, 234 Or 37 (1963). One of the exceptions to this rule is the dual purpose exception under which trips to or from the workplace serving both personal and business purposes may be compensable. 1 Larson, Workmen's Compensation Law, Section 18.12 at 4-252 thru 4-267 (1985). However, if the accident happened after the business purpose had been completed and while claimant was on his way home, the injury would not be compensable. 1 Larson, supra, Section 19.24 at 4-344 thru 4-346; Gumbrecht v. SAIF, 21 Or App 389, 394 (1975).

Even allowing that claimant's delivery to German Autoworks was within the dual purpose exception, that delivery had been completed at the time of claimant's accident. Therefore, claimant must prove that he was in the process of making another delivery or performing some other business purpose for the employer when the accident occurred in order for the dual purpose exception to apply.

Because of the severe brain damage claimant suffered as a result of the accident, he was unable to make any statement as to the purpose of his trip. Therefore, the record consists mainly of hearsay and circumstantial evidence. Claimant was headed away from his normal route home and in the general direction of a customer at the time of the accident. (Tr. 35, 40, 56, Ex. 15-7). A box of headers was in the trunk of claimant's car, and an invoice for an alternator was on claimant's person at the time of the accident. (Ex. 11-47).

However, there was no direct evidence from the employer or any customer that claimant intended to make another delivery. No invoice for the headers was found in the car and there was no evidence that claimant had written up the charge. No alternator part was found at the scene of the accident. The alternator invoice was at cost. (Ex. 15-8). Also, there is evidence that claimant's car had a charging problem and that this type alternator could be used in claimant's car. (Ex. 11-47, Tr. 83, 95).

We conclude that this record is insufficient to establish that claimant was on his way to make a second delivery at the time of the accident. Accordingly, we conclude that the claim is not compensable under the dual purpose doctrine.

Employer Conveyance Exception

Claimant also argues that because the employer knew that claimant delivered parts for the employer and forbade him to use the employer's cars, claimant needed to bring his car to work to perform his duties. Therefore, claimant

argues he is covered during his journeys coming to and going from work under Jenkins v. Tandy Corp., supra.

In Jenkins, the employer required the claimant to bring his personal car to work and to have it available for use in the employer's business during the work-day and to make deliveries after work. Citing Giltner v. Commodore Con. Carriers, 14 Or App 340, 347 (1973), the court found that Jenkins' injuries walking to his car after work were compensable because he came within an exception to the going and coming rule. The court reasoned that if an employee, as part of his job, is required to bring his own car to work during his working day, his trip to and from work is, by that fact alone, within the course of employment. Jenkins, 86 Or App at 137.

Here, the record establishes that the employer told claimant not to make deliveries in the employer's cars. (Exs. 11-26, 12-7, 12-8, 15-3, 15-6, 15-14, 15-15, Tr. 91, Tr. 103, Tr. 106, Tr. 107). There is evidence that the employer knew that claimant was making deliveries in his own car and allowed this. (Ex. 15-14. Tr. 93).

Nevertheless, the record does not show that the employer required claimant to bring his car to work so that it could be used during the day or for deliveries on the way home. Claimant received no travel pay, mileage or expense account for the use of his car, a further indicaiton that the employer did not require claimant to bring his car to work. (Ex. 11-15, 15-18, Tr. 89). We conclude that the exception in Jenkins does not apply in this case because the employer did not require claimant to have his personal car at work so that it could be used during the day and for deliveries on the way home.

Special Errand Exception

Alternatively, claimant argues that the injury falls within the special errand exception. Larson states the special errand rule as follows:

> "When an employee, having identifiable time and space limits on his employment, makes an off-premises journey which would normally not be covered under the usual going and coming rule, the journey may be brought within the course of employment by the fact that the trouble and time of making the journey, or the special inconvenience, hazard, or urgency of making it in the particular circumstances, is itself sufficiently substantial to be viewed as an integral part of the service itself."

1 Larson, supra, Section 16.11 at 4-124 thru 4-141. If an off-premises journey falls within the special errand rule, an injury during the return trip home is compensable. Id. See also Hickey v. Union Pacific Railroad Co., 104 Or App 724 (1990).

Larson considers the following variables in determining whether a journey is within the special errand exception: (1) the relative regularity or unusualness of the particular journey (the more irregular or unusual the more likely it would be within the special errand rule); and (2) the relative onerousness of the trip compared with (3) the service to be performed at the end of the journey. 1 Larson, supra, Section 16.13 at 4-145 thru 4-149. See Hickey, supra, 104 Or App at 730 (decedent's trip home was within the special errand rule "because of the added hazard, the deviation from normal working hours, the lack of advance notice and primary benefit to employer").

Claimant asserts that he often made deliveries on his way home. (Tr. 16, 33, 57). Therefore, claimant does not meet the requirement of an irregular or unusual journey. German Autoworks is located on S.W. Shaw which is about a block off of claimant's usual route home on Tualatin Valley Highway. Therefore, the delivery was not particularly "onerous." Furthermore, the delivery was not made at a time when the route would be more dangerous than claimant's usual route home. Further, as discussed above, claimant has not established that he was on his way home at the time of the injury. Thus, the present case is distinguishable from Hickey, supra, and the special errand cases cited in Larson, where the claimant was either going to or enroute home from the special errand. E.g., Johnson v. Fairbanks Clinic, 647 P.2d 592 (Alaska 1982); O'Reilly v. Roberto Homes, Inc., 31 N.J. Super 387, 107 A.2d 9 (1954). Under these circumstances, we conclude that claimant does not come within the special errand exception.

In summary, claimant has not shown that he comes within one of the exceptions to the general coming and going rule. Therefore, claimant has not proven that his injuries arose out of and in the course of employment.

ORDER

The Referee's order dated February 8, 1990 is affirmed.

February 19, 1991 Cite as 43 Van Natta 332 (1991)

In the Matter of the Compensation of
RANDAL S. HENSON, Claimant
WCB Case Nos. 89-03699, 89-03700 & 89-10734
ORDER ON REVIEW
Jeff Carter, Claimant Attorney
Scheminske & Lyons, Defense Attorneys
Davis & Bostwick, Defense Attorneys
Virgil E. Dugger, Defense Attorney
David Ray Fowler (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

The noncomplying employer, Max White Trucking, requests review of that portion of Referee Irving's order that set aside the SAIF Corporation's denial, on its behalf, of compensability and responsibility for multiple injuries claimant sustained in a motor vehicle accident. The issues on review are compensability and responsibility. We affirm.

FINDINGS OF FACT

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

On April 20, 1989, claimant was involved in a vehicle accident that caused injuries to his head and right elbow. He was in a layover status as a traveling employee for Max White Trucking when this accident occurred. In the emergency room he complained of pain in both arms and the neck. A cervical collar was prescribed and claimant was released from work. Seven days later claimant was also complaining of low back pain with radiation and numbness into the left leg.

Claimant was hired by a business partner and employee of the noncomplying employer, Max White. Mr. White had no knowledge of claimant being hired until after claimant had already performed services for his trucking company. Max White Trucking paid claimant one time during their brief employment arrangement.

Mr. White also sent money to claimant after the accident for the purpose of assisting claimant to return from Merced, California.

On May 31, 1989, the Department of Insurance and Finance (DIF) issued a Proposed and Final Order that found Max White Trucking, Inc. a noncomplying employer on April 20, 1989. It listed claimant as a subject worker.

CONCLUSIONS OF LAW AND OPINION

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

Subject Worker

Claimant must be a "subject worker" in order to receive "compensation" under the Worker's Compensation Act. ORS 656.027. The Referee concluded that it was the law of the case that claimant was a subject employee of Max White Trucking in April 1989. We agree with the result, but not the basis for the Referee's conclusion.

The Referee based her conclusion on a May 31, 1989, DIF Proposed and Final Order that found Max White Trucking to be a noncomplying employer and claimant a subject employee on April 20, 1989. This prior matter on compliance involved only an enforcement proceeding between the Department and the employer. See ORS 656.017, 656.052 and 565.735. The DIF order, if final, established that the employer was subject and noncomplying. The issue of whether claimant was either an employee or a "subject worker" was, however, not litigated and the DIF order has no "issue preclusive" effect. We must determine whether claimant was a "subject worker" based upon the present record.

ORS 656.005(13) provides that an "employer" is any person who contracts to pay a remuneration for and secures the right to direct and control the services of any person. ORS 656.005(27) provides that a "worker" is any person who engages to furnish services for a remuneration, subject to the direction and control of an employer. Thus, the right of the employer to direct and control the activities of the worker is an essential ingredient of the test for an employer/employee relationship. The test requires an application of the traditional "right to control" analysis. See Woody v. Waibel, 276 Or 189, 196 (1976); Castle Homes, Inc. v. Whaite, 95 Or App 269, 271 (1989).

Under the traditional test of the right to control, the factors to be considered include: (1) evidence of the right to, or the exercise of, control; (2) the method of payment; (3) the furnishing of equipment by the employee; and (4) the right to fire at will, without liability. Castle Homes, Inc. v. Whaite, supra.

Right to Control

In April 1989 claimant was hired by Dan Mahaffey to drive a truck belonging to Max White Trucking. Mr. White was out of town and unaware of Mr. Mahaffey's actions. However, White and Mahaffey are business "partners" in a brokerage company called "Trails Transport" and Mahaffey is employed by White as a dispatcher. Although Max White did not expressly approve the hiring of claimant, he received telephone notification of the hire prior to the accident and he did not then terminate the employment arrangement.

Shortly after he was hired, claimant drove a truck load of produce to Bakersfield, California for Max White. In Bakersfield he had a four-day layover while waiting for instructions and another load. Claimant's next trip was from

Bakersfield to Reno. Dan Mahaffey made the arrangements for this second trip and instructed claimant to either contact him or a Chris Farley for his next assignment. Mr. Farley told claimant his next load would come out of either Salinas or Bakersfield, California. On April 20, 1989, claimant went to Merced, California, which is centrally located between these two cities to await his next assignment.

Claimant spent the afternoon of April 20, 1989 at a Merced pool hall. He made several calls during the day to Dan Mahaffey, who performs the duties of "dispatcher" for Max White, and Mr. Farley, who is a produce buyer doing business with the company. The purpose for these contacts was to receive work orders from Max White Trucking.

Given that claimant was hired by a partner and employee of Max White and he received all of his orders from this "partner," we conclude that Max White Trucking exercised control over claimant's work.

Method of Payment

After driving Max White's truck for about a week, claimant received one check from Mr. White. Claimant was paid under the terms negotiated with Mr. Mahaffey. Claimant received 20 percent of the profit from the haul. Mr. White also sent money to claimant for the purpose of making the trip home after the accident. The employer acknowledges that he made these payments but asserts that he did not "approve" claimant being hired by Dan Mahaffey and that he was only trying to do the right thing. This method of remuneration is more characteristic of an independent contractor relationship, than an employer-employee arrangement.

Furnishing Equipment

Unlike an independent trucker, claimant did not furnish his own truck. He was driving a truck owned, licensed, and insured by Max White and one that had been parked at the Max White Trucking yard. When the employer furnishes valuable equipment, the relationship is invariably that of employment because under those circumstances "the right of control is a matter of common sense." 1C Larson, Worker's Compensation Law, Sec. 44.34(a)(b) (1986). We conclude that the employer's furnishing of the equipment necessary to perform claimant's job, indicates that he had the status of an employee.

Right to Fire at Will

The record is sparce as to the employer's right to "fire" claimant. However, Max White testified that once he learned that claimant was moving produce for him and was waiting in Reno, Nevada for his next assignment, he ordered Dan Mahaffey to have claimant bring the truck back home and park it in the yard. This would indicate that, once claimant returned the company truck, Max White intended to sever the employment arrangement. There is nothing in the record that suggests there was a contractual arrangement between Mr. White and claimant that would result in liability if Max White terminated their "arrangement."

Considering the above-mentioned elements of control, we conclude that Max White Trucking had the right to, and did, exercise control over claimant's work. Although Max White did not personally hire claimant or make his hauling assignments, a business "partner" or "employee" of his company did hold himself out as having the authority to take these actions. An agency may be implied from the attending circumstances and the apparent relations and conduct of the parties. See Durham v. Warnberg, 62 Or App 378, 382 (1983). Once the employer learned of the employment arrangement, rather than terminating it immediately, he ordered

claimant, through Mr. Mahaffey, to drive the truck from Reno back to Portland. Minimally, the employer acquiesced to or ratified the unauthorized employment arrangement pending return of his truck. Yarbrough v. The Oregon Bank, 64 Or App 370, 375 (1983) (A principal can ratify after the fact any act he could but did not authorize before the fact).

We conclude that the record as a whole supports the Referee's determination that claimant was a subject employee of Max White Trucking.

ORDER

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

February 19, 1991 Cite as 43 Van Natta 335 (1991)

In the Matter of the Compensation of
EDGAR C. SIXBERRY, Claimant
WCB Case No. C1-00012
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Francesconi & Associates, Claimant Attorneys
Roy Miller (Saif), Defense Attorney

On January 7, 1991, the Board received the parties' revised claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

Previously on December 31, 1990, the Board issued an Order Disapproving Claim Disposition Agreement because the agreement attempted to impermissibly resolve issues pertaining to denied conditions. On motion for reconsideration, claimant has submitted a revised claim disposition agreement. We note that the revised agreement excises the references to the denied conditions. And that further claimant's counsel and counsel for SAIF Corporation have agreed to these deletions.

However, we further note that although the Director's representative was a signatory on the original agreement, the Director or his representative has not been made a party to the revised claim disposition agreement. The attached letter from Compliance dated November 16, 1990 offered by claimant's counsel is not incorporated in the revision. Furthermore, this letter is dated prior to our disapproval order.

In addition, we note that the agreement states that approval of this claim disposition agreement is a condition precedent to the settlement of the claim, and that absent such approval the settlement is void. ORS 656.236(6) provides that any claim in which the parties enter into a claim disposition agreement shall not be eligible for reimbursement from the Handicapped Workers Reserve without the approval of the director. Therefore, we conclude that the Director was an essential party to the agreement, and that lacking his approval the revised claim disposition agreement is not an enforceable contract.

Under these circumstances, the proposed disposition is unreasonable as a matter of law. See OAR 438-09-020(2). Accordingly, we decline to approve the agreement and return it to the parties.

Inasmuch as the proposed disposition has been disapproved, the SAIF Corporation shall recommence payment of temporary or permanent disability that was

stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

February 20, 1991 Cite as 43 Van Natta 336 (1991)

In the Matter of the Compensation of
MAGDALENO BOTELLO, Claimant
WCB Case No. 89-19947
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Pamela Schultz, Defense Attorney

Reviewed by Board Members Cushing and Myers.

The insurer requests review of that portion of Referee T. Lavere Johnson's order that: (1) set aside its denial of claimant's occupational disease claim for an umbilical hernia; and (2) directed the insurer to accept claimant's surgery to repair the umbilical condition. On review, the issues are compensability and medical services. We affirm in part and reverse in part.

FINDINGS OF FACT

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

Claimant's work activities were a material contributing cause of claimant's umbilical hernia.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions of Law and Opinion" which found that claimant's work activities in July 1989 were a material contributing cause of his umbilical hernia. We make the following comment.

The Referee ordered that claimant's claim for an umbilical hernia, including the recommended surgery to correct the condition, be remanded to the insurer for acceptance as a compensable claim.

The insurer essentially contends that the Referee erred in finding that the proposed surgical repair of claimant's umbilical hernia was compensable, arguing that compensability of medical treatment was not at issue at the hearing and that the Referee exceeded his authority in ordering the surgery be accepted. We agree.

Claimant requested a hearing concerning the denial of his umbilical hernia. The denial did not address the compensability of medical services associated with the hernia condition. In fact, the Referee did not specifically address the issue of the compensability of medical services associated with the hernia. He merely directed, in the "Order" portion of his Opinion and Order, that the recommended surgery to correct claimant's hernia be remanded to the insurer for acceptance, in addition to the claim for the hernia condition itself.

Since the denial addressed only the compensability of the condition itself, we find that the only issue before the Referee was the compensability of the hernia condition. Consequently, we affirm the Referee's order insofar as it set aside the insurer's denial of claimant's umbilical hernia condition. However, that portion of the order which remands the recommendation of surgery to the insurer for acceptance should be vacated.

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 occupational disease issue is $1,200, 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 May 21, 1990 is affirmed in part and reversed in part. That portion of the order that remands to the insurer the claim for recommended surgery for acceptance is vacated. The remainder of the order is affirmed. For services on Board review concerning the issue of compensability of the occupational disease, claimant's attorney is awarded a reasonable assessed fee of $1,200, payable by the insurer.

In the Matter of the Compensation of
DOUGLAS P. EVANS, Claimant
WCB Case No. 89-24783
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Quillinan's order that affirmed a Notice of Closure award of 12 percent (38.4 degrees) unscheduled permanent disability for a low back injury. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant regularly worked for the employer as a sander operator, a position that involved little physical exertion. He was not performing that job when he was injured, however. Due to a curtailment of operations, he was temporarily working on the spreader crew. That work required rapid and repetitive motion of the arms, twisting and bending, and lifting in excess of 20 pounds. Following surgery, claimant returned to work as a sander operator.

The Referee found that claimant had returned to his usual and customary job and, consequently, did not rate claimant's age, education and adaptability in determining his permanent disability under the appropriate standards. See former OAR 436-35-290(2)(a), 436-35-300(2)(a) and 436-35-310(2)(a). On review, claimant contends that he is entitled to ratings under those categories, because he returned to modified work. We agree.

"Usual and customary work," as defined in the standards for rating unscheduled permanent disability, means the job held at the time of injury. Former OAR 436-35-270(3)(a). "Modified work" means some job other than the job held at the time of injury, or the job held at the time of injury with any modification of duties or the conditions under which those duties are performed. Former OAR 436-35-270(3)(b). Although claimant regularly worked as a sander, the job he held at the time of injury was that as a spreader operator. See Carol Tuggle, 42 Van Natta 2729 (1990). Thus, by returning to work as a sander, claimant returned to a modified job, that is, a job other than the job held at the time of injury. Consequently, claimant is entitled to ratings under his age, education and adaptability.

The parties have stipulated that claimant's total age/education factor is 5. Consequently, we adopt that value and discuss only claimant's adaptability.

The adaptability value for a claimant 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.

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

When claimant's age/education value of 5 is multiplied by claimant's adaptability value 3, the product is 15. When that value is added to claimant's impairment value 12, the result is 27 percent unscheduled permanent partial disability. Former OAR 436-35-280(7).

ORDER

The Referee's order dated April 18, 1990 is modified. In addition to claimant's prior award, claimant is awarded 15 percent (48 degrees) unscheduled permanent disability, giving him a total award to date of 27 percent (86.4 percent) unscheduled permanent disability for a low back injury. 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.

In the Matter of the Compensation of
THERESA J. LESTER (Deceased), Claimant
WCB Case No. TP-90061
THIRD PARTY DISTRIBUTION ORDER
Goldberg & Mechanic, Claimant Attorneys
Nelson, et al., Defense Attorneys

Jill E. Golden, the personal representative of the deceased worker's estate, (hereafter referred to as "claimant"), has petitioned the Board for resolution of a dispute concerning the "just and proper" distribution of proceeds from a third party settlement. ORS 656.593(3). Specifically, the dispute concerns whether Liberty Northwest Insurance Corporation, as paying agency, is entitled to recover its lien for claim costs attributable to survivor benefits for the decedent's surviving spouse from the decedent's minor children's equal shares of the third party settlement, or whether Liberty Northwest may only recover from the children's shares its liens for claim costs attributable to each child's respective survivor benefits.

We conclude that Liberty Northwest's lien for claim costs related to each specific beneficiary is only recoverable from that particular beneficiary's share of the third party recovery. We further hold that, as of December 1, 1990, the present value of Liberty Northwest's reasonably to be expected future expenditures for the minor children are $13,903 for Sarah Lester and $12,929 for Jeromy Lester.

FINDINGS OF FACT

In July 1988 the deceased worker died when, while working as a highway flagger for an asphalt paving company, she was struck by a truck. Decedent was survived by her estranged husband, William, and their two minor children, Jeromy and Sarah. Jill E. Golden ("claimant"), a probate attorney with 15 years of experience, was appointed personal representative of the decedent's estate. Prior to her appointment, claimant had never met any member of the decedent's family or any member of the decedent's estate's law firm.

Liberty Northwest accepted the claim. It has continued to provide compensation to the surviving spouse and minor children. The surviving spouse is receiving a monthly payment of $806.84. The children are receiving monthly survivor's benefits of $150 each.

Claimant initiated a wrongful death action against the truck driver. The third party insurer offered $300,000 to settle the action. Liberty Northwest did not object to the amount of the settlement. However, it contended that its "third party" lien applied to the total amount of the settlement, rather than to each particular beneficiary's share.

Claimant petitioned the Lane County Probate Court for distribution of the settlement proceeds to the heirs of the estate.
A hearing was held before Circuit Court Judge Allen. Claimant, the decedent's husband, and Liberty Northwest appeared at the hearing.

At the hearing, claimant presented evidence in support of her position that the settlement proceeds should be equally apportioned between the two minor children with the decedent's estranged husband receiving nothing. This evidence included testimony from claimant and the decedent's husband.

Claimant testified that she had investigated the relationship between the decedent, her husband, and their children. This study involved interviews with surviving family members, coworkers, friends, the children's babysitter, teachers, and a mental health counselor. Claimant's investigation revealed that the Lesters had not been living together for approximately one year at the time of decedent's death. Furthermore, two separate dissolution of marriage proceedings had been filed, the most recent of which had been dismissed a few months before the decedent's death for lack of prosecution. Although intimidated and fearful, the decedent had intended to proceed with the divorce at the time of her death.

Prior to the decedent's death, the children had solely resided with her. Their relationship was excellent, with the decedent actively participating in such social functions as the Girl Scouts and serving as a coach for athletic teams. The loss experienced by the children from the death of their mother was considered to be profound.

Based on her investigation, claimant concluded that the following distribution of wrongful death settlement proceeds would be reasonable and appropriate. After deductions for litigation expenses and attorney fees, the two minor children should share equally in the remaining balance of proceeds with the decedent's husband receiving nothing. The decedent's husband agreed that such a

distribution would be proper because "they suffered the most damages by losing their mother."

Judge Allen granted claimant's request for the proposed distribution and signed an order to that effect. The order further provided that Liberty Northwest would retain "whatever rights it possesses under Oregon law to assert a statutory lien against the distribution to Jeromy Lester and Sarah Lester."

As of December 1, 1990, Liberty Northwest projects the present value of its future indemnity costs for the surviving spouse and children to be as follows: (1) $113,186 for William; (2) $14,616 for Sarah; and (3) $13,445 for Jeromy. This conclusory projection was offered by means of an unsworn affidavit from Mr. Carlson, the supervisor of Liberty Northwest's statistical department. These calculations were made by using a "discount factor of 7 percent."

At claimant's counsel's request, Mr. Meligan, President of "Settlement Professionals, Inc.," calculated the cost of an annuity contract which would provide the remainder of the children's statutory benefits beginning December 1, 1990. After explaining his calculations, Meligan persuasively described how annuity contracts could be purchased at a cost of $13,903 for Sarah Lester and $12,929 for Jeromy Lester.

The present value for Liberty Northwest's reasonably to be expected future claim costs, as of December 1, 1990, are $13,903 for Sarah Lester and $12,929 for Jeromy Lester.

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, or if death results from the injury, the other beneficiaries, 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 or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593(1). "Beneficiary" means an injured worker, and the husband, wife, child or dependent of a worker, who is entitled to receive payments under Chapter 656. ORS 656.005(2).

Here, the decedent's husband and her two minor children are beneficiaries under the workers' compensation statutes. ORS 656.005(2). Thus, they are entitled to receive workers' compensation benefits as a result of the decedent's death and their respective shares of the third party settlement proceeds are subject to Liberty Northwest's statutory lien. Scarino v. SAIF, 91 Or App 350, 355, rev den 306 Or 660 (1988).

Liberty Northwest has approved of the settlement of the wrongful death action for $300,000. However, it contends that it has only one lien, composed of actual and projected claim costs for the surviving spouse and minor children. Based on such reasoning, Liberty Northwest argues that it can recover its lien from each beneficiary's respective share of the settlement without regard to the claim costs for that particular beneficiary. Specifically, Liberty Northwest asserts that it is entitled to recover claim costs solely attributable to the surviving spouse from the minor children's shares of the third party settlement. We disagree.

To begin, Liberty Northwest's position can be interpreted as a contention that the proposed distribution of settlement proceeds would not be just and proper. As we recently stated in Neil C. Duclos, 43 Van Natta 28 (1991), we judge each case on its own set of circumstances when determining a just and proper distribution pursuant to ORS 656.593(3).

As set forth in the transcript of hearing before Judge Allen, and as persuasively supported by reports from and interviews conducted with family members, coworkers, mental health counselors, and the children's babysitter, a distribution of settlement proceeds in equal portions to the two minor children with the surviving spouse receiving nothing represents an appropriate and reasonable apportionment commensurate with their respective financial and emotional losses resulting from the decedent's death. In addition to this evidence, we are further persuaded by the sworn affidavit from Mr. Chadsey, the third party's lead attorney. Considering the couple's extensive history of marital discord and estrangement, as well as the decedent's active plans to obtain a divorce, Chadsey opined that any jury determination of damages resulting from the decedent's death would have been limited to the loss suffered by the two minor children and not to the surviving husband.

Other than Liberty Northwest's unsubstantiated suggestion that this settlement disbursement is designed to avoid its lien for claim costs attributable to the surviving spouse, there is no basis for believing that any "gamesmanship" has occurred in this proposed allocation. We further note that this proposed distribution has previously received contingent approval by the Probate Court. Under such circumstances, we find no grounds to disturb a proposed distribution of settlement proceeds conducted in accordance with the personal representative's statutory obligations. See ORS 30.030(4), 30.040; Scarino v. SAIF, supra, at page 355, n. 2; Neil C. Duclos, supra.

Furthermore, since the claim costs for each specific beneficiary can be identified, we consider it just and proper that the lien for each beneficiary be recovered solely from the corresponding beneficiary's share of the third party settlement. See ORS 656.593(3). To do otherwise would permit the paying agency to receive reimbursement for claim expenditures related to a particular beneficiary (surviving spouse) from other beneficiaries' (children) portions of a third party settlement. Since those other beneficiaries have not and will not realize any benefits from those claim costs, we would not consider such a proposed distribution to be just and proper.

Consequently, because decedent's husband has received no share of the settlement, Liberty Northwest will receive no reimbursement for its claim costs attributable to his survivor's benefits. However, Liberty Northwest is entitled to recover from the minor children's shares of the settlement its actual and projected claim costs for each particular child.

We turn to a determination of the amount of Liberty Northwest's lien for each specific child. Pursuant to ORS 656.593(1)(c), the paying agency is entitled to recover 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.

Claimant submitted a report from Mr. Meligan, President of "Settlement Professionals, Inc." At claimant's counsel's request, Meligan was asked to determine the cost of an annuity contract which, commencing December 1, 1990, would pay the balance of the children's statutorily required benefits. After conducting his calculations, Meligan concluded that such annuities would cost $13,903 for Sarah Lester and $12,929 for Jeromy Lester. Meligan further explained that such annuities were available to the paying agency "through their Structured Settlement Consultants from Confederation Life Insurance Company, an A.M. Best & Co. rated A+ "X" carrier."

In response, Liberty Northwest presented an "Indemnity Reserve Worksheet" from Mr. Carlson, the supervisor of its statistical department. By means of an

unsworn affidavit, Carlson states that, as of December 1, 1990, the present value of anticipated indemnity costs for Sarah Lester and Jeromy Lester are $14,616 and $13,445 respectively. These figures were arrived at by using a "discount factor of 7 percent." No explanation is provided as to why such a factor was applied nor does Liberty Northwest reply to the representations offered by Mr. Meligan concerning the purchase of annuity contracts.

We find the opinion of Mr. Meligan to be more persuasive than that of Mr. Carlson. In contrast to the conclusory statements from Liberty Northwest's statistician, Meligan provided a detailed explanation for purchasing annuity contracts which would pay the minor children their statutory benefits. Rather than contest the conclusions offered by this settlement professional regarding the cost of annuity contracts, Liberty Northwest submitted a worksheet from its statistician stating, without explanation, that the present value of its anticipated claim costs for the children was calculated using a discount factor of 7 percent. Under such circumstances, we find that the present values of Liberty Northwest's future claim costs for the children as of December 1, 1990 are as represented by Mr. Meligan.

Consequently, we conclude that, in addition to its actual claim costs incurred prior to December 1, 1990 concerning the minor children's benefits, Liberty Northwest is entitled to recover as its present value of reasonably to be expected future expenditures as of December 1, 1990 the following amounts. $13,903 from Sarah Lester's share of the settlement proceeds and $12,929 from Jeromy Lester's share of the settlement proceeds.

Finally, claimant seeks the award of an attorney fee pursuant to ORS 656.382(1) for Liberty Northwest's "unreasonable behavior." 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). Consequently, we lack authority to grant claimant's request.

Accordingly, we hold that Liberty Northwest is entitled to recover its lien for the minor children's benefits from the respective child's share of the third party settlement. Specifically, Liberty Northwest shall recover its actual claim costs incurred as of December 1, 1990 from each child's share of the settlement, plus $13,903 from Sarah Lester's share and $12,929 from Jeromy Lester's share. Therefore, claimant is directed to distribute to Liberty Northwest the aforementioned amounts from the minor children's shares of the settlement, which we find to be a just and proper distribution of the third party settlement. See ORS 656.593(3).

IT IS SO ORDERED.

February 20, 1991 Cite as 43 Van Natta 342 (1991)

In the Matter of the Compensation of
JOYCE M. RAMIREZ-JONES, Claimant
WCB Case No. 89-02293
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The insurer requests review of Referee Bennett's order that increased claimant's unscheduled permanent disability award for a low back injury from 29

percent (92.8 degrees), as awarded by a Determination Order, to 62 percent (198.4 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

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.

Here, because claimant's claim was closed by an August 23, 1989 Determination Order, the "standards" adopted effective January 1, 1989, former OAR 436-35-010 et seq, apply to the rating of claimant's permanent disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent disability.

The determination of unscheduled permanent partial disability 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 insurer does not dispute the values assigned by the Referee for claimant's age, education and impairment. We adopt the Referee's opinion and conclusion regarding those values and address only the issue of adaptability.

Adaptability

The adaptability value for a worker who has either returned to modified work or received a work offer is determined from a matrix of values at former OAR 436-35-310(3). That matrix compares the physical capacity of the worker's usual and customary work with the physical capacity required by the modified work. On the other hand, the adaptability value for a worker who is not working as a result of the compensable injury/condition is determined by the worker's residual physical capacity, without regard to that worker's physical capacity prior to the injury. Former OAR 436-35-310(4).

Although claimant returned to modified work as a seasonal employee, the Referee found the latter provision appropriate because claimant had not received an offer of "continuing" employment. He evidently believed that post-injury work that becomes unavailable prior to hearing is irrelevant to a determination of a worker's compensable disability. We disagree.

Unscheduled permanent disability benefits are awarded for loss of earning capacity, defined as the ability to obtain and hold gainful employment, caused by the compensable injury. ORS 656.214(5). Therefore, a worker's ability to hold a job following an injury does not lose its relevance simply because it is unavailable at the time of hearing. To the contrary, the ability to perform such work provides a valued measure of claimant's residual capabilities and

earning capacity. Therefore, we conclude that claimant's adaptability is properly determined under former OAR 436-35-310(3).

Claimant's usual and customary work required the physical capacity to do heavy work. Claimant's modified work required a sedentary physical capacity. Therefore, the appropriate adaptability value is 3. Former OAR 436-35-310(3)(a).

Computation of Unscheduled Permanent Partial 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 3, the sum is 4. When that value is multiplied by claimant's adaptability value 3, the product is 12. When that value is added to claimant's impairment value 22, the result is 34 percent unscheduled permanent partial disability. Former OAR 436-35-280(7).

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 (1987).

After our de novo review of the record, we conclude that neither party has established that the degree of disability suffered by claimant is more or less than the entitlement indicated by the standards. Consequently, we decline to modify claimant's award from that indicated above.

ORDER

The Referee's order dated May 14, 1990 is modified. In lieu of the Referee's increased award of unscheduled permanent disability, claimant is awarded 5 percent (16 degrees) unscheduled permanent partial disability in addition to the 29 percent (92.8 degrees) awarded by a Determination Order, for a total award of 34 percent (108.8 degrees). Claimant's attorney fee shall be adjusted accordingly.

February 20, 1991 Cite as 43 Van Natta 344 (1991)

In the Matter of the Compensation of
VINCENT B. SWEENEY, Claimant
WCB Case No. 90-09754
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
David J. Lillig (Saif), Defense Attorney

Reviewed by Board Members Cushing and Myers.

The SAIF Corporation requests review of Referee Hoguet's order that: (1) increased claimant's unscheduled permanent disability award for a low back injury from 17 percent (54.4 degrees), as awarded by a Notice of Closure, to 25 percent (80 degrees); (2) directed it to fully comply with an unappealed July 28, 1989 Determination Order, which awarded 36 percent (115.2 degrees) unscheduled permanent disability; and (3) assessed a penalty and related attorney fee for its allegedly unreasonable claims processing. On review, the issues are unscheduled permanent partial disability, claims processing and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claims Processing

We adopt the conclusions and reasoning concerning SAIF's processing of claimant's claim as set forth in the Referee's order with the following comment.

We agree with SAIF that, if an injured worker enters an authorized training program after a Determination Order has issued, the insurer must suspend permanent disability payments and replace them with temporary disability payments. ORS 656.268(5). We also agree that, if the worker has returned to regular employment, the insurer may reevaluate and close the claim without the issuance of a Determination Order. See ORS 656.268(5); OAR 436-60-040(6).

However, we do not agree with SAIF that, because it had the right to reevaluate and close the claim at the end of claimant's formal training program, the July 28, 1989 Determination Order, in effect, became null and void and it is only required to pay claimant the permanent disability awarded under its April 30, 1990 Notice of Closure. The option of reevaluating and closing the claim by notice of closure is an alternative to resubmitting the claim for determination under ORS 656.268(4), which provides for the determination of any further compensation owed, including permanent disability. See ORS 656.268(5). It is not an alternative to resuming the payment of the suspended award. Thus, given the fact that the original determination had become final by operation of law, the Referee correctly found that SAIF was required to resume the suspended payments owed thereunder.

Unscheduled Permanent Disability

With regard to the extent of claimant's permanent disability, we note that, although SAIF had authority to rate claimant's permanent disability at the time it issued the April 30, 1990 Notice of Closure, it did not have authority to reduce the previous award of 36 percent. As mentioned above, that award had become final by operation of law. Thus, SAIF's Notice of Closure, in effect, simply declined to award permanent disability beyond the amount claimant had previously been awarded.

Because claimant sought no increase beyond 36 percent, we find the Referee's analysis and increase of the extent of permanent disability has been rendered moot. See Kevin Hoffman, 42 Van Natta 2117 (1990). Consequently, we reverse the Referee's increased award of 8 percent unscheduled permanent partial disability and related attorney fee.

Penalty and Attorney Fee

We adopt the conclusions and reasoning concerning the penalty and attorney fee for SAIF's allegedly unreasonable claims processing as set forth in the Referee's order.

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 extent of unscheduled permanent partial disability and claims processing issues is $1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues,

and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for defending on the penalty and attorney fee issue. Saxton v. SAIF, 80 Or App 631 (1987); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated August 2, 1990 is affirmed in part and reversed in part. The Referee's increased award of 8 percent unscheduled permanent partial disability and related attorney fee are reversed. For services on Board review, claimant's attorney is awarded $1,000, to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
ALFRED P. WALTER, Claimant
WCB Case No. 89-11695
ORDER ON REVIEW
Lon N. Bryant, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Myers, Cushing and Crider.

The self-insured employer requests review of Referee Craine's order that: (1) set aside its denial of claimant's occupational disease claim for a myocardial infarction; and (2) awarded claimant an assessed attorney fee of $9,286.64. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

Claimant experienced chest pain in 1987. Subsequent test results were normal.

Claimant was an insurance salesman for the employer. On March 18, 1989, he suffered a myocardial infarction. There was no work-related incident which preceded the myocardial infarction.

Claimant was under considerable stress brought on by work activities.

CONCLUSIONS OF LAW AND OPINION

Persuaded by the opinion of claimant's treating physician, the Referee found that chronic stress stemming from work activities was the major contributing cause of claimant's myocardial infarction. Without reaching a conclusion concerning the effect of stress on claimant's myocardial infarction, we reverse.

Claimant argued that his condition was compensable as an occupational disease under former 656.802(1). Because claimant's last exposure to working conditions involving stress was March 17, 1989, his claim is analyzed under the occupational disease law which became effective January 1, 1988. See Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240; Philip V. Berning, 42 Van Natta 1193 (1990); Donna E. Aschbacher, 41 Van Natta 1242 (1989).

Claimant argued that his myocardial infarction was caused by a series of stressful work events and should be compensable as an occupational disease.

We have recently, held that "traumatic" as used in former 656.802(1)(c) refers only to physical trauma, not psychological trauma. See Ronald V. Dickson, 42 Van Natta 1102 (1990); Philip V. Berning, supra. Accordingly, claimant's myocardial infarction is not compensable as having been caused by a series of traumatic events under former 656.802(1)(c).

Furthermore, claimant's disease did not result from exposure to substances included in former ORS 656.802(1)(a), and is therefore not compensable under that subsection. Id.

In addition, pursuant to former 656.802(1)(b) and (2), to establish an occupational disease, claimant must establish that: (1) he has a mental or emotional disorder which is generally recognized in the medical or psychological community; (2) the disorder required medical services or was disabling; (3) the mental disorder was due to employment conditions which were real and objective; (4) such employment conditions are not generally inherent in every working environment; and (5) the evidence is clear and convincing that the mental disorder arose out of and in the course of employment.

While there is evidence that claimant suffered from a compulsive personality disorder, there is no evidence linking the personality disorder to employment conditions. Moreover, there is no evidence that claimant's disorder contributed to the myocardial infarction. Therefore, claimant has not established a compensable occupational disease claim under former ORS 656.802(1)(b) and (2).

Finally, claimant's treating physician, Dr. Hedmann, opined that claimant was suffering from chronic stress related to his work activities. Hedmann concluded the job related stress was the major contributing cause of claimant's March 1988 myocardial infarction.

Claimant has only proven that he experienced stress due to his working conditions. "Stress," in and of itself, is not a condition which is generally recognized as a "mental disorder." See Ronald V. Dickson, supra; Sharon Schettler, 42 Van Natta 2540 (1990). Because the absence of a recognized mental or emotional disorder related to working conditions is determinative, we do not address the remaining elements for establishing a stress-related occupational disease.

Since we have determined that claimant's myocardial condition is not compensable, we need not address whether the Referee's attorney fee award to claimant was excessive.

ORDER

The Referee's order dated April 10, 1990 is reversed. The self-insured employer's denial is reinstated and upheld. The Referee's award of a $9,286.64 attorney fee is reversed.

Board Member Crider concurring:

Were I writing on a clean slate, I would have concluded that former ORS 656.802(1)(c), rather than (1)(b), governed compensability of physical conditions allegedly caused by chronic workplace stress. See Ronald V. Dickson, 42 Van Natta 1102, 1109 (dissenting opinion of Member Myers). And I would have affirmed the Referee's order which found the claim compensable. I am not writing on a clean slate. Therefore, there being no evidence that workplace stress caused a mental disorder which in turn caused the myocardial infarction, this result is compelled by the Board's decision in Ronald V. Dickson, 42 Van Natta 1102 (1990).

In the Matter of the Compensation of
RICHARD G. BAILEY, Claimant
WCB Case No. 89-17403
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Howell and Speer.

The self-insured employer requests review of those portions of Referee Livesley's order which: (1) increased claimant's scheduled permanent disability award from 60 percent (10.8 degrees) for claimant's left great toe and 7 percent (.28 degrees) for loss of each of claimant's four other toes of his left foot as awarded by Determination Order, to 19 percent (25.65 degrees) for loss of use or function of claimant's left foot in addition to 7 percent (.28 degrees) for each of claimant's second, third, fourth and fifth toes; and (2) awarded 6 percent (19.2 degrees) unscheduled permanent disability for claimant's psychological condition whereas the Determination Order awarded no disability for a psychological condition. On review, the issues are compensability and extent of scheduled and unscheduled permanent disability. We modify.

FINDINGS OF FACT

With the exception of the last sentences in the second paragraph on page two regarding the percentage of disability for claimant's psychiatric condition, we adopt the Referee's "Findings of Fact" with the following supplementation.

Claimant has suffered from Raynaud's disease since childhood. (Ex. 5-1). Raynaud's disease is a gangrene condition which follows a local inflammation. Physicians noted that claimant's toes were purple on November 12, 1988 and in May 1989. (Ex. 5-1, 6-3). Claimant's hypertension and Raynaud's phenomena are not related to his injury. (Ex. 8-1).

On November 30, 1988, claimant's range of ankle motion was limited. (Ex. 6-2). Claimant's ankle and foot, separate from his toes, were treated for residual problems stemming from the injury. (Ex. 6-5). Dr. Woolpert, orthopedist, examined claimant on May 27, 1989, noted discoloration and scarring at the base of claimant's toes on the dorsum, and further noted that Dr. Streitz released claimant to return to light duty work in March 1989, and found claimant medically stationary. (Ex. 6-2).

Dr. Streitz, orthopedist, treated claimant in the hospital and for awhile after claimant was discharged until claimant changed physicians and Dr. Sacks, internist, became his treating physician. (Tr. 18).

Dr. Sacks referred claimant to Dr. Middlekauff, psychiatrist, for the "psychological affect from his injury." (Ex. 13-1). Nine days after the accident, Dr. Middlekauff examined claimant, who was still hospitalized from the compensable toe injury. Dr. Middlekauff diagnosed adjustment disorder, depressed type. (Ex. 5A).

Claimant was found medically stationary on June 2, 1989 and his claim closed on August 23, 1989. (Ex. 10).

Claimant's foot swells up to his ankle chronically. (Tr. 23). Claimant has returned to his usual and customary work. (Tr. 33).

CONCLUSIONS OF LAW AND OPINION

Concluding that claimant sustained a chronic foot condition and a partial loss of plantar sensation as a result of his compensable injury, the Referee converted toe values under the "standards" to foot values, citing former OAR 436-35-180, and increased claimant's scheduled permanent disability over that awarded by the Determination Order. The self-insured employer argues that claimant has not sustained his burden to show a causal connection between the foot condition (as opposed to merely the toes) and his compensable injury. The employer argues that claimant's foot condition is related to claimant's pre-existing hypertension and Raynaud's phenomenon. Additionally, the employer argues that claimant is not entitled to an award of scheduled permanent disability in excess of that awarded by the Determination Order.

Compensability of Ankle/Foot Condition

Claimant bears the burden of proving by a preponderance of the evidence that an industrial injury materially contributed to the disability of his foot and ankle condition and his need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979). The compensable injury need not be the sole cause or most significant cause of the need for treatment, but only a material contributing cause. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987).

Claimant testified that his whole foot swells up to his ankle. Both Drs. Sacks and Woolpert specifically attribute the chronic swelling of claimant's foot and ankle to the November 11, 1988 injury. There is no contrary opinion. Claimant has met his burden to show that the swelling of his foot is compensably related to the November 11, 1988 industrial injury.

Extent of Scheduled Permanent Disability

For purposes of determining injury-related permanent 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(1).

Because claimant's claim was closed by Determination Order on August 23, 1989, we apply the "standards" effective that date in rating claimant's permanent disability. Former OAR 436-35-001 et seq. In the present case, former OAR 436-35-010 through 436-35-260 apply to the rating of claimant's scheduled permanent disability.

Disabilities in the toes are not converted to foot values, regardless of the number of toes involved, unless the foot is also impaired. Former OAR 436-35-130(3). Claimant testified that his foot chronically swells up to his ankle especially after standing on his feet at work. Drs. Sacks and Woolpert note that claimant's ankle and foot swell periodically and correlate the swelling condition to the toe condition. We conclude that claimant is entitled to 5 percent disability for loss of repetitive use of his left foot due to the chronic swelling. Former OAR 436-35-010(7).

The Referee concluded that claimant had also sustained partial loss of plantar sensation of his left foot. We disagree. There are no medical findings of loss of plantar sensation and claimant's testimony is vague regarding such a loss of sensation. Furthermore, Dr. Woolpert specifically notes that claimant told him that he did not have numbness or tingling. Accordingly, we conclude

that claimant has failed to prove entitlement to a value for loss of plantar sensation of the left foot.

Great Toe

The Referee found claimant was entitled to a value of 60 percent for his left great toe. We disagree.

Claimant has retained 10 degrees flexion in the interphalangeal joint of the great toe for a value of 30 percent loss of use. Former OAR 436-35-150(1). (Exs. 6-5, 9).

Claimant has retained 20 degrees plantar flexion in the metatarsophalangeal joint of the great toe for a value of 7 percent. Former OAR 436-35-150(5). (Exs. 6-5, 9).

The multiple impairments of claimant's great toe are combined, not added, for a total rating of 35 percent. Former OAR 436-35-150(7).

Second Through Fifth Toes

The Referee found that claimant was entitled to a value of 7 percent for each toe.

No rating is given for loss of motion in the distal interphalangeal joint of the second through fifth toes except in the case of ankylosis. Former OAR 436-35-160(1). There is no evidence claimant has sustained ankylosis of the DIP joint of his second through fifth toes of his left foot.

Each toe is rated individually. Former OAR 436-35-160(9)(a).

Claimant has retained 20 degree of plantar flexion in the metatarsophalangeal joints of the second through fifth toes of his left foot for a value of 7 percent for each toe. Former OAR 436-35-160(7). (Ex. 9).

Conversion of Toe Values to Foot Values

Each toe is converted to the foot separately and then the converted values are added. Former OAR 436-35-180(3).

Claimant has sustained a 35 percent loss of use of his great toe for a converted value of 6 percent loss of use or function of his left foot. Former OAR 436-35-180(2).

Claimant has sustained a 7 percent loss of use of each of his second through fifth toes for a converted foot value of .23 percent for each toe and a total of .92 percent loss of use or function of his left foot. Former OAR 436-35-180(3).

The total converted value from toes to foot is 6.92 percent which is combined with the 5 percent value for loss of repetitive use of claimant's left foot for a total of 11.6 percent. Former OAR 436-35-160(9)(b). This value is rounded up to the next whole number with the result that claimant is entitled to 12 percent permanent disability for loss of use or function of his left foot. Former OAR 436-35-010(6).

Extent of Disability Due to the Psychological Condition

Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled 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. Former OAR 436-35-280.

Because claimant has returned to his usual and customary work no value is given for adaptability. Former OAR 436-35-310(2)(a). Because the adaptability factor is a multiplier and the value in this case is 0, claimant's age and education are not factored in the "standards" calculations.

Former OAR 436-35-400(1) requires the psychological condition to be diagnosed by a psychiatrist or psychologist as a permanent condition. The self-insured employer argues that claimant's condition is not permanent. We disagree.

Claimant has sustained an injury-related psychological condition -- an adjustment disorder, depressed type. Claimant was medically stationary on August 23, 1989 and that fact is undisputed. "Medically stationary" means no that no further material improvement would reasonably be expected from medical treatment or the passage of time. After claimant became medically stationary, Dr. Middlekauff indicated that claimant had continuing psychological impairment. Furthermore, claimant has continued to receive psychological treatment since claim closure. Dr. Middlekauff hoped that at some indefinite time in the future claimant would not have any psychiatric impairment. We do not consider the doctor's hope inconsistent with a finding that claimant's psychological condition is permanent. We conclude from the record as a whole, that claimant's mental disability is permanent under former OAR 436-35-400.

Former OAR 436-35-400(4) allows an impairment value for a permanent state of mental disorder diagnosed by a psychiatrist or psychologist that causes a loss of function due to anxiety reactions and/or depressive reactions. Dr. Middlekauff stated that claimant's depression interferes with his job performance "at times" and rated claimant's disability in the 0-6 percent range. We conclude from Dr. Middlekauff's description of claimant's condition that claimant's condition falls into the class 1 range for a value of 3 percent unscheduled permanent partial disability. Former OAR 436-35-400(4)(a)(B).

ORDER

The Referee's order dated January 16, 1990 is modified. In lieu of the Referee's increased award of scheduled permanent disability and in lieu of the Determination Order's award of scheduled permanent disability, claimant is awarded 12 percent (16.2 degrees) scheduled permanent disability for loss of use or function of his left foot. In lieu of the Referee's award of unscheduled permanent disability, claimant is awarded 3 percent (9.6 degrees) for claimant's psychological condition. Claimant's attorney fee is adjusted accordingly.

In the Matter of the Compensation of
EDWIN L. CARSON, Claimant
WCB Case No. 89-08904
ORDER OF ABATEMENT
David Schieber (Saif), Defense Attorney

The Board has received the SAIF Corporation's Motion for Abatement and Reconsideration of our Order on Review dated January 23, 1991.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and withdrawn. Claimant is requested to file a response to the motion within ten days from the date of this order. Thereafter, this matter will be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
NOLA M. CHRESTENSEN, Claimant
WCB Case No. 89-21448
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Myzak's order that upheld the insurer's partial denial of claimant's current low back condition. On review, the issues are the procedural propriety of the denial, compensability and penalties and related attorney fees. We affirm.

FINDINGS OF FACT

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

Claimant felt a pull in her lower back while lifting boxes at work on November 21, 1988. Her claim for a nondisabling low back strain was accepted on December 27, 1988. (Ex. 3).

Post-injury x-rays revealed early degenerative changes in the facets at L4-5, as well as minimal osteophytic changes at L3-4. (Ex. 5).

In August 1989, claimant fell in her yard and experienced an acute onset of pain in her left leg. (Tr. 8).

On October 19, 1989, the insurer issued a partial denial of claimant's lumbar canal stenosis at L3-4-5 and associated anterolisthesis of L4 on L5 with cauda equina compression. The denial stated that claimant's current need for treatment for these conditions was not related to her accepted lumbar strain, nor to her work activities for the insured. (Ex. 16).

Claimant had occasional minor back problems prior to her industrial injury. (Ex. 8-2, Tr. 9, 13, 14). She has diabetes.

Claimant's stenosis at L3-4-5 and anterolisthesis of L4 on L5 are separable from her compensable low back strain.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Opinion and Conclusions of Law" on the merits, with the following comment regarding the procedural propriety of the denial.

Claimant did not object to the denial on procedural grounds at hearing. On review, she argues that the insurer improperly denied the accepted condition while the claim was still open. The insurer responds that it accepted only the injury, not claimant's preexisting condition, and that claimant's accepted lumbar strain did not worsen her preexisting degenerative disease. We agree with the insurer.

We are reluctant to consider the newly-raised preclosure denial issue, because compensability was fully litigated at hearing. However, the Court of Appeals has held that a partial denial of a previously accepted inseparable condition may not issue while the claim is still open. Guerrero v. Stayton Canning Co., 92 Or App 209, 212 (1988). Although the Supreme Court's holding in Boise Cascade Corp. v. Katzenbach, 307 Or 391, 394 (1989), casts doubt on the continued validity of the Guerrero doctrine, we consider claimant's argument.

An insurer may not deny further responsibility for any condition arising from the accepted claim while the claim is in open status and before the extent of the accepted condition has been determined pursuant to the statutory procedures for claim closure. Roller v. Weyerhaeuser Co., 67 Or App 583, amplified 68 Or App 743, rev den 297 Or 601 (1984); Safstrom v. Riedel International, Inc., 65 Or App 728 (1983). However, the Supreme Court's holding in Katzenbach, supra, indicates that a preclosure partial denial is procedurally permissible where no one "authorized to do so" has found the worker's two conditions to be inseparable. Katzenbach at 394.

In this case, we are persuaded by the well-reasoned opinion of Dr. Zivin, neurologist. After reviewing claimant's x-rays and treatment records, Zivin considered a variety of potential causes for claimant's current need for treatment, including diabetes-related neuropathy and impaired balance, vascular claudication, degenerative disc disease and the 1988 injury. He concluded that the injury affected claimant's back muscles, but not her spine. (Ex. 21-8-9).

Zivin also opined that claimant's diffuse hyperreflexia -- loss of reflexes in the legs and pattern of sensory impairment at the feet and lower legs -- is probably attributable to peripheral neuropathy caused by her diabetes. (Ex. 18-8). In addition, he concluded that claimant's fall at home was likely due to a combination of her degenerative disc disease and impaired proprioceptive (balancing) functions, again related to her diabetes rather than the work injury. (Id.) In this regard, he noted that claimant manifests symptoms which indicate that her balancing abilities are impaired due to her diabetes. (Ex. 21-25-26).

Zivin also opined that claimant's symptoms suggesting claudication of the cauda equina -- where pain and numbness of the legs develops with walking -- are not necessarily caused by nerve root compression. Noting that symptoms of vascular claudication are very similar to those of claudication of cauda equina, Zivin was unwilling to attribute claimant's symptoms to her injury, rather than to vascular insufficiency.

Zivin's well-reasoned opinion is based on a thorough review of claimant's history and clearly analyzes claimant's various conditions separately. Inasmuch as no other medical opinion considers the multiple potential causes for claimant's current symptoms, we are persuaded by Zivin's expert analysis. We conclude that claimant's current condition is separable from, and unrelated to, her

accepted lumbar strain. Therefore, the insurer's denial was both procedurally and substantively proper.

ORDER

The Referee's order dated April 2, 1990 is affirmed.

February 21, 1991 Cite as 43 Van Natta 354 (1991)

In the Matter of the Compensation of
JUDITH A. GAIDOSH, Claimant
WCB Case Nos. 89-24097 & 89-20149
ORDER ON REVIEW
Parker & Bush, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Knapp's order that upheld the insurer's denial of medical services related to her current neck and upper back condition. On review, the issue is medical services. 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 exception of the Referee's conclusion pertaining to a required showing of progress in order for chiropractic services to be reasonable and necessary. We agree that a showing of progress or evidence that the services enabled claimant to return to work (see e.g. West v. SAIF, 74 Or App 317, 321 (1985)) goes to the weight of whether or not such services are reasonable and necessary. However, evidence of progress is not required in every case in order for chiropractic care to be compensable.

ORDER

The Referee's order dated March 5, 1990 is affirmed.

February 21, 1991 Cite as 43 Van Natta 354 (1991)

In the Matter of the Compensation of
ASHANTI HUSAIN, Claimant
WCB Case No. 88-21312
ORDER ON RECONSIDERATION
Hollander & Lebenbaum, Claimant Attorneys
Roy Miller (Saif), Defense Attorney

On December 12, 1990 we issued an Order of Abatement stating that we had decided to reconsider our Order on Review dated November 14, 1990. In our initial order, we reversed Referee Tenenbaum's order setting aside the April 19, 1988 Determination Order as premature, and we reinstated and modified the Determination Order to award 10 percent (15 degrees) scheduled permanent disability for loss of use or function of the left forearm/wrist.

It has now come to our attention that, pursuant to Referee Tenenbaum's order, the claim was reclosed and a hearing held on that closure before Referee Schultz. In an opinion issued November 13, 1989, Referee Schultz awarded 5 percent scheduled permanent disability for loss of use or function of claimant's left forearm/wrist.

On reconsideration, the SAIF Corporation contends that claimant's award should be offset by the 5 percent scheduled permanent partial disability awarded by Referee Schultz. We agree.

Referee Schultz rated claimant's permanent disability as it existed in November 1989, after the claim had been reclosed subsequent to Referee Tenenbaum's order which set aside the April 1988 Determination Order. Since our November 14, 1990 order reinstates the April 1988 Determination Order, Referee Schultz's order and permanent disability award become a nullity and are of no effect. Thus, our order represents the total award for this claim.

Claimant is, therefore, awarded a total of 10 percent scheduled permanent disability for loss of use or function of the left forearm. SAIF may offset permanent partial disability previously paid under Referee Schultz's order against the compensation awarded under this order. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, without regard to the offset. See OAR 439-15-055; 438-15-085.

Accordingly, on reconsideration, as amended herein, we adhere to and republish our November 14, 1990 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

February 21, 1991 Cite as 43 Van Natta 355 (1991)

In the Matter of the Compensation of
ANITA F. SALTMARSH, Claimant
WCB Case No. 89-23267
ORDER ON REVIEW
Black, Chapman & Webber, Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Mongrain's order that affirmed a Determination Order award of 5 percent (16 degrees) unscheduled permanent disability for a low back injury. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

Claimant's highest specific vocational preparation (SVP) value during the ten years preceding the date of hearing was a 6, for working as a secretary/receptionist. She has a degree in accounting from Trend Business College. Claimant has demonstrated competence in a specific vocational pursuit.

Claimant is not working as a result of her injury. She is capable of performing light work. She suffers from permanent loss of lumbar range of motion

and from a chronic condition which limits repetitive use of her back. These limitations are due to her compensable injury.

CONCLUSIONS OF LAW AND OPINION

We adopt that portion of the Referee's "Opinion", as set forth on pages 2 and 3, and the first two sentences on page 4, concluding that, under the standards, claimant is entitled to 22 percent unscheduled permanent disability.

The Evaluation Section, in determining the extent of claimant's disability, determined that claimant was entitled to 25 percent unscheduled permanent disability under the standards. Then, after considering a prior 20 percent permanent disability award, reduced claimant's unscheduled permanent disability award for her current injury to 5 percent, which was awarded by the Determination Order. (Ex. 3).

The Referee, in making his determination of the extent of claimant's permanent disability resulting from her current injury, found claimant entitled to 22 percent unscheduled permanent disability under the standards. He then considered the "prior award," reduced claimant's award by 17 percent, and affirmed the Determination Order award of 5 percent unscheduled permanent disability.

Claimant contends the Referee erred in allowing an offset for a prior disability award under ORS 656.222. We agree.

The only evidence in the record regarding a prior permanent disability award includes a notation on the Evaluation Division's worksheet stating "20 percent previously received in Standard Fire Insurance, claim number E42CC2494553, offset in this claim. 5 percent now due," and a statement on the September 21, 1989 Determination Order providing that, "your previous disability, past receipt of money for such disability, and the combined effects of your injuries have been considered in this award." (Exs. 3 and 4). The only other evidence regarding prior problems was claimant's testimony that she had had problems with her back before the March 1989 compensable injury. (Tr. 7).

Generally, the criterion for rating unscheduled permanent disability is the loss of earning capacity due to the injury in issue, which is "determined by the extent of disability compared to the worker before such injury and without such disability." See former ORS 656.214(5); See also ORS 656.222.

The Court of Appeals has held, however, that application of ORS 656.222 ". . . is limited to subsequent awards for scheduled disability." City of Portland v. Duckett, 104 Or App 318 (1990) (Emphasis in original); But see Thomason v. SAIF, 73 Or App 319 (1985); Cascade Steel Rolling Mills v. Madril, 57 Or App 398 (1982).

Therefore, even assuming that the prior back injury about which claimant testified resulted in the earlier disability award, such an award would have been an unscheduled permanent disability award. On that basis, an offset pursuant to ORS 656.222 would be inappropriate. Duckett, supra; But see Thomason, supra; Madril, supra.

Former ORS 656.214(5) requires that unscheduled permanent disability due to a compensable injury be determined by comparing the worker before such injury and without such disability. Thus, under former ORS 656.214(5), an injured worker is entitled to that unscheduled permanent disability which results from the injury in question. However, the worker is not entitled to be doubly compensated for a permanent loss of earning capacity which would have resulted from

the injury in question, but which had already been produced by an earlier accident and compensated by a prior award. Mary A. Vogelaar, 42 Van Natta 2846 (1990); Lawrence W. Scott, 40 Van Natta 1721 (1988). Furthermore, the principle established by former ORS 656.214(5) applies equally whether a series of accidents involves injury to the same or different unscheduled parts of the body. See e.g. Jerry R. Miller, 42 Van Natta 571 (1990); Mary A. Vogelaar, 42 Van Natta 2846 (1990); Alberta M. Lakey, 43 Van Natta 30 (1991).

After our de novo review of the record, particularly claimant's testimony, we conclude that, more likely than not, all of claimant's impairment is due to her current compensable injury. Therefore, we find that all of the 22 percent unscheduled permanent disability determined under the "standards" is due to the compensable injury and that none of this award represents permanent disability which was present prior to the compensable injury. Consequently, we find that the Referee erred in offsetting the 20 percent award under the prior claim against claimant's current unscheduled permanent disability award as calculated under the "standards." Accordingly, we find that claimant is entitled to 22 percent unscheduled permanent disability for her lost earning capacity resulting from her current compensable back injury.

ORDER

The Referee's order dated April 25, 1990 is modified. In addition to the Determination Order and Referee's award, claimant is awarded 17 percent (54.4 degrees) unscheduled permanent disability, for a total of 22 percent (70.4 degrees) unscheduled permanent disability arising from her compensable low back injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

February 21, 1991 Cite as 43 Van Natta 357 (1991)

In the Matter of the Compensation of
THANH T. THI, Claimant
WCB Case Nos. 89-14663, 89-11538, 89-14662 & 89-13253
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Saif Legal Department, Defense Attorney
Rankin, et al., Defense Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

Liberty Northwest Insurance Corporation requests review of those portions of Referee Davis' order that: (1) set aside its denial of claimant's aggravation claim for his low back condition after May 8, 1989; and (2) upheld the SAIF Corporation's denial of claimant's "new injury claim" for the same condition after the same date. On review, the issue is responsibility.

The Board affirms and adopts the order of the Referee with the following comment. We review de novo.

The Referee was correct in initially assigning SAIF the burden of proof on the question of responsibility. However, since he found a discrete injury at the second employment, Liberty's insured, the burden would then shift to the last employer, Liberty's insured. Linda L. Wise, 42 Van Natta 115 (1990).

Further, this shift in the burden of proof is only dispositive when the evidence is in equipoise. Here, the evidence was not in equipoise as the Referee found as a fact that the underlying condition had worsened as a result of the incident at Liberty Northwest's insured. Thus, we agree with the Referee's reasoning and conclusion.

ORDER

The Referee's order dated April 25, 1990 is affirmed.

February 21, 1991 Cite as 43 Van Natta 358 (1991)

In the Matter of the Compensation of
JAMES D. WATSON, Claimant
WCB Case No. 89-25066
ORDER ON REVIEW
Martin McKeown, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee McCullough's order that increased claimant's unscheduled permanent disability for his neck injury from 15 percent (48 degrees), as awarded by a Determination Order, to 18 percent (57.6 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

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 for the Department of Insurance and Finance pursuant to ORS 656.726(3)(f). See ORS 656.283(7). Specifically, the Referee applied former OAR 436-35-000 et seq, which were effective at the time of the November 28, 1989 Determination Order. See former OAR 438-10-005; 438-10-010. These are the rules which we apply as well. Id. Because it is undisputed that claimant had returned to work at his regular job, claimant's disability is determined on the basis of impairment only. Former OAR 436-35-290(2)(a); 436-35-300(2)(a); and 436-35-310(2)(a).

The Referee increased claimant's unscheduled permanent disability award from 15 percent to 18 percent. Claimant agrees that the Determination Order award was insufficient. He contends, however, that the Referee's calculation of his impairment neglected several factors.

Claimant first seeks additional disability for loss of strength due to alleged nerve damage. He relies on Dr. Freeman's closing report of October 23, 1989, in which he reported that "[at] this point in time he is medically stationary with a minimal/moderate disability secondary to his fusion and nerve root injury that brought about the same." (Ex. 19). In his appellant's brief, claimant concludes that "there is a loss of strength here and, at minimum, it should be worth 10 percent." We disagree.

Former OAR 436-35-350(4) allows an award of unscheduled disability for "[i]injuries to spinal nerve plexus with resulted loss of strength." However,

Dr. Freeman's conclusion, upon which claimant relies, is unexplained and not supported by the medical evidence. Claimant has never been diagnosed with actual nerve damage. Dr. Freeman himself explicitly described his diagnosis and observations during surgery and never mentioned any permanent neurological impairment. (Exs. 10-12). Moreover, there is no mention of any residual nerve damage in the medical evidence following surgery. (Exs. 13, 16, 19).

After our de novo review of the record, we conclude that Dr. Freeman's statement is neither well-reasoned nor based on the medical record. Consequently, we give it little weight. Somers v. SAIF, 77 Or App 259 (1986). We find that his statement was not made as a diagnosis, but rather as a general closing remark alluding to claimant's persuasive medical problems.

Claimant next disputes the Referee's calculation of impairment or spinal findings relating to his surgeries. He first contends that he is entitled to a 5, not a 4, percent value for each of his two diskectomies. Claimant is correct. A laminectomy with a single discectomy is rated at 5 percent. Former OAR 436-35-350(2).

Claimant further contends that he is entitled to a 10, not a 5, percent value for the fusion of three cervical vertebrae. We disagree.

The ratings for ankylosis in the spine (spinal fusion), are figured with ankylosis in the position of 0 degrees, which is referred to as the "favorable" or "neutral" position. If the ankylosis is in any other position, it is considered "unfavorable." A "favorable" spinal fusion of 3 cervical discs is rated at 5 percent, while a similar "unfavorable" fusion is rated at 10 percent. Former OAR 436-35-350(3). Here, there is no evidence that the ankylosis is in any other position than 0 degrees. Thus, we conclude that claimant is entitled only to a rating of 5 percent.

When the impairment values for claimant's diskectomies and fusion are combined, the sum is 14.26 percent. See former OAR 436-35-360(11). When that value is combined with the uncontested impairment value of 5 percent for his range of motion loss and repetitive activity limitations, claimant's total impairment value is 18.55 percent. 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, 19 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 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 concluded that neither party had established that claimant's disability is greater or less than that indicated by the standards. After our de novo review of the record, we agree.

ORDER

The Referee's order dated May 10, 1990 is modified. In addition to the Determination Order and Referee's awards, claimant is awarded 1 percent (3.2 degrees) unscheduled permanent disability, giving him a total award to date of 19 percent (60.8 degrees) unscheduled permanent disability for a neck 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
DERWIN W. WILSON, Claimant
And, In the Matter of the Complying Status of
ERSKINE-DELOE, Noncomplying Employer
WCB Case Nos. 89-17526 & 89-09948
ORDER OF DISMISSAL
Michael B. Dye, Claimant Attorney
Michael L. Brant, Defense Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of that portion of Referee Peterson's order that set aside a Director's order insofar as it found claimant to be a subject worker. We review the request to determine whether we have jurisdiction over the matter. On review, the issues are jurisdiction and subjectivity. We dismiss for lack of jurisdiction.

FINDINGS OF FACT

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

The alleged noncomplying employer requested a hearing concerning the Department's Order of Noncompliance. This hearing request was acknowledged as WCB Case No. 89-09948. In addition, claimant requested a hearing, seeking penalties and attorney fees for an alleged discovery violation. This request was acknowledged as WCB Case No. 89-17526. The requests were consolidated for hearing.

At commencement of the hearing, claimant withdrew his hearing request concerning the discovery violation. The hearing proceeded on the question of whether claimant was a subject worker for purposes of noncompliance. Following hearing, the Referee issued an order concluding that claimant was a nonsubject worker. The Department's Order on Noncompliance was modified. In addition, claimant's hearing request in WCB Case No. 89-17526 was dismissed.

The Referee's findings and conclusions were contained in one order, which carried both WCB Case numbers. Claimant requested Board review within 30 days of the Referee's order. The alleged noncomplying employer subsequently moved for an order dismissing claimant's request for Board review on the grounds that claimant lacked standing to request review. We denied the motion. Derwin W. Wilson (unpublished order dated April 13, 1990).

ULTIMATE FINDING OF FACT

The only issue contested at the December 21, 1989 hearing was the Department's noncompliance order.

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(4). When a Referee issues an order concerning a Director's order of noncompliance or any other matters unrelated to a claim, the Referee's order becomes a final order of the Director and must be appealed directly to the Court of Appeals. ORS 656.183.480(1), (2); Denise K. Rodriguez, 40 Van Natta 1788 (1988). When an order declaring a person to be a noncomplying employer is contested at the same hearing as a matter concerning a claim pursuant to ORS 656.283 and 656.704, the

review thereof shall be as provided for a matter concerning a claim. ORS 656.740(4)(c). Matters concerning a claim are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. ORS 656.704(3).

Here, claimant's request for hearing raising penalties and attorney fees was consolidated with the alleged noncomplying employer's request for hearing challenging the Director's noncompliance order. Claimant's request for hearing raised matters concerning a claim. However, for jurisdictional purposes, the proper inquiry is not which issues were raised by a request for hearing. In this regard, ORS 656.740(4)(c) provides:

> "When an order declaring a person to be a noncomplying employer is contested at the same hearing as a matter concerning a claim pursuant to ORS 656.283 and 656.704, the review thereof shall be as provided for a matter concerning a claim." (Emphasis supplied).

Claimant withdrew his request for hearing at commencement of the hearing. Thus, it cannot be said that a matter concerning a claim was contested at the hearing. Rather, the only issue actually contested at hearing was subjectivity for purposes of deciding the noncompliance issue. Because no matter concerning a claim was contested at the same hearing as the noncompliance issue, the Board does not have jurisdiction over claimant's appeal of the Referee's order. See Larry J. Powell, 42 Van Natta 1594 (1990) (Board lacks jurisdiction over appeal where compensability, in the form of SAIF's claim acceptance, raised as issue in hearing request but only noncompliance contested at hearing).

While the Referee's order language also dismissed claimant's hearing request in WCB Case No. 89-17526, that does not alter our conclusion. The fact remains that no issue concerning a claim was contested at hearing. Rather, only noncompliance was actually contested at the hearing. See Willis N. Weltz, 43 Van Natta 110 (1991) (Referee's order which gratuitously directed SAIF to continue to process claim does not involve matter concerning a claim where only noncompliance contested by the parties.) To the extent our prior order denying the alleged noncomplying employer's motion to dismiss suggests a different conclusion, we disavow that holding.

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.

In the Matter of the Compensation of
PAMELA C. WOLD, Claimant
WCB Case No. 89-03448
ORDER ON REVIEW
Rick W. Roll, Claimant Attorney
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Quillinan's order that: (1) upheld the SAIF Corporation's denial of her occupational disease claim for a mental disorder; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial. On review, the issues are compensability and penalties and related attorney fees. We affirm.

FINDINGS OF FACT

Claimant began working as a sales clerk at Miller's Fish Market in March 1988. She was friendly and flirtatious with customers and her employer, Jim Miller. Claimant's psychological problems began in late September or early October, when her boyfriend moved to California and claimant perceived that Miller began sexually harassing her. During the first two weeks of October, claimant felt anxious and afraid. She stopped working on October 16, 1988 and left Oregon to join her boyfriend in California, expecting to return to her job in two weeks.

When claimant returned around November 10, her job was no longer available due to a seasonal slow down. Miller suggested that claimant might work one day per week, when there was enough business. Claimant did not return to work. She sought and obtained unemployment benefits, which were terminated when Miller reported that claimant left work voluntarily.

In December 1988, claimant sought psychological help at a crisis center. There, Dr. Vander Wall diagnosed "depression secondary distress created by sexual harassment" and claimant began counseling in January 1989.

Claimant filed a Workers' Compensation claim on December 22, 1988; it was denied on December 30. She also filed a civil rights suit in March 1989 and reported sexual harassment to the Employment Division in May 1989. Her complaints were found to be unsubstantiated.

Dr. Turco performed a psychiatric evaluation on March 15, 1989.

CONCLUSIONS OF LAW AND OPINION

We affirm and adopt the "Opinion" of the Referee, with the following supplementation.

Compensability

At the outset, we note that we generally defer to a Referee's determination of credibility, when it is based on the Referee's opportunity to observe the witness. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). In this case, the Referee found neither claimant nor the employer to be credible, based on their demeanor. On this record, we find no reason to disturb the negative credibility finding and proceed to the causation issue.

Because of the multiplicity of potential causes for claimant's psychological problems in this case, resolution of the issue requires expert medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). We rely on medical opinions which are well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986).

We generally give great weight to the opinion of the treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find such reasons. Dr. Vander Wall, treating psychologist, reported claimant's history that "[t]he stress of the job caused her to seek some time off in October. . . ." (Ex. 3). Turco, on the other hand, reported that claimant left work "to be with her boyfriend." (Ex. 14-2). There is no indication that Vander Wall was aware that the reported onset of claimant's troubles coincided with her boyfriend's move to California. Vander Wall concluded that "there were no other contributing factors [other than harassment at work], to my knowledge, which could have caused the emotional upheaval." (Ex. 22). Vander Wall was precluded from considering claimant's potential off-work stressors, because claimant apparently did not tell him about her off-work circumstances. Inasmuch as Vander Wall did not have a complete history, we accord his opinion no weight. Somers v. SAIF, supra.

The only other medical evidence is provided by Dr. Turco, psychiatrist, who evaluated claimant on March 15, 1989. Turco concluded that claimant's problems were related to harassment at work -- as she described it to him -- "if the story she is telling me is essentially truthful." (Ex. 14-6).

As we have stated, we defer to the Referee's demeanor-based credibility finding, which, in this case, casts serious doubt on claimant's reporting. Under such circumstances, we are not persuaded by medical evidence regarding causation which is reliable only to the extent that claimant's reporting is reliable. Because Turco's opinion is expressly conditioned on claimant's truthfulness, we accord it no weight. We conclude that there is no persuasive evidence relating claimant's current psychological problems to her job.

Assuming, without deciding, that Miller's behavior amounted to sexual harassment, we nevertheless conclude, as did the Referee, that claimant has not proven by clear and convincing evidence that the employer's conduct caused her current psychological problems. See former ORS 656.802(2)(d); Riley Hill General Contractor Inc. v. Tandy Corp, 303 Or 390, 407 (1987).

Penalties and Attorney Fees

Claimant has not proven that the denial was unreasonable. Moreover, even if it was unreasonable, there are neither "amounts then due," upon which to base a penalty, nor evidence of unreasonable resistance to the payment of compensation, to support a related attorney fee.

ORDER

The Referee's order dated March 26, 1990 is affirmed.

In the Matter of the Compensation of
LINDA COITEUX, Claimant
WCB Case No. 88-12642
ORDER ON REVIEW
Linda Love, Claimant Attorney
Jerry Larkin (Saif), Defense Attorney

Reviewed by Board Members Brittingham, Nichols and Crider.

Claimant requests review of Referee Mills' order that dismissed her request for hearing on the issue of whether her March 11, 1986 claim was an aggravation claim that should have been closed by Determination Order rather than by Board own motion order. On review, the issues are res judicata and perfection of an aggravation claim. We reinstate the hearing request, but do not find that claimant perfected an aggravation claim.

FINDINGS OF FACT

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

Claimant's claim was initially closed on December 3, 1980; thus, her aggravation rights terminated as of December 3, 1985, not March 11, 1985, as recited in the Referee's findings.

Dr. Ordonez, consulting neurologist, examined claimant on February 8, 1985 and on March 11, 1985. The SAIF Corporation received Ordonez' report on March 18, 1985, but neither accepted nor denied the claim prior to the termination of claimant's aggravation rights.

In January 1986, claimant filed a request for hearing requesting penalties and attorney fees for SAIF's failure to timely pay temporary total disability benefits following authorization of surgery. This was the only issue at hearing. (Ex. 9A-2, 9B). By a September 18, 1986 stipulation, SAIF agreed to pay a penalty and attorney fees for untimely payment of temporary total disability. SAIF had voluntarily begun payment of temporary disability prior to the stipulation. Claimant's request for hearing, including all issues raised or raisable, was dismissed.

In March 1987, SAIF requested that the Board close claimant's claim under its own motion jurisdiction. (Ex. 13). A copy of the request was sent to claimant. In an August 1987 own motion order, the Board closed the claim and awarded temporary total disability benefits from December 19, 1985 through July 17, 1987.

Claimant requested reconsideration, objecting to closure by own motion order.

On December 31, 1987, the Board upheld its own motion closure, stating:

> "Assuming that claimant perfected an aggravation claim within her statutory five-year aggravation rights, we find that the claim for aggravation was encompassed within the issues of TTD and authorization for surgery which were raised in claimant's January 1986 request for hearing. All issues raised or raisable by this hearing request were dismissed with prejudice pursuant to the parties' September 1986 stipulation. . . . Inasmuch as SAIF voluntarily reopened claimant's claim after her aggravation rights had expired, we conclude that we had jurisdiction to close the claim pursuant to ORS 656.278."

Claimant did not appeal this order to the Court of Appeals.

On July 25, 1988, claimant filed a Request for Hearing on the issue of whether her March 1985 claim should have been closed by Determination Order.

FINDINGS OF ULTIMATE FACT

The Referee had jurisdiction to rule on claimant's claim that she perfected an aggravation claim under ORS 656.273.

Claimant's condition had not worsened between the 1983 stipulation and the 1985 claim for aggravation.

SAIF voluntarily reopened claimant's claim for medical services and paid temporary total disability benefits.

CONCLUSIONS OF LAW AND OPINION

The Referee stated that claimant's request for hearing was barred under the doctrine of res judicata because the Board, in its 1987 own motion order, had previously decided that claimant had waived her aggravation claim and that claim closure was properly within its own motion jurisdiction. The Referee concluded that he lacked jurisdiction to consider claimant's request for hearing.

Claimant contends that because she perfected an aggravation claim prior to the expiration of her aggravation rights, closure of her claim was not properly within the Board's own motion jurisdiction and, accordingly, that the Board's order is not the law of the case. She further contends that res judicata does not operate to preclude consideration of whether she had perfected her aggravation claim before her aggravation rights expired because that issue was not raised or raisable at the time of the September 1986 stipulation.

SAIF maintains that the Referee correctly dismissed claimant's request for hearing for lack of jurisdiction, citing David L. Waasdorp, 38 Van Natta 81 (1986), and Timothy Dugan, 39 Van Natta 388 (1987). SAIF further maintains that claimant's only avenue to appeal the Board's own motion order was to the Court of Appeals. We disagree with SAIF and the Referee for the following reasons.

The doctrine of res judicata precludes relitigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, 50, modified 305 Or 468 (1988). A claim is a transaction or series of transactions arising from the same set of operative facts. Carr v. Allied Plating Co., 81 Or App 306, 310 (1986). Under the res judicata doctrine of "claim preclusion," litigation of a claim or cause of action to final judgment precludes a subsequent action between the same parties on the same claim or any part thereof. Carr v. Allied Plating, supra at 309; Restatement (Second) of Judgments, Sections 17-19, 24 (1982). Under the doctrine of "issue preclusion," 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 District, supra at 53. A Referee's order approving a stipulation and dismissing a claimant's request for hearing is a "judgment" within the meaning of the above rules. See ORS 656.289(4); Proctor v. SAIF, 68 Or App 333, 335-36 (1984); Ronald G. Hill, 37 Van Natta 14, 15 (1985).

Preclusive Effect of 1986 Stipulation

The subject of the 1986 stipulation was claimant's entitlement to penalties and attorney fees for late payment of temporary total disability benefits. The issue of the timeliness of her aggravation claim was not litigated. Consequently, that issue was not precluded under the doctrine of issue preclusion.

We next turn to claim preclusion by the stipulation. Claimant waived her right to closure of her claim by Determination Order only if she intended to waive that right when she signed the stipulation. See David M. Marvin, 42 Van Natta 1778 (1990). As noted above, the claim which was the subject of the September 1986 stipulation was SAIF's failure to commence temporary total disability payments when claimant was hospitalized for surgery. The stipulation did not address whether the claim should later be closed by the Board, as an own motion claim, or by Evaluation, as an aggravation claim. The preclusive effect of the stipulation was limited by agreement of the parties to all issues raised or raisable in connection with the claim for temporary disability compensation. Claimant had not requested own motion opening of the claim. SAIF's March 1987 letter to the Board, some months subsequent to the September 1986 stipulation, served as the initial notice to claimant that SAIF believed her claim would be considered under own motion. The closure itself did not issue until August 1987. Thus, the dispute concerning the proper procedure at claim closure had not arisen at the time of the September 1986 stipulation. Consequently, it was neither raised nor raisable at that time.

Furthermore, claimant's claim for temporary total disability did not issue from the same set of operative facts as the claim that an aggravation occurred and was perfected before the expiration of claimant's aggravation rights. Claimant's entitlement to temporary total disability benefits depended on when she became totally disabled due to the worsening. Her entitlement to closure by Determination Order, on the other hand, depended on when this claim for aggravation was filed and when the worsening occurred. For this reason, we do not construe the stipulation to bar the current litigation. Tana L. Wilson, 40 Van Natta 476 (1988).

Preclusive Effect of Own Motion Order

Although we disagree with the statement in the Board's Own Motion order that the stipulation encompassed the aggravation claim issue, the current litigation is precluded if the own motion order is a res judicata bar.

SAIF's citation of David L. Waasdorp, supra, and Timothy Dugan, supra, for the proposition that the Referee had no jurisdiction to consider claimant's request for hearing is inapposite. In those cases the Board held that the Hearings Division lacked jurisdiction to enforce an own motion order where the request for reopening originated under the Board's own motion jurisdiction and where there was no contention that claimant's aggravation rights still existed. See David L. Waasdorp, supra at 82. Here, there was no request for reopening under own motion, and claimant contends that her aggravation rights still existed.

We note that SAIF correctly cited Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988), for the proposition that claimant was not precluded from seeking review in the Court of Appeals of the Board's determination that it had own motion jurisdiction over claimant's claim. However, the Board's order is not before us. Rather, the issue before us is claimant's perfection of an aggravation claim and ensuing right to closure by Determination Order. Therefore, we decline to address SAIF's contention that claimant's only avenue of appeal from the Board's order was to the Court of Appeals.

We next turn to issue preclusion. SAIF maintains that the issue claimant raised at hearing regarding the timeliness of her aggravation claim was identical to the issue that the Board addressed in its own motion order and, thus, that it precludes consideration of this issue by the Referee. We disagree. The own motion order issued without opportunity to produce evidence or to cross-examine witnesses. Moreover, the Board made no finding of fact regarding when

the aggravation claim was filed or whether the condition actually worsened. Instead, the Board relied on the September 1986 stipulation regarding the issue of the timeliness of claimant's temporary disability payments to hold that claimant had waived her right to contend that a worsening occurred before the expiration of her aggravation rights. Moreover, the perfection of the aggravation claim, as a factual matter, was not essential to the result reached in the stipulation. Therefore, because there was no actual litigation concerning the perfection of claimant's aggravation claim, the own motion order does not operate as a bar to litigation under the res judicata doctrine of issue preclusion.

The doctrine of claim preclusion only applies where there has been a valid judgment. The Board's own motion order was not valid if claimant perfected an aggravation claim prior to expiration of her aggravation rights. If she perfected an aggravation claim, then the Board did not have own motion jurisdiction to close, and claimant is entitled to a Determination Order, notwithstanding the own motion order. See ORS 656.268 and 656.278(2); Carter v. SAIF, 52 Or App 1027, 1032 (1981); Coombs v. SAIF, 39 Or App 293, 298-299 (1979); see also Miltenberger v. Howard's Plumbing, supra. For this reason, the Referee erred in dismissing the request for hearing.

Perfection of the Aggravation Claim

The issue of whether claimant perfected an aggravation claim was before the Referee at hearing. The parties fully litigated the issue, even though they chose to submit the issue on the record at hearing. Thus, we have jurisdiction to consider the issue on review. Because the parties neither requested nor argued remand on review, we address the issue on the merits in our de novo review of the record.

Claimant maintains that she perfected her aggravation claim by means of the March 11, 1985 letter from Dr. Ordonez requesting right ulnar transposition surgery, which SAIF received prior to the termination of her aggravation rights on December 3, 1985.

Claimant is partially correct, insofar as an aggravation claim may be made by a physician's report requesting additional medical services. ORS 656.273(3); Krajacic v. Blazing Orchards, 84 Or App 127 (1987). However, in order to perfect an aggravation claim, the report must put the insurer on notice that the requested medical services are for "worsened conditions," see ORS 656.273(1), i. e., something more than continuing conditions. Krajacic, supra. In this case, even though the letter from Dr. Ordonez requesting ulnar surgery was received prior to the termination of claimant's aggravation rights, the medical treatment records do not provide sufficient notice of a claim for a worsened condition.

After claimant's claim was closed by a December 3, 1980 Determination Order, she sought reopening of her claim for aggravation and surgical release of a right ulnar nerve entrapment as diagnosed by Dr. Nash. The reopening and the request for surgery were both denied and the denials were upheld by a June 13, 1983 stipulation. No medical reports regarding claimant's condition at the time of the 1983 stipulation were provided in the record. In 1985, Dr. Ordonez reported the following history: Claimant's initial symptoms in 1980 consisted of pain in the right arm region, which localized in the right side of the neck, where it remained; the results of a nerve conduction test led to Dr. Nash's 1981 request for surgery and, after the denial, claimant had another nerve conduction test ordered by Dr. Krein, chiropractor, with similar results; claimant continued to have chiropractic manipulation but made no progress. Finally, Ordonez reported that in 1985, "[claimant's] symptoms are constantly present, particularly in the cervical spine and right arm. From time to time the pain shoots

down into the forearm and hand. The dysesthesia and paresthesias in the right hand are present all the time."

We find that there is nothing in this record to indicate that claimant's condition had worsened since the 1983 stipulation denying her request for right ulnar nerve entrapment surgery. Rather, the medical evidence indicates that claimant had been receiving treatment for a continuing condition, and that the ailment for which she requested surgery in 1985 was the same ailment as that for which she requested surgery in 1981. Accordingly, we find that claimant has failed in her burden to prove that her compensable condition worsended prior to the expiration of her statutory five-year aggravation rights. Perry v. SAIF, 93 Or App 631 (1988), rev'd on other grounds 307 Or App 654, on remand 99 Or App 52, N.2 (1989); Krajacic, supra; Ronald L. McMahill, 39 Van Natta 399 (1987).

ORDER

The Referee's order dated November 23, 1988 is reversed. Claimant's hearing request is reinstated. Claimant's request for relief is denied.

Board Member Crider, dissenting.

The question presented by this case is whether claimant's condition, which resulted in a reopening of the claim for surgery and for payment of additional temporary disability compensation, worsened before or after the expiration of her aggravation rights. If the worsening occurred before aggravation rights expired, then claimant is entitled to claim closure by Determination Order. If the worsening occurred after aggravation rights expired, then she is not entitled to a Determination Order.

The question is not whether a claim for aggravation was filed before the expiration of aggravation rights: A request for authorization for surgery for the compensable condition clearly constitutes a claim for aggravation. Former ORS 656.273(2) and (3). Dr. Ordonez submited such a report before the expiration of claimant's aggravation rights.

Nor is the question whether in fact claimant suffered a compensable aggravation: The aggravation was conceded when SAIF reopened the claim.

Therefore, the only question is when the worsening occurred. The need for surgery had matured when Dr. Ordonez submitted his report. Therefore, although surgery was delayed until claimant's aggravation rights had expired due to SAIF's reluctance to authorize it, the worsening occurred before her rights expired and thus she is entitled to closure by Determination Order.

In the Matter of the Compensation of
CHARLENE NEWMAN, Claimant
WCB Case No. 88-14236
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Tom Ewing (Saif), Defense Attorney

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Mills' order that found claimant's hearing request from the SAIF Corporation's denial of her occupational disease

claim for a stress-related heart condition was untimely filed, and upheld the denial. On review, the issues are jurisdiction and compensability. We reverse.

FINDINGS OF FACT

Claimant was employed as an Admittance Clerk with the Hooper Detox Center (Center) since late 1984. Claimant's job as an Admittance Clerk was consistently stressful. Her primary job involved admitting patients undergoing drug and alcohol detoxification. On occasion, these patients were subject to mental illness, withdrawal, violent behavior, or suicidal tendencies. When claimant first began working at the Center there were inadequate security safeguards in place for the protection of employees. There were also inadequate procedures for acquiring police or medical assistance if required.

As a consequence of these working conditions claimant experienced "panic attacks." These attacks were sudden in onset and accompanied by feelings of intense anxiety as well as heart palpitations requiring medical care. Since May 1986, the medical record indicates that claimant suffered from a recurring pattern of tension, anxiety, and increased awareness of irregular heart beats. (Ex. 13).

During the summer and fall of 1986, claimant sought treatment from Dr. Ball, psychiatrist, for her stress. In November 1986 claimant began psychiatric sessions with Dr. Dixon, psychiatrist. Claimant had six sessions with Dr. Dixon.

Claimant filed an occupational disease claim on June 12, 1988.

On July 29, 1988, SAIF denied claimant's claim for stress-related heart irregularities and need for treatment.

In November 1988 claimant was seen by the Western Medical Consultants for an independent medical examination. The panel psychiatrist, Dr. Friedman, diagnosed "Panic Disorder without Agoraphobia." The panel cardiologist, Dr. Hurst, did not render a working diagnosis for claimant's heart condition because he found no evidence of significant heart disease, and recommended no treatment.

As of the date of hearing, claimant continued to work for the Center.

Before her work at the Center, claimant had previously received minimal psychiatric counseling as a young woman. However, there is no evidence claimant had ever been diagnosed with a psychological condition.

Also prior to her work with the Center, claimant had a history of stress-related heart irregularities. In 1980, 1981, and 1982 she was hospitalized for heart symptoms.

Claimant has not experienced significant off-work stressors.

ULTIMATE FINDINGS OF FACT

Claimant's psychological condition arose out of and in the course of her employment as an Admittance Clerk for the Center.

The psychological condition resulted in medical treatment for claimant's heart condition.

Claimant's psychological condition was diagnosed as "Panic Disorder without Agoraphobia." That condition is generally recognized in the psychological community.

Employment conditions, which existed in a real and objective sense, materially contributed to claimant's psychological condition and need for treatment for her stress-related heart condition.

The conditions which resulted in claimant's psychological condition were not conditions generally inherent in every working situation.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's occupational disease claim was untimely filed. He therefore did not reach the merits. We disagree.

Jurisdiction

SAIF argues that there is no jurisdiction over this occupational disease claim because it was not timely filed under ORS 656.807. ORS 656.807(1) provides that an occupational disease claim shall be void unless a claim is filed within one year from the date the worker first discovered, or should have discovered, the occupational disease; or one year from the date the claimant becomes disabled, or is informed by a physician that the worker is suffering from an occupational disease; whichever is later.

Claimant must be clearly told that her injury is caused by work so that the limitation period can commence. Robinson v. SAIF, 69 Or App 534 (1984). In addition, the carrier has the burden of proving that it has been prejudiced by an untimely filing. Robinson, supra; Inkley v. Forest Fiber Product Co., 288 Or 337 (1980).

Our review of Dr. Dixon's testimony indicates that the earliest date by which claimant was clearly told that her occupational disease was caused by work so that the limitation period could commence, was Dr. Dixon. Dr. Dixon testified that it was his assessment that claimant's work was a major contributing cause of her psychological condition manifested by panic attacks. His assessment was based on the information provided to him by claimant regarding the relationship between her job related stress and the resulting heart symptoms. Therefore, we conclude that the time period of November 1986 to March 1987 triggered the limitation period. Giving claimant the benefit of the doubt, we conclude that claimant had one year from March 1987 to file her claim. Thus, she should have filed no later than March 1988. Here, claimant filed her claim on June 12, 1988, at least three months too late.

Finding that claimant was untimely in her filing, we consider whether or not SAIF was prejudiced by this late filing noting that the passage of time is not sufficient to show prejudice. Ford v. SAIF, 71 Or App 825, rev den 299 Or 118 (1985). In this case, we find that SAIF has not been prejudiced by the late filing, inasmuch as there is neither contention nor proof that SAIF was prejudiced. Accordingly, we conclude that claimant is not time barred. See Victor Southwell, 41 Van Natta 23 (1989). We turn to the merits.

Compensability

Although the Referee did not address the merits, we find the record has been sufficiently developed in order to proceed to the compensability issue.

At hearing and on review, claimant framed the issue as compensability of job related stress and anxiety reactions as well as compensability of stress-related heart irregularities. Thus, we find this claim is for an occupational disease. Inasmuch as claimant's last exposure to potentially causal employment conditions occurred after January 1, 1988, we apply former ORS 656.802 as amended effective January 1, 1988.

To be compensable, claimant's occupational disease must fall within one of the three subsections of former ORS 656.802. In this case, claimant seeks compensation for her heart condition which she alleges is caused by work induced stress. In Ronald V. Dickson, 42 Van Natta 1102 (1990), we held that an occupational disease claim for a stress-related physical condition is properly analyzed under former ORS 656.802(1)(b). In other words, claimant must establish that the causative factor of stress is compensable in its own right as a mental disorder. Dickson, supra.

Consequently, this claim must be analyzed under that section of the statute. Pursuant to former 656.802(1)(b) and (2), to establish a mental stress condition, claimant must establish that: (1) she has a mental or emotional disorder which is generally recognized in the medical or psychological community; (2) she required medical services or was disabled; (3) the mental disorder was due to employment conditions which were real and objective; (4) such employment conditions are not generally inherent in every working environment; and (5) the evidence is clear and convincing that the mental disorder arose out of and in the course of employment.

We find that the medical record supports and the lay testimony corroborates, that claimant suffered a psychological condition arising from November 1986 to March 1987. The independent medical examiner, psychiatrist, Dr. Friedman, diagnosed the condition as "Panic Disorder without Agoraphobia." We find claimant's condition is generally recognized in the psychological community. (See DSM III 300.01).

This condition required medical services. Although claimant was apparently able to continue with her employment, she was increasingly subject to an anxiety reaction. Specifically, claimant experienced "panic attacks." Since May 1986, these episodes were numerous in frequency and severe in intensity. As explained by Dr. Hurst, cardiologist, in the midst of these "panic attacks" claimant would become aware of her heart beat. Due to the "panic attack" this awareness would be enhanced by fear and magnified to the point that claimant would experience what she perceived to be "a sense of impending doom" requiring her to seek medical attention.

The medical record supports the finding that claimant's "heart irregularities" were psychologically induced symptoms of the panic disorder. Dr. Hurst indicated there was no evidence of significant heart disease or a life threatening state to account for claimant's heart condition. He also noted that the "number of ectopic beats" experienced by claimant were not out of the ordinary. After noting the fact that claimant had had several cardiac work-ups, he recommended no treatment.

With respect to causation of claimant's symptoms Dr. Hurst deferred to Dr. Friedman's assessment. Dr. Friedman stated that he strongly suspected that claimant's physical symptoms were a manifestation of the panic attacks. Additionally, Dr. Dixon testified that claimant's heart palpitations were symptoms of a psychological disorder. We therefore find the weight of medical evidence establishes that claimant's heart condition was a product of stress.

The working conditions experienced at the Center have been persuasively described as stress producing by claimant and her treating psychiatrist, Dr. Dixon. Dr. Dixon testified that he was familiar with the working conditions and environment of the Hooper Center. Accordingly, we find these work conditions existed in a real and objective sense. Dr. Dixon stated that these work conditions were a major contributing cause of her condition. Dr. Dixon also testified that claimant's off work stressors were not significant. Furthermore, Dr. Friedman, noting that claimant did not experience her "full blown panic attacks" until one year after beginning her employment with the Hooper Center, concluded that while work stress did not cause the panic disorder, "it was likely a contributing factor." He also noted no other significant stressors. We therefore, find that claimant's employment was a material contributing cause of claimant's psychological condition.

We have interpreted the phrase "generally inherent in every working situation" to mean conditions that are usually present in all jobs or occupations. Kathleen M. Payne, 42 Van Natta 1900 (1990). Evidence concerning the "generally inherent" issue need not be direct, it may be circumstantial. Louis R. Orman, 43 Van Natta 226 (1991). The testimony indicates, and we find, that the stressful working conditions to which claimant was exposed as an Admittance Clerk supervising a patient population that was afflicted with drugs, alcohol and sometimes violent or suicidal behavior is not generally inherent in every working situation.

Although claimant had had previous episodes of stress-related heart symptoms, we note that the "panic attacks" increased in frequency and intensity as a result of claimant's employment. Thus, we find claimant's preexisting condition, although not caused by claimant's employment, was worsened as a result of work related stress. See Stephen D. McElroy, 41 Van Natta 433, 440 (1989).

There is no contrary evidence to these findings. Claimant has established by clear and convincing evidence that the psychological condition arose out of and in the course of her employment. Claimant's mental stress is compensable as an occupational disease. Consequently, the psychological symptoms manifested as claimant's stress-related heart irregularities are compensable as well. See Dickson, supra.

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 $2,230, to be paid by SAIF. 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 February 17, 1989 is reversed. The denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $2,230, payable by SAIF.

In the Matter of the Compensation of
JOHN T. SEIBER, Claimant
WCB Case No. 89-14515
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
Roberts, et al., Defense Attorneys

On February 12, 1991, we abated our January 24, 1991 Order on Review. We took that action in order to consider claimant's motion for reconsideration and request for remand. Having received the self-insured employer's response, we proceed with our reconsideration.

In our January 24, 1991 Order on Review, we concluded that, because claimant was a member of the work force at the time of his aggravation, he was entitled to temporary total disability from the date of disability, May 26, 1988, until the medically stationary date of November 23, 1988. In his request for reconsideration, claimant acknowledges that he is substantively entitled to temporary total disability only until the date he became medically stationary. Nonetheless, he argues that he is procedurally entitled to such benefits through June 2, 1989, the date his claim was closed by a Determination Order. We agree.

As a procedural matter, an injured worker is entitled to payment of temporary disability compensation until he is both medically stationary and released by the attending physician to return to regular work, or until he becomes medically stationary and his claim is closed. ORS 656.268; Fazzolari v. United Beer Distributors, 91 Or App 592 (1988). In this case, claimant was never released to regular work. His claim was closed by a June 2, 1989 Determination Order. Accordingly, claimant is procedurally entitled to the payment of temporary disability compensation through June 2, 1989. Betty J. McKiernan, 43 Van Natta 213 (1991).

In reaching this decision, we recognize that this award results in an overpayment of temporary disability compensation beyond the medically stationary date. Therefore, we authorize the employer to offset the overpayment of temporary disability compensation between November 24, 1988 and June 2, 1989, against any future awards of permanent disability.

Accordingly, the request for reconsideration is granted and our prior order withdrawn. On reconsideration, as supplemented herein, the Board adheres to and republishes our January 24, 1991 Order on Review. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM SHAW, Claimant
WCB Case No. 89-02190
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The self-insured employer requests review of those portions of Referee Schultz's order that: (1) set aside its denial of claimant's chiropractic treatments in excess of the Director's guidelines; and (2) assessed penalties

and related attorney fees for failure to accept or deny within 60 days claimant's aggravation claim for a low back condition. Claimant in his brief, objects to that portion of the Referee's order that upheld the employer's denial of claimant's aggravation claim for a low back condition. On review, the issues are aggravation, medical services and penalties and related attorney fees.

We affirm and adopt the order of the Referee as supplemented.

The Referee found that the employer's failure to pay interim compensation from November 16, 1988 until February 24, 1989 was an unreasonable resistance to the payment of compensation, subjecting the employer to penalties and attorney fees. We agree, but add the following comment.

ORS 656.273(6) requires an employer to commence the payment of interim compensation within 14 days of notice or knowledge of medically verified inability to work resulting from a worsened condition, unless the claim has been denied. Nevertheless, where a claimant has withdrawn from the work force at the time of the worsening, there is no entitlement to temporary disability or interim compensation. Cutright v. Weyerhaeuser, 299 Or 290 (1985); Miller v. SAIF, 78 Or App 158, 160 n.2 (1986).

Here, claimant has not worked since 1986, despite having been released to light duty after claim closure. On November 16, 1989, Dr. Collison reported to the employer that claimant had suffered a marked exacerbation of the compensable injury and was unable to work. Claimant credibly testified that, although he was willing to work, he was unable to do so due to his physical condition originating from the compensable injury. He also testified that he had not retired. We therefore find that claimant had not withdrawn from the work force and his inability to work was due to the compensable injury. See Mary S. Warren, 42 Van Natta 2878 (1990).

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 concerning the medical services issue is $600, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. In addition, inasmuch as penalties and attorney fees are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for successfully defending the Referee's order concerning these issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated May 18, 1989 is affirmed. For services on Board review concerning the medical services issue, claimant's counsel is awarded an attorney fee of $600, payable by the employer.

In the Matter of the Compensation of
WILLIAM SHAW, Claimant
WCB Case No. 89-12651
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The self-insured employer requests review of Referee Quillinan's order that assessed a penalty and related attorney fee for its allegedly unreasonable refusal to pay compensation pursuant to a prior Referee's order. On review, the issue is penalties and related attorney fees. We affirm.

FINDINGS OF FACT

At hearing, the parties stipulated that by Opinion and Order dated May 18, 1989 Referee Schultz ordered the employer to pay claimant interim compensation for the period November 16, 1988 through February 24, 1989.

The parties further stipulated that as of the date of hearing, the employer had not paid the award ordered by Referee Schultz.

On June 1, 1989, the employer notified claimant of its intent not to pay the interim compensation ordered by Referee Schultz.

CONCLUSIONS OF LAW AND OPINION

The Referee found the employer was required to comply with Referee Schultz's order of May 18, 1989, and that its failure do so supported the imposition of penalties and related attorney fees. We agree.

In his order, Referee Schultz required the employer to pay claimant interim compensation from November 16, 1988 through February 24, 1989. Subsequently, the employer requested review of the order. Although in William Shaw, 43 Van Natta 373 (1991) (hereafter referred to as Shaw I), we affirmed and adopted the Referee's order, the parties here have framed the issue as an enforcement action of the prior order. Thus, the specific resolution of the issue presented for appeal in Shaw I is irrelevant to the matter before us now.

A fair reading of Referee Schultz's order leaves no reasonable doubt that he intended to award claimant interim compensation from November 16, 1988 through February 24, 1989 payable by the employer. The order is unambiguous by its terms. Moreover, whether or not the order was in fact correct is irrelevant. The order was a valid and enforceable order and the employer was required to comply with it. See Glen D. Roles, 43 Van Natta 278 (1991).

Therefore, we find that the employer had 14 days from the date of the order in which to pay claimant the interim compensation. See former OAR 436-60-150(3)(e). The fact that the order was on appeal was without effect. Inasmuch as interim compensation is considered compensation, payment was not stayed pending appeal. See former ORS 656.313; Georgia-Pacific v. Hughes, 305 286 (1988). As of the date of hearing the employer had not paid the required interim compensation. Accordingly, we find that the employer's failure to obey a valid order was unreasonable and supported assessment of penalties and related attorney fees.

We also do not agree with the employer's argument that penalties and attorney fees should not be assessed because it complied with the prior Referee's order by calculating claimant's time loss rate as zero. Claimant is entitled to have his time loss rate calculated based on his wage at the time of injury. Former ORS 656.210(2)(b)(A). We note that at the time of injury claimant was working, and continued to work until 1986. Furthermore, we note that previously the employer had been able to calculate claimant's time loss rate as evidenced by the award of temporary total disability in 1988 as authorized by the March 16, 1988 Determination Order. Accordingly, we do not find that claimant's time loss rate was incapable of calculation.

Inasmuch as penalties and attorney fees are not compensation for the purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for successfully defending the Referee's order concerning these issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated October 17, 1989, as reconsidered November 29, 1989, is affirmed.

In the Matter of the Compensation of
MANUEL A. YBARRA, Claimant
WCB Case No. TP-90062
THIRD PARTY DISTRIBUTION ORDER
James G. Rice, Claimant Attorneys
J. David Thurber, Attorney

The SAIF Corporation, as a paying agency, has petitioned the Board for resolution of a conflict concerning the "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, the dispute pertains to the amount of SAIF's share of the settlement proceeds. We conclude that a distribution in accordance with ORS 656.593(1) is "just and proper."

FINDINGS OF FACT

Claimant sustained a compensable low back injury involving a third party. SAIF accepted the claim and has provided compensation. To date, it has incurred actual claim costs totalling $32,244.52. These costs are comprised of $13,601.82 in medical expenses, $6,392 in permanent disability benefits, $11,669.15 in temporary disability benefits, and $581.55 in vocational assistance.

Claimant secured legal counsel to pursue a lawsuit against the third party for claimant's injury. With SAIF's approval, claimant and the third party reached a $13,000 settlement.

Thereafter, SAIF received a "Settlement Disbursement" from claimant's counsel. In addition to litigation costs which were reduced by claimant's retainer ($412.70 - $297.27 = $115.43) and an attorney fee ($4,044.85), claimant's counsel had deducted $750 as "Reimbursement of PIP lien" from the $13,000 settlement. As a result of these deductions, SAIF and claimant each received $4,044.86 from the remaining balance of settlement proceeds.

SAIF accepted the aforementioned sum as a partial payment on its statutory share of the settlement proceeds. It seeks its entire statutory share. Neither claimant nor his counsel have responded to the Board's letters seeking a reply to SAIF's petition for third party relief.

A distribution of the third party settlement proceeds in accordance with ORS 656.593(1) is "just and proper." Such a distribution would permit SAIF to retain the balance of the proceeds remaining after the deduction of claimant's attorney fees, litigation expenses, and statutory 1/3 share.

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 SAIF, who has provided compensation. Inasmuch as SAIF has paid benefits to claimant as a result of a compensable injury, it is a paying agency. ORS 656.576. As such, it is entitled to its statutory share of the third party recovery. ORS 656.593(1).

When claimant chose to seek recovery from the third party, the provisions of ORS 656.580(2) and 656.593(1) became applicable. Thus, the third party settlement became subject to SAIF's lien for its "just and proper" share. See ORS 656.593(3). We now proceed to a determination of a "just and proper" distribution.

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. Therefore, after the deduction of attorney fees, litigation costs, and claimant's statutory 1/3 share, SAIF is entitled to 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)(a), (b), & (c).

Claimant has neither contested SAIF's assertion that it has incurred $32,244.52 in actual claim costs nor its representation that such costs would exceed the remaining balance after the settlement proceeds were distributed in accordance with ORS 656.593(1). Under such circumstances, we conclude that a distribution of proceeds from the third party settlement in accordance with ORS 656.593(1) would be "just and proper." We further hold that SAIF's "just and proper" share of such a distribution would be the remaining balance of settlement proceeds after the deduction of claimant's attorney fee, litigation expenses, and statutory 1/3 share.

Applying the aforementioned distribution scheme, we reach the following totals:

Settlement	$13,000.00
Attorney Fee	$-4,044.85
Litigation Costs	$- 412.70
Sub-Total	$ 8,542.45
Claimant's 1/3 Share	$ 2,847.48
Remaining Balance to SAIF	$ 5,694.97
Partial Payment	$ 4,044.86
Unpaid Balance to SAIF	$ 1,650.11

In reaching this conclusion, we note that, according to SAIF's calculations, its statutory share should total $5,594.35, rather than the $5,694.97 listed above. However, SAIF based its calculations on an attorney fee of $4,195.77, whereas claimant's counsel computed an attorney fee of $4,044.85. With neither a retainer agreement nor evidence from claimant or his counsel concerning their financial arrangements, we decline to modify the amount of claimant's previously stated attorney fee.

We further note that our calculations have not considered the $297.27 retainer from claimant. Since this sum was apparently provided to offset claimant's litigation costs and because claimant's attorney has received full credit for these expenses in our calculations, it follows that claimant's attorney should reimburse claimant for these costs. Thus, claimant's full share from the settlement would be $3,144.75 ($2,847.48 + $297.27), rather than the $4,044.86 distributed to him by his counsel.

Rather than distributing the settlement proceeds in accordance with the aforementioned statutory scheme, claimant's counsel paid $750 of the proceeds as reimbursement of a "PIP lien." There is no provision that would permit the disbursement of any portion of the proceeds from a third party recovery directly to a physician, a medical services provider, an insurer other than the paying agency, or any other entity. See Steven B. Lubitz, 40 Van Natta 450 (1988). Thus, claimant's counsel's action was clearly contrary to the statutory distribution scheme as set forth in ORS 656.593(1) and (3).

As a result of claimant's counsel's impermissable distribution, SAIF's recovery has been unilaterally and invalidly reduced. Under such circumstances, we have previously held that the paying agency may recover the unpaid portion of its lien from claimant's attorney. Steven B. Lubitz, supra.

In accordance with the reasoning discussed above and the rationale articulated in the Lubitz holding, we conclude that claimant's attorney is jointly and severally responsible for remedying this situation. Accordingly, claimant and/or claimant's attorney are directed to pay SAIF the unpaid portion of its rightful share of the settlement proceeds. i.e., $1,650.11.

IT IS SO ORDERED.

In the Matter of the Compensation of
GLEN D. ROLES, Claimant
WCB Case Nos. 88-19267 & 89-06314
ORDER ON RECONSIDERATION
Welch, et al., Claimant Attorneys
Dennis S. Martin (Saif), Defense Attorney

On January 22, 1991, we filed with the Court of Appeals a Notice of Withdrawal of our January 10, 1990 Order on Review. See ORS 183.482(6); ORAP 4.35. We took such an action to reconsider our decision in conjunction with our review of cases involving the same parties and essentially the same issues which are pending before the Board. Having completed our review of these matters, we issue the following reconsideration order.

The relevant facts are as follows. Referee M. Johnson ordered the SAIF Corporation to pay over $10,000 in what he characterized as temporary total disability compensation. When SAIF refused to pay, claimant requested a hearing seeking enforcement of Referee Johnson's order. Referee Harri ordered SAIF to pay the monies ordered by Referee Johnson, as well as a penalty and related attorney fee. When SAIF continued to refuse to pay, claimant requested another hearing. Thereafter, Referee Emerson assessed an additional penalty and related attorney fee.

On review of the aforementioned Referee orders, we reversed those portions of Referee Johnson's order that gave rise to the enforcement proceedings before Referee Harri and Emerson. Specifically, we reinstated the four Determination Orders that Referee Johnson had set aside. Glen D. Roles, 42 Van Natta 68 (1990).

This case concerns our consolidated review of the Harri and Emerson orders. In our previous order, we reversed those portions of the Referee orders that assessed penalties. Glen D. Roles, 42 Van Natta 73 (1990). Without expressly addressing the enforcement portion of Referee Harri's order, we affirmed the remainder of his order.

This date, we have concluded that, because Referee Johnson lacked jurisdiction and statutory authority to set aside the four Determination Orders, his order awarding what he characterized as temporary disability, as well as Referee Harri's enforcement order and that portion of our January 11, 1990 order affirming Referee Harri's enforcement decision, were void and unenforceable. Glen D. Roles, 43 Van Natta 278 (1991)(WCB Case Nos. 89-14455; 90-02445). Based on the reasoning and conclusions expressed in that order, we reverse that portion of Referee Harri's order that directed SAIF to pay the amounts ordered by Referee Johnson.

Furthermore, we reverse those portions of Referee Harri's order and Referee Emerson's order that awarded penalty-related attorney fees for SAIF's allegedly unreasonable failure to comply with Referee Johnson's and Referee Harri's orders. Inasmuch as we have found Referee Johnson's and Referee Harri's directions to pay temporary disability compensation to be invalid, it follows that SAIF's failure to comply with those directives was not unreasonable. Moreover, since neither directive required the payment of "compensation," SAIF has not unreasonably resisted the payment of compensation. Consequently, penalty-related attorney fees under ORS 656.382(1) are not warranted.

Accordingly, as modified and supplemented herein, we adhere to and republish the findings and conclusions expressed in our January 10, 1990 Order on Review. In addition, the "Order" portion of our January 10, 1990 order is replaced with the following paragraphs.

In WCB Case No. 88-19267, Referee Harri's order dated February 27, 1989, as reconsidered March 16, 1989, is reversed. The Referee's direction to SAIF to pay the temporary disability compensation awarded by Referee Johnson's order is reversed. The Referee's assessment of a 25 percent penalty and a $3,000 penalty-related attorney fee are reversed. Inasmuch as claimant has not prevailed on review concerning the temporary disability compensation, the $500 attorney fee awarded by our January 10, 1990 order is withdrawn.

In WCB Case No. 89-06314, Referee Emerson's order dated May 16, 1989 is reversed. The Referee's assessment of a 25 percent penalty and a $600 penalty-related attorney fee are reversed.

IT IS SO ORDERED.

Board Member Crider dissenting.

I do not share the view articulated in the Board's order in WCB Case No. 89-14455 and 90-02445 that disability benefits are not compensation because a referee should not have conducted the hearing which gave rise to the award of benefits. The disability benefits awarded by Referee Johnson were compensation. The only question is whether compensation awarded under these circumstances must be paid under former ORS 656.313.

I would adhere to our original order.

In the Matter of the Compensation of
PRISCILLA J. BOSLEY, Claimant
WCB Case No. 89-03907
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Leahy's order that: (1) affirmed a Determination Order finding that claimant was medically stationary on November 8, 1988; (2) declined to assess penalties and related attorney fees for an allegedly unreasonable "de facto" denial of claimant's alleged aggravation claim; (3) upheld the insurer's "de facto" denial of claimant's claim for medical services; (4) awarded a $300 attorney fee for the insurer's failure to timely accept or deny claimant's medical services claim; and (5) declined to rate claimant's psychological condition. In her brief, claimant argues that interim compensation should have been paid subsequent to the alleged aggravation claim. In its brief, the insurer contends that claimant's psychological condition is not related to her industrial injury of February 17, 1986. On review, the issues are compensability, premature closure, claims processing, medical services, extent of disability and penalties, related attorney fees and the amount of the fee awarded by the Referee. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant suffered from a psychological condition for a number of years prior to her 1986 compensable back injury. Her condition was characterized by periodic, wide mood swings. Lithium maintenance treatment was recommended, after the condition was variously diagnosed as agitated depression, manic-depressive illness, or moderate bipolar affective disorder. (Exs. 8-2, 9-1, 10-2).

On February 2, 1986, claimant compensably injured her left hip, thigh and low back. She underwent a microdiskectomy six weeks later and was fully released to work in July 1986.

After the 1986 compensable injury, claimant continued to seek treatment for her various complaints, including pain. On August 8, 1988, Dr. Burchiel, M.D., wrote to the insurer proposing an intrathecal enhanced CT scan and a "trial of epidural stimulation for pain control." (Ex. 51-1). The insurer did not respond. On July 11, 1989, the insurer received a request for authorization to perform a CT scan only, as a diagnostic measure. (Ex. 84). It did not respond thereafter.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that the Referee dismissed claimant's hearing request, although no party requested dismissal. Inasmuch as we are aware of no authority for dismissal, we conclude that the Referee should not have dismissed claimant's request in this case. Therefore, we reinstate claimant's hearing request and proceed with our review.

As a second preliminary matter, we note claimant's argument that her psychological claim was accepted, because she received counseling for two years and the insurer paid the counselor's bills. We find no evidence that this claim was accepted. In this regard, we note that payment of medical bills does not constitute acceptance. ORS 656.262; Richmond v. SAIF, 85 Or App 444 (1987). See also, Gregg v. SAIF, 81 Or App 395 (1986); Faught v. SAIF, 70 Or App 388 (1984); Jacobsen v. SAIF, 36 Or App 789 (1978).

Compensability of Psychological Condition

On the merits, claimant bears the burden of proving that her psychological condition is compensably related to her accepted left hip and thigh injury. Poole v. SAIF, 69 Or App 503 (1984). To carry that burden, she must establish that her industrial injury was a material contributing cause of her psychological condition, or, if the mental condition predated the injury, that the injury worsened that preexisting condition. Jeld-Wen, Inc. v. Page, 73 Or App 136, 139 (1985). Considering the multiplicity of potential causes in this case, we conclude that the question of causation is complex enough to require expert medical analysis. Uris v. Workers' Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Claimant's treating counselor and the psychologists at the Colistro Clinic were under the impression that claimant had "positive" psychological functioning prior to her 1986 industrial injury. That impression forms the basis for their opinion regarding causation, as well as their treatment and prognosis. However, based on the following uncontroverted medical evidence, we conclude that the treating psychologists relied upon an inaccurate history.

In February 1976, claimant complained of nervousness, night sweats, weight loss and diarrhea. Dr. Ellerbrook suspected hyperthyroidism and prescribed Valium and Indoral. For about three years, claimant reported waxing and waning symptoms including depression, headaches and tiredness. (Ex. 2).

Ellerbrook referred claimant to Dr. Melvin in May 1982 for evaluation of possible hyperthyroidism and diplopia, or double vision. Melvin noted claimant's history that she had been "thin, anxious and hot for most of her life and attributed these to stress." (Ex. 5-1). Claimant developed ptosis in one eye and ocular myesthenia. On October 5, 1982, she reported diarrhea, nausea, worsened diplopia, nervousness, clumsiness and disorientation. (Ex. 5-7). On

October 12, 1982, she was feeling "great." On October 29, claimant telephoned Melvin, "worried that she should feel good one day and bad the next." (Ex. 5-8).

In December 1982, Melvin noted that the hyperthyroid diagnosis was a clinical diagnosis, not objectively confirmed. (Ex. 5-10). When claimant stated that she "felt hypo," in January 1983, Melvin opined that her "symptoms could be anxiety." (Ex. 5-11). He told claimant that her thyroid was functioning normally and that her symptoms were more likely related to her psyche than to organic disease. In May 1983, Melvin again advised claimant of normal thyroid and sugar lab results. He doubted that claimant's hyperthyroidism was recurring and opined that her symptoms were related to an anxiety state. (Exs. 5-11-12; 6).

In February 1984, claimant reported that she felt "better than at any time in her life: but concerned that she senses a turnaround back to old problem." (Ex. 5-15). In April 1984, Melvin noted that claimant was very unhappy, reportedly in a "cycle" of feeling bad. He found no signs of hyper or hypo thyroidism. (Id.)

Melvin referred claimant to Dr. Hammerstad, neurologist. In so doing, Melvin reported claimant's fluctuating symptom complex, "frequently recurring symptoms of nervousness, fluctuating temperature intolerance from one extreme to the other, irritability and fatigue." (Ex. 8-2). He stated that he had seen her quite frequently for these symptoms and repeatedly confirmed that her thyroid function was normal. Melvin concluded that claimant's symptoms were "stress related and best characterized as an agitated depression." (Id.)

Hammerstad evaluated claimant on May 22, 1984. Claimant described her "cycles of 'feeling on top of the world' which may last up to three months, and other times when she 'feels rotten.'" (Ex. 9-1). Hammerstad noted that claimant's list of somatic complaints were "all compatible with depression although she denies a depressed, sad mood." (Id.) He concluded that claimant was describing a moderate bipolar affective disorder and recommended psychiatric consultation.

Dr. Sack, M.D., and professor of psychiatry, evaluated claimant on June 16, 1984. He noted claimant's report that her mood swings were cyclic, in a fairly regular pattern of two or three months in each direction. When depressed, claimant's symptoms included intermittent crying spells, lethargy, irritability, losing weight, social withdrawal and diminished appetite, libido and ability to concentrate. (Ex. 10-1). Sack concluded that claimant has a propensity for manic-depressive illness and recommended Lithium maintenance. (Ex. 10-2). In August 1984, Sack began to suspect that a sleep disorder may underly claimant's changes in energy. (Ex. 14).

All the above complaints and medical opinions issued prior to claimant's compensable injury. Inasmuch as there is no evidence to the contrary, we conclude that claimant suffered from a psychological condition which preexisted the 1986 injury.

Although we ordinarily give great weight to the opinion of the treating physician(s), see Weiland v. SAIF, 64 Or App 810, 814 (1983), we decline to do so here, for the following fundamental reason. Dr. Worthington, one of claimant's treating psychologists, admitted that nothing in his file predated March 1987. (Ex. 89-29). Claimant admitted that she told Diane Worthington, counselor, that she had never been depressed before the 1986 injury. (Tr. 61). It is undisputed that Diane Worthington and her colleagues, Drs. Worthington and Colistro, were unaware of claimant's preexisting condition at least until Dr.

Worthington's deposition in 1989. Nevertheless, both Worthington and Dr. Colistro accepted claimant's history regarding the onset of her symptoms and restated it as fact in their chart notes and reports. (Exs. 36-4, 80-2, 86-29-30). Based on claimant's history that her psychological difficulties began after her 1986 injury, the psychologists concluded that claimant's problems were caused by her injury and its sequelae. However, inasmuch as claimant's treating psychologists relied on an inaccurate and incomplete history, we accord their opinions regarding causation no weight. Somers v. SAIF, 77 Or App 259 (1986).

As we have stated, claimant may prove that her current psychological condition is compensable by establishing that her preexisting condition worsened, due to her compensable injury. Jeld-Wen, Inc. v. Page, supra. Accordingly, we proceed to consider whether claimant's current psychological condition represents a worsening of her preexisting condition.

Claimant began treating with Dr. Noren, chiropractor, in January 1987. At the outset, claimant listed past and present problems with neck, arms and legs, sore muscles, numbness, headaches, forgetfulness, confusion, depression, irritability, and vision problems. She reported prior problems with low back pain, pain between the shoulders, swollen painful joints, dizziness, exhaustion, fatigue and weakness. (Ex. 29-2). In March 1987, claimant presented at the Colistro Clinic, describing symptoms of worry, muscle tension, headaches, gastrointestinal disturbances, irritability, tearfulness, weight loss, rapid pulse and pain interfering with sleep occasionally. (Ex. 31-1). Over the following months, Diane Worthington reported claimant's symptoms of tearfulness, anger, and frustration. Claimant continued to complain of irritability, diminished frustration tolerance, sleep disturbance, anergia, anhedonia, periods of tearfulness, "apparent psychophysiologic problems such as tension headaches and gastrointestinal disturbance and morbid preoccupation with her pain." (Ex. 39-1). As before, claimant's symptoms waxed and waned. (See Exs. 31, 38).

Dr. Davies, Psy.D., evaluated claimant on August 4, 1987 and again on August 16, 1988. After a thorough review of claimant's history, Davies concluded that there had been no change in claimant's cyclical mood swings of a fairly regular pattern since her injury. (Ex. 81-12). He opined that claimant suffers from a personality disorder, as distinguished from an injury-related, or traumatic, disorder. (Ex. 81-9). In this regard, Davies found claimant's current problems to be "extremely" similar to the problems she has had at least since 1984, and probably since the mid-1970's. (Ex. 81-14, 23). He concluded that claimant has suffered from dysthymia (a type of depression) since 1983, and that she is "currently having the same symptoms she has had all along." (Ex. 81-31).

Davies' opinion, unlike that of claimant's treating psychologists, is based on a complete history. He observed that claimant has the same complaints now as she had before her injury and concluded that her condition is the same now as it was then. We find no persuasive evidence that claimant's psychological condition has worsened, or that her periodic cycles of depression symptoms differ in frequency or intensity from those which occurred prior to the 1986 injury. Accordingly, we conclude that claimant has not carried her burden of proving that her compensable injury caused a worsening of her preexisting psychological condition. Therefore, claimant's psychological condition is not compensable.

Premature Closure and Extent of Disability

Claimant argues that her claim was prematurely closed, solely on the basis of her psychological condition. In the event that her claim was not prematurely closed, claimant contends that she is entitled to a disability rating for her psychological condition.

Inasmuch as we have determined that her psychological condition is not compensable, her claim was not prematurely closed and she is not entitled to a permanent disability award for that condition.

Medical Services

On August 8, 1988, Dr. Burchiel, neurologist, wrote to the insurer, proposing a CT scan and a trial period of epidural stimulation for pain control. (Ex. 51-1). The insurer did not respond. Burchiel filed a second request on July 11, 1989. (Ex. 84). The second letter requested authorization to perform only a CT scan, for the purpose of determining whether epidural stimulation would be appropriate treatment for claimant's pain. Again, the insurer did not respond. Claimant appeals the second "de facto" denial only.

Claimant is entitled to all reasonable and necessary medical treatment required for recovery from her compensable injury or for relief of pain. ORS 656.245(1); Wetzel v. Goodwin Bros., 50 Or App 101 (1981); See James v. Kemper Insurance Co., 81 Or App 80, 84 (1986).

A diagnostic service, such as the proposed CT scan, is a compensable medical service, so long as it is reasonable and necessary and related to a compensable condition. See ORS 656.245; Finch v. Stayton Canning Co., 93 Or App 168, 173 (1988). Here, there is no serious argument that the CT scan was not recommended as a diagnostic measure, related to claimant's compensable back condition. There is some dispute about whether it is reasonable and necessary.

Burchiel was the treating physician for purposes of the proposed medical service. That, combined with the fact that his 1989 letter requested permission to perform a diagnostic procedure only, for the purpose of determining whether further pain treatment is indicated, persuade us that claimant has carried her burden of proving that the CT scan is reasonable and necessary.

Claims Processing, Penalties and Attorney Fees

Claimant contends that Diane Worthington's March 7, 1989 letter put the insurer on notice of her worsened psychological condition. (See Ex. 76). The insurer did not respond, and claimant seeks a penalty and related attorney fee for the insurer's failure to accept or deny the alleged aggravation claim within 60 days.

In the March 1989 letter, Worthington reported that claimant "continues to suffer from symptoms of depression, her vocational status is unresolved and she has recently been experiencing a significantly [sic] increase in pain. . . .She continues to suffer symptoms of tearfulness, agitation and intermittent acute distress. . . .[She] will continue to need structured vocational assistance. . .and we are continuing to provide outpatient psychotherapy on an ongoing basis." (Id., emphasis added).

Inasmuch as Worthington's letter refers to continued symptoms and continued treatment, we find that it did not put the insurer on notice that treatment for more than a continuing condition was indicated. Therefore, the letter did not constitute an aggravation claim. See Krajacic v. Blazing Orchards, 84 Or App 127 (1987).

Because no claim was made, there was nothing for the insurer to accept or deny. There were no amounts "then due" and no evidence of unreasonable resistance to the payment of compensation. Therefore, we conclude that the insurer's failure to respond supports neither a penalty nor an attorney fee.

In her brief, claimant also argues that the insurer should have paid interim compensation after Diane Worthington declared claimant to be psychologically temporarily totally disabled. (See Ex. 73). This issue was not raised at hearing and the record is closed. Under such circumstances, the issue will not subsequently be considered. Mavis v. SAIF, 45 Or App 1059 (1980); Tobert L. White, 42 Van Natta 2832 (1990). 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). Therefore, we decline to consider this issue on review.

Amount of Fee Awarded on Medical Services Issue

The Referee awarded claimant's attorney a $300 fee, associated with the insurer's unreasonable resistance to the payment of compensation by way of its "de facto" denial of the medical services claim. Claimant seeks an increased award, arguing that the award "did little to prompt the insurer to mend its ways."

Burchiel's 1989 letter constitutes a claim for medical services. See Jack O. Pichette, 42 Van Natta 2136 (1990). As such, it triggered the insurer's duty to accept or deny it within 60 days. Billy J. Eubanks, 35 Van Natta 131 (1983). However, because the medical services had not been rendered at the time of hearing, there were no "amounts then due" upon which to base a penalty.

On the other hand, an attorney fee may be awarded, pursuant to ORS 656.382(1), if an insurer unreasonably resists payment of compensation. Lloyd L. Cripe, 41 Van Natta 1774 (1989). In this case, we find that the insurer's failure to respond to claimant's claim for diagnostic services was unreasonable and that it had the effect of delaying benefits which were compensable. See Pichette, supra at 2137-38. Therefore, the insurer unreasonably resisted the payment of compensation to claimant. We agree with the Referee's assessment of an attorney fee and with the amount of the fee awarded. In arriving at the proper fee amount, we have considered the factors set forth in OAR 438-15-010(4) and applied them to this case.

Claimant's counsel is statutorily entitled to a reasonable insurer-paid fee for services at hearing and on review concerning the medical services issue. Former ORS 656.386(1). 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 medical services issue is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to this issue and the value of the interest involved.

ORDER

Claimant's request for hearing is reinstated. The insurer's "de facto" denial of claimant's claim for diagnostic medical services is set aside and the case is remanded to the insurer for further processing according to law. For services at hearing and on Board review regarding the medical services issue, claimant's attorney is awarded a reasonable assessed fee of $500, to be paid by the insurer. The Referee's order dated April 6, 1990 is otherwise affirmed.

In the Matter of the Compensation of
EARNEST E. LASLEY, Claimant
WCB Case No. 88-21542
ORDER ON REVIEW
Coughlin, et al., Claimant Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Howell, Speer and Crider.

The SAIF Corporation requests review of that portion of Referee Galton's order that modified the Director's order which found that claimant was not eligible for restoration of his vocational assistance. On review, the issue is whether the Referee was correct in modifying the Director's vocational assistance order. We reverse.

BACKGROUND

Claimant sustained a compensable injury on April 24, 1979. Following a May 1984 aggravation of his injury, claimant returned to light work until March 1985. He has not worked since that time.

Subsequent to his aggravation, SAIF twice terminated claimant's vocational assistance, due to his physical inability to participate. In December 1988, claimant completed a three week program at the Northwest Pain Center. The Center recommended that claimant work with his vocational counselor to find employment within his limitations.

In February 1989, claimant's treating physician, Dr. Dahlin, found claimant to be medically stationary. Dr. Dahlin recommended that claimant seek alternative employment within his current physical capacities.

In March 1989, claimant reported to his vocational counselor, Mr. Elliott, that he felt physically unable to participate in vocational assistance. In May 1989, claimant met with the counselor and informed him that his condition had worsened and he could no longer participate in vocational services. At that time, Mr. Elliott told claimant that participation was required in order to maintain eligibility for assistance.

On May 5, 1989, Mr. Elliott wrote to claimant to remind him of his responsibility to participate in the vocational program. Mr. Elliott also wrote to Dr. Dahlin and inquired whether or not claimant was physically capable of participating in vocational services.

On May 19, 1989, Dr. Dahlin reported that claimant should continue to pursue vocational assistance. Dr. Dahlin wrote that claimant was capable of continuing in the activity, "which in point and fact is a top priority for him at this time." Dr. Dahlin also noted that he had requested a consultation in order to assess claimant's psychological level. However, Dr. Dahlin noted that claimant's physical condition was "probably stabilized at this time...."

In a May 23 letter, Mr. Elliott sent claimant an official written warning which stated that active involvement was required for continuing vocational eligibility. Mr. Elliott noted that claimant had not remained in contact and had not returned a participation agreement which had been given to him earlier in the month. Mr. Elliott also stated that if he could not participate, it was claimant's responsibility to furnish a doctor's statement to that effect.

On May 24, claimant contacted the vocational counselor and informed him that he was physically unable to participate. After Mr. Elliott received Dr. Dahlin's letter of May 19, he contacted claimant and reviewed the contents of the letter with him. Claimant reiterated that he was not able to participate.

A second warning letter was sent by Mr. Elliott on May 26, 1989, providing claimant with an extended June 9 deadline by which time claimant could sign and return the participation agreement, provide proof of his inability to participate or lose his eligibility for further services.

A legal assistant from claimant's counsel's office phoned Mr. Elliott on June 9, 1989. The counselor explained what steps claimant could take in order to comply with the program requirements. Neither claimant nor his counsel further contacted Mr. Elliott.

On June 21, 1989, SAIF notified claimant that his eligibility for vocational assistance was terminated on the basis that, following written warning, he failed to participate in services. On July 5, 1989, claimant appealed SAIF's decision to the Director.

On August 10, 1989, Dr. Dahlin reported that, at the time SAIF terminated vocational assistance, a combination of physical and mental factors prevented claimant from meaningful participation in such services.

On October 9, 1989, the Director issued his order declining to restore claimant's vocational services. The Director concluded that claimant had failed to comply with SAIF's written warnings in order to preserve his eligibility for future services. The Director authorized termination of vocational assistance, pursuant to OAR 436-120-050(7).

Claimant requested review by a Referee, pursuant to ORS 656.283(2). The Referee held an evidentiary hearing and concluded that the Director had abused his discretion. Consequently, after concluding that claimant's entitlement to vocational assistance should have been terminated pursuant to OAR 436-120-050(10), the Referee modified the Director's order. SAIF brings this appeal.

CONCLUSIONS OF LAW AND OPINION

SAIF contends that the Referee erred in modifying the Director's order to terminate entitlement to vocational assistance pursuant to OAR 436-120-050(10). We agree.

ORS 656.283(2) provides that the Director's decision as to vocational assistance matters may be modified only if the decision: (a) violates a statute or rule; (b) exceeds the statutory authority of the agency; (c) was made upon unlawful procedure; or (d) was characterized by an abuse of discretion or clearly unwarranted exercise of discretion. A finding of one of the circumstances listed at ORS 656.283(2)(a) through (d) is mandatory before a Director's order may be modified by a Referee. See SAIF v. Severson, 105 Or App 67 (1990); Richard A. Colclasure, 42 Van Natta 2454 (1990).

In order to determine whether or not the Director has abused his discretion, we review the record made before the Referee. In so doing, we do not substitute our judgment for the Director's by deciding how the evidence preponderates nor do we determine if there is substantial evidence to support the Director's order. We may only modify the Director's order pursuant to ORS 656.283(2)(d) if the hearing record "as a whole" indicates that the Director acted (found fact, reached conclusions or applied the law)...to an end or purpose not justified by, and clearly against reason and evidence. Colclasure, supra.

In the present case, the Director applied OAR 436-120-050(7), which provides that the eligibility of the worker for vocational assistance shall end when:

> "The worker has failed, after written warning, to cooperate in the development of a return-to-work plan."

Claimant contends that the Referee correctly found that his vocational assistance should have been terminated pursuant to OAR 436-120-050(10), rather than OAR 436-120-050(7). OAR 436-120-050(10) provides that the eligibility of the worker for vocational assistance shall end when:

> "The worker's lack of suitable employment cannot be resolved by currently providing vocational assistance."

Claimant argues only that the Director abused his discretion by failing to assign more weight to reports that found that his psychological condition was not medically stationary. Claimant asserts that the reports indicate that, at the time services were terminated, he was unable to participate in vocational services. For this reason, claimant argues that it was an abuse of discretion for the Director to authorize termination of the services. We disagree.

In the present case, we cannot conclude that the Director abused his discretion by finding that SAIF properly terminated claimant's vocational assistance due to his failure, after written warning, to cooperate in the development of his return-to-work plan. The record supports the Director's conclusion that claimant was provided with written warnings that his eligibility would be terminated if he did not take steps to maintain contact and participate in the provided services. The record also supports the conclusion that claimant did not comply with the written warnings.

In reaching his conclusion, the Director arguably could have applied OAR 436-120-050(10) and determined whether termination of services was proper due to the fact that claimant's lack of suitable employment could not be resolved by currently providing vocational assistance. However, we do not find that it was an abuse of discretion for the Director to base his conclusion upon OAR 436-120-050(7). We are unconvinced that, even if claimant was not medically stationary at the time of termination of vocational services, his status precluded him from cooperating in the development of a return-to-work plan, as prescribed by that rule.

Moreover, even if the Director's authorization of termination properly could have been based upon more than one administrative rule (i.e., OAR 436-120-050(7) and OAR 436-120-050(10)), we cannot conclude that it was an abuse of discretion for the Director to place more reliance upon one of those rules in arriving at his conclusion.

In the present case, we are unable to conclude that the hearing record indicates that the Director acted to an end or purpose that was clearly against reason and evidence. Further, claimant asserts no basis other than abuse of discretion which would authorize modification of the Director's order. ORS 656.283(2). Accordingly, the Referee's order is reversed.

ORDER

The Referee's order dated February 14, 1990 is reversed. The Director's order is affirmed in its entirety.

Board Member Crider, dissenting.

The Referee found, as a matter of fact that, at the time eligibility for vocational services was terminated, vocational services would not have been successful in resolving claimant's lack of employment. He made this finding based on medical evidence that claimant was unable to participate in vocational services due to his severe depressive condition. Based on this finding, the Referee concluded that the Director abused his discretion when he affirmed the insurer's decision to terminate eligibility for vocational services for noncooperation. The majority reverses. In so doing, the majority declares it is not the referee's province to determine the facts upon review of a Director's order pursuant to ORS 656.283(2). Because I disagree with that view of the referee's role, I dissent.

As I stated in my dissenting opinion in Richard A. Colclasure, 42 Van Natta 2454 (1990), I believe that the referee must act as independent fact-finder on review of a Director's order in a vocational services matter. If, on de novo review, we agree with the Referee's findings of fact, it follows necessarily that the Director's decision was inconsistent with the administrative rules governing eligibility. OAR 436-120-050. In that event, the decision both violated a statute or rule and constituted an abuse of discretion; and the Referee's order modifying the Director's decision ought to be affirmed.

The majority has failed to decide, based on the hearing record, whether or not claimant was able to participate in vocational services at the time eligibility was terminated. That is error.

February 25, 1991 Cite as 43 Van Natta 389 (1991)

In the Matter of the Compensation of
DOLLY S. MACK, Claimant
WCB Case Nos. 89-13174, 89-20116, 89-12393 & 89-20115
ORDER ON REVIEW
Flaxel, Todd, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

The self-insured employer, Payless Drug Stores, requests, and claimant cross-requests, review of Referee Emerson's order that: (1) set aside Payless' denial of a new injury claim for a neck condition, (2) upheld the SAIF Corporation's denial of an aggravation claim for the same condition, and (3) awarded claimant a $500 attorney fee for services prior to hearing. On review, the issues are responsibility and attorney fees. We reverse in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" except for the final paragraph of those findings. We make the following additional findings:

At the time of claimant's June 1987 compensable injury, Sun Plywood was insured by SAIF.

Claimant's symptoms grew more frequent while she was working for Payless. However, the symptoms were in the same part of the body and were of the same type as they had been following the 1987 compensable injury.

FINDINGS OF ULTIMATE FACT

Claimant's condition, requiring surgery, was materially related to the 1987 compensable injury.

Work exposure at Payless did not independently contribute to a worsening of claimant's underlying neck and shoulder condition.

No .307 order had issued at the time of hearing. Compensability was conceded by both SAIF and Payless at hearing. A .307 order issued between the time of hearing and the issuance of the Referee's order.

The rate of temporary total disability compensation (TTD) payable in this claim will be greater if SAIF is responsible than if Payless is responsible.

CONCLUSIONS OF LAW AND OPINION

Standard of Review

We review de novo. Although the Referee captioned his order "Arbitrator's Decision," at the time the hearing commenced, no .307 order had issued. Since the Referee issued his order, we have concluded that a referee's order in a responsibility case is an arbitrator's decision for purposes of former ORS 656.307(2) only if the hearing is convened pursuant to a Director's order referring the case for hearing. Where, as here, no .307 order issued prior to hearing, the limited review provisions of ORS 656.307(2) do not apply. Ronald L. Davis, 42 Van Natta 2077 (1990).

Moreover, even had the hearing commenced after issuance of the .307 order, we would hold that our review is de novo. Claimant seeks review. The .307 order indicates that claimant's TTD rate will be $306.43 if SAIF is responsible and only $88.81 if Payless is responsible. Consequently, claimant has established on the arbitration record that the responsibility determination resolves "a matter concerning a claim" because if SAIF is responsible, her temporary disability benefits will be greater than if Payless is responsible. Accordingly, the standard of review is as provided for matters concerning a claim. ORS 656.307(2) and ORS 656.704(3). See John L. Riggs, III, 42 Van Natta 2816, corrected 2877 (1990); Jon E. Robinson, 42 Van Natta 512 (1990).

Responsibility

The Referee found that claimant's work at Payless may have independently contributed to her herniated disc and need for surgery. In accordance with our decision in Donald D. Davis, 40 Van Natta 2000 (1988), he therefore concluded that Payless was responsible for claimant's worsened condition and need for surgery unless it could establish that work for Payless actually did not independently contribute to the worsening of the underlying condition. He concluded that Payless did not satisfy that burden. We disagree.

The Board has since disavowed that portion of our decision in Davis that assigned the burden of proof to the last employer where no discrete accident occurred in the course of employment there. See Linda L. Wise, 42 Van Natta 115 (1990). More importantly, whichever employer bears the burden of proof, we are persuaded that claimant's exposure at Payless did not independently contribute to the worsening of her underlying condition.

In making this critical finding, we rely on the opinions of Dr. Kitchel, orthopedic surgeon, who began treating claimant in December 1988 on referral from Dr. Whitney, and of Dr. Hockey, also an orthopedic surgeon, who examined claimant in March 1989 to render a second opinion on the advisability of

surgery. Dr. Kitchel has opined that claimant's work at Payless caused an increase in symptoms but did not independently contribute to the causation of her condition. Dr. Hockey also stated, based on claimant's history, which we believe to be accurate, that claimant's condition did not change as a result of work at Payless. He also believed that only claimant's symptomatology had changed as a result of the new work exposure.

No medical expert has contended that the work at Payless actually independently contributed to the worsening. Dr. Woolpert, who examined claimant for SAIF, simply concluded that the work at Payless could possibly have caused a pathological worsening. Dr. Woolpert drew this conclusion based on a comparison of the MRI taken in April 1988, prior to claimant's work at Payless, to the myelogram taken in April 1989. We note that he recognized that one must be cautious in drawing any conclusions based on such a comparison. Moreover, assuming claimant did experience a worsening--which could be demonstrated radiographically as well as symptomatically--during the one year interval between the tests, no physician has opined that if the worsening occurred during that interval the worsening was necessarily caused by the work at Payless.

Generally, absent persuasive reasons not to do so, we rely on the treating physician. We see no reason not to do so in this case. SAIF contends that Dr. Kitchel's opinion is not persuasive because he relied on claimant's history which indicated that her symptoms in 1989 were the same as they had been after the compensable injury. SAIF notes that Dr. Hockey, after his March 30, 1989 exam, noted numbness in the right upper arm, whereas it had been previously noted by Drs. Bernstein and Whitney that claimant had no upper extremity symptoms. It appears likely that the distinction is but an artifact of reporting. We note that even in 1989, Dr. Hockey, while he noted arm numbness, found no radicular pain. Moreover, Dr. Whitney, in November 1988, apparently took a history indicating some upper extremity difficulties as he reported "no real numbness or weakness in the arm." Finally, claimant's testimony at hearing supports the history taken by Drs. Hockey and Kitchel. Consequently, we reject SAIF's contention that their opinions should be disregarded because they were rendered based on accurate symptomatic history.

Because the record establishes that claimant's work at Payless did not independently contribute to the causation of her condition, responsibility must be assigned to SAIF. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984).

Attorney Fees

The Referee awarded claimant's attorney a fee of $500, under ORS 656.386(1), for services in obtaining a .307 order. Neither Payless nor claimant is satisfied. Payless argues that the fee, if any, should be awarded under ORS 656.307(5) rather than ORS 656.386(1). Because claimant unsuccessfully contended at hearing that SAIF was responsible, Payless argues that her attorney's participation was not active and meaningful within the meaning of the statute. Consequently, no fee should have been awarded. Claimant, on the other hand, seeks a greater award.

An order designating a paying agent under ORS 656.307 had not issued by the time of hearing. Thus, although the carriers only contested the issue of responsibility at hearing, claimant's right to compensation remained at risk. Jan C. Leech, 42 Van Natta 2047, 2048 (1990). Under such circumstances, a claimant is entitled to an attorney fee, even where her counsel actively argues responsibility against a carrier ultimately found not responsible. See Riley E. Lott, 43 Van Natta 209 (1991). We reach such a conclusion because, even though responsibility is the only issue litigated at hearing, claimant's counsel is nonetheless required to protect against possible re-assertions of compensability

because the carriers have not obtained a .307 order and have not previously conceded compensability. Lott, supra.

Here, not only had no .307 order issued by the time of hearing, but claimant argued a position that has ultimately prevailed - i.e., SAIF is the responsible carrier. In accordance with the Lott and Leech rationale, her counsel is entitled to a reasonable attorney fee for services at the hearing level. This fee shall be paid by SAIF, the carrier ultimately found responsible for the claim. Tanya L. Baker, 42 Van Natta 2818 (1990).

After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable fee for claimant's counsel's services at the hearings level is $2,000. In reaching this conclusion, we have particularly considered the time devoted to the case (as indicated in counsel's statements of services), the novelty of a number of the legal issues, the average complexity of the factual issues, and the value of the interest involved.

We turn to the issue of claimant's entitlement to an attorney fee for services on Board review. Because compensability was not an issue on review, claimant's right to compensation was not at risk of disallowance. Ray Schulten's Ford v. Vijan, 105 Or App 294 (1991). Moreover, since claimant's TTD rate under the SAIF claim is higher than under the Payless claim, claimant's compensation was not at risk of reduction as a result of Payless' appeal of the Referee's order. See Ray Schulten's Ford v. Vijan, supra; Riley E. Lott, supra. Finally, claimant is not entitled to an attorney fee concerning the Referee's attorney fee award. Dotson v. Bohemia, Inc., 80 Or App 233 (1986). Under such circumstances, we hold that claimant is not entitled to an assessed fee under ORS 656.382(2).

However, claimant has successfully prevailed on review in reversing the Referee's responsibility decision. Since claimant's TTD rate under the SAIF claim is higher than under the Payless claim, claimant's counsel's efforts on review have resulted in increased compensation. Consequently, her counsel is entitled to an approved attorney fee payable from the increased temporary disability compensation created by this order. See ORS 656.386(2); OAR 438-15-055(1); Ronald K. Miller, 43 Van Natta 223 (1991).

ORDER

The Referee's order dated October 19, 1989 is reversed in part and modified in part. The denial issued by Payless Drug, the self-insured employer, is reinstated and upheld. The SAIF Corporation's denial is set aside, and the claim is remanded to SAIF for processing in accordance with law. In lieu of the fee awarded by the Referee for services at hearing, claimant's attorney is awarded an assessed fee of $2,000 for services at the hearing level, to be paid by the SAIF Corporation. Claimant's attorney is also awarded an approved attorney fee equal to 25 percent of the increased temporary disability compensation created by this order, not to exceed $3,800, payable by SAIF directly to claimant's attorney.

In the Matter of the Compensation of
EVERETT RENNE, Claimant
WCB Case No. 89-21841
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
C. Douglas Oliver (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of that portion of Referee Knapp's order that increased claimant's unscheduled permanent disability award for a back injury from 18 percent (57.6 degrees), as awarded by a Determination Order, to 22 percent (70.4 degrees). On review, the issue is extent of unscheduled permanent partial disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" subject to the following correction. Claimant's injury occurred on June 29, 1988, not June 29, 1980 as stated in the first sentence of the Referee's findings.

CONCLUSIONS OF LAW AND OPINION

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

The Referee awarded claimant 22 percent (70.4 degrees) unscheduled permanent partial disability for claimant's low back injury. The Referee did not consider whether claimant had proven by clear and convincing evidence that his loss of earning capacity was greater than that provided for under the standards.

Claimant does not dispute the Referee's application of the "standards". However, claimant contends that his physical limitations, his lack of transferable skills, and his pre- and post-injury wage differential establish by clear and convincing evidence that his loss of earning capacity, as measured by his ability to obtain and hold gainful employment in the general labor market, exceeds that provided for under the "standards".

The criteria for rating of unscheduled disability shall be the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). Earning capacity is the ability to obtain and hold gainful employment in the broad field of general occupations, taking into consideration such factors as age, education, impairment and adaptability to perform a given job. Id.

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". Former 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).

Dr. Peterson, claimant's treating surgeon, opined that claimant is able to work in the medium range but is limited in his ability to twist, bend, sit, stand, and walk for extended periods of time. (Exs. 16B, 16E-9, 18). Claimant contends, and the record establishes, that claimant is unable to perform his at injury work as a pipe threader operator which Mr. Barrett, rehabilitation consultant, classified as heavy. (Ex. 16E-9). Claimant argues that these physical limitations establish that the "standards" do not adequately compensate him for his loss of earning capacity. However, contrary to claimant's argument, the Referee adequately considered these physical limitations in assigning claimant an adaptability value under former OAR 436-35-310(3), and in awarding impairment values for lost range of motion and loss of repetitive use.

Claimant also argues that he lacks transferable skills. However, Mr. Barrett found that claimant, though not a fully qualified machinist, did have some skill in machine operation and was able to operate several kinds of lathes. (Ex. 16E-3). Furthermore, at hearing, claimant was adequately performing a job as a machine tool operator. We find that this demonstrates that claimant has transferable skills.

Finally, claimant argues that his pre- and post-injury wage differential establishes that his loss of earning capacity is greater than that provided for under the standards. At the time of hearing, claimant was earning $8.00 an hour as a machine tool operator. Claimant's at injury job was a heavy job which paid $10.52 per hour. This job paid $11.02 per hour at hearing. Because of claimant's work-related physical limitations, he can no longer perform this job or any other heavy job.

Loss of earning capacity must reflect claimant's handicap in obtaining and holding gainful employment in the broad field of general occupations and not just in relationship to his occupation at any given time. Ford v. SAIF, 7 Or App 549, 552 (1972). Mr. Barrett provides the only vocational evidence and he discussed claimant's employment potential only in relation to claimant's past jobs and as a machine tool operator or a lathe operator. Mr. Barrett did not address claimant's employment potential in the broad field of general occupations. There is no evidence in the record that establishes that claimant is now physically and vocationally qualified for a small percentage of the job market and that those jobs pay less than claimant's job at injury.

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.

ORDER

The Referee's order dated March 21, 1990, as amended April 18, 1990, is affirmed.

February 25, 1991 Cite as 43 Van Natta 394 (1991)

In the Matter of the Compensation of
KERRIE D. SKINNER, Claimant
WCB Case Nos. 89-14204 & 84-10780
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Daniel DeNorch (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

The SAIF Corporation requests review of those portions of Referee Podnar's order that increased claimant's unscheduled permanent partial disability award for his shoulder, cervical spine and thoracolumbar spine conditions from 37 percent (118.4 degrees), as awarded by a Determination Order, to 93 percent (297.6 degrees). Claimant cross-requests review of that portion of Referee Podnar's order that authorized a $3,686.79 offset of overpaid temporary total disability compensation. On review, the issues are extent of unscheduled permanent partial disability and offset. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" as our own.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Partial 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 former ORS 656.283(7). Specifically, the Referee applied the version of OAR 436-35-001 et seq, in effect at the time of the October 24, 1989 Determination Order. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. These are the rules which we apply as well. Wade A. Webster, 42 Van Natta 1707 (1990).

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 and Education

The parties do not dispute the following values assigned by the Referee: 0 for age, 0 for formal education, and +1 for training.

The highest specific vocational pursuit (SVP) level demonstrated by a claimant during the ten years preceding the date of hearing is used to determine a value for skills. Former OAR 436-35-300(4). The Referee assigned a SVP value of +4, based on his classification of claimant's at injury job as a "metal shop helper". (DOT 619-686-022, SVP 2). Claimant's undisputed testimony described his at injury job as a "helper" working on a trimmer which involved trimming the ends of pipes and running a test rack which involved filling pipes with water and testing them under pressure. (Tr. 12, 13).

SAIF argues that claimant's job should be classified as a welder, pipe making. (DOT 616-360-026, SVP 5). It contends that operating a "trimmer" qualifies claimant as a machine operator. SAIF also notes that claimant was described as a "welder" in the history portion of a report from Dr. Cowan, D.C., who performed an independent medical examination. (Ex. 24A-1). Nevertheless, the DOT description of a metal shop helper's duties more closely matches claimant's undisputed testimony.

Alternatively, SAIF argues that claimant should get no SVP value because of his eight month on-the-job training program as a legal investigator (DOT 376-267-018, SVP 5). However, the on-the-job employer was having financial problems, and SAIF cancelled the program before claimant had completed it. Further investigative training was required and contemplated, and claimant was not successfully doing the legal investigator job because of his deficient writing skills. (Exs. 27-2, 28-2, 31-3, 32-3, 33-3, Tr. 101). For these reasons, we find that claimant's on-the-job training does not qualify him to be a legal investigator. Moreover, assuming claimant were qualified as an investigator, claimant would be entitled to a value of +2, rather than no value as SAIF argues.

Accordingly, we agree with the Referee's assignment of a +4 skills value based on claimant's at injury job as a metal shop helper. Former OAR 436-35-300(4).

Claimant's value for the education factor is +5 (0, +4, +1).

Adaptability

The adaptability value for a claimant who is not working as a result of his or her compensable injury/condition 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 not working as a result of his injury/condition and has not been offered work. The Referee found claimant limited to light-sedentary work and averaged the values of these two categories (light +4, sedentary +8) for a value of +6.

Claimant contends that he is further limited in his ability to sit, stand and walk, so that he is entitled to a higher value under former OAR 436-35-310(4)(d). However, there is no medical evidence supporting these limits. Claimant reported to Drs. Cowan and Christensen that he was limited in his ability to do these activities due to pain; however, neither doctor restricted claimant from performing these activities. (Exs. 24A-3, 25-2). Therefore, we find that the Referee correctly assigned an adaptability value of +6.

Impairment

Right Shoulder

In rating claimant's shoulder impairment at 36 percent, the Referee relied on the October 25, 1989 report of Dr. Christensen, D.C. SAIF argues that the Referee should have deferred to the finding of the treating chiropractor, Dr. Moskowitz, that claimant's total shoulder impairment was 18 percent. SAIF also argues that Christensen's rating is not persuasive because it is based on claimant's unreliable pain complaints.

The record supports the Referee's reliance on Dr. Christensen. His exam was a month before the November 1989 hearing, whereas Dr. Moskowitz last examined claimant in June 1989. Dr. Moskowitz reviewed Dr. Christensen's examination procedures and conclusions and concurred with them. (Ex. 25a-1). Furthermore, Dr. Christensen's report is thorough and well reasoned, whereas Dr. Moskowitz did not include any value for claimant's surgery and valued claimant's lost strength according to the Manual for Orthopedic Surgeons, rather than former OAR 436-35-330(19). Finally, the record does not support SAIF's contention that Dr. Christensen's report is unreliable because it is based on exaggerated complaints. Although the record suggests that claimant exaggerates his symptoms, there is no evidence that the range of motion and strength values reported by Christensen were due to functional overlay or not accurately demonstrated because of functional overlay. See Deborah L. Sherfield, 42 Van Natta 1025 (1990). For these reasons, we rely on Dr. Christensen's findings for claimant's shoulder impairment.

Dr. Christensen found claimant retained 110 degrees forward elevation, 110 degrees abduction and 70 degrees external rotation. (Ex. 25-3). The Referee valued these at 4 percent, 4 percent, 3 percent, respectively. However, the correct values are 2 percent each for a total of 6 percent lost shoulder range of motion. Former OAR 436-35-330(17). Dr. Christensen rated claimant's loss of strength at 20 percent. Former OAR 436-35-330(19). Claimant had a partial acromioplasty, which is rated at 5 percent. Former OAR 436-35-330(14).

Finally, claimant is restricted from repetitively using his right shoulder (Ex. 25-7); this loss is rated at 5 percent. Former OAR 436-35-320(4). SAIF argues that claimant is not entitled to a rating for loss of repetitive use because such a rating is limited to workers who have no loss of function under the standards. However, we rejected this argument in Larry L. McDougal, 42 Van Natta 1544 (1990).

When applying the version of OAR 436-35-001 et seq in force from January 1, 1989 through October 1, 1990, we have previously held that multiple shoulder impairments are combined to reach the total shoulder impairment value, not added. David E. Fitzsimonds, 42 Van Natta 2362 (1990). Such a conclusion is in accordance with former OAR 436-35-005(4), which provides that:

> "'Combine' describe the way any two percentages of impairment are put together unless the standard specifically calls for them to be added . . ."

We recently reached a conclusion contrary to this rule and the Fitzsimonds holding. Specifically, in Edwin C. Elliott, 42 Van Natta 2720 (1990), multiple shoulder impairment values were added, rather than combined.

After further consideration of this issue, we conclude that the Elliott holding is inconsistent with former OAR 436-35-005(4). Consequently, we adhere to the Fitzsimonds holding, as supplemented by our reliance upon former OAR 436-35-005(4). Accordingly, to the extent that the reasoning in Elliott is contrary to this conclusion, it is expressly disavowed. Therefore, after combining claimant's multiple shoulder residuals, his total shoulder impairment is 33.

Cervical and Thoracolumbar

Dr. Christensen did not examine or rate claimant's cervical and thoracolumbar spine. Dr. Moskowitz provides the only rating of claimant's cervical and back impairment, and we rely on his most recent measurements. On June 27, 1989, Dr. Moskowitz noted the following losses in cervical range of motion: right lateral flexion 35 degrees, left lateral flexion 20 degrees, right rotation 50 degrees and left rotation 50 degrees. (Ex. 23-2). The respective values for these limitations (.67 percent, 1.67 percent, 1.5 percent and 1.5 percent) are added for a total of 5.34 percent cervical impairment.

On February 11, 1989, Dr. Moskowitz reported normal thoracolumbar range of motion. (Ex. 20C-2). He further stated that there was no ratable impairment for loss of sensation, loss of strength, or altered reflexes. (Ex. 20C-3). Claimant had no surgery on his back and no doctor limited claimant from repetitive use of his back.

Therefore, claimant has an impairment value of 5.34 percent for his cervical spine and no impairment value for his thoracolumbar spine.

Psychological Impairment

The Referee assigned claimant a value of 25 percent for his psychological impairment. SAIF argues that claimant is not entitled to this value because he failed to prove how much of his psychological impairment was preexisting and how much was caused by the work injury. We disagree. Dr. Yospe, claimant's long time treating psychologist, diagnosed depression, anxiety, and psychophysiological reactions related to claimant's work injury, and a preexisting personality disorder that was exacerbated by that injury. (Exs. 2-1, 15-1, 16-2, 22-1). Dr. Bellville, psychiatrist, independently examined claimant and concurred in Dr. Yospe's opinion. (Ex. 14-4). Drs. Yospe and Bellville provided the only psychiatric opinions in the record. There is no evidence that claimant's psychological condition was disabling prior to his industrial injury. (Ex. 14-2). Based on the above, we find that claimant has established that his psychological impairment is due to his injury.

Alternatively, SAIF argues that the 25 percent psychological impairment assigned by the Referee is excessive. The Referee relied on Dr. Yospe's diagnosis of: Personality Disorder, Class 1, mild (6 - 10 percent); Anxiety Reaction,

Class 1 (0 - 5 percent); Depressive Reaction, Class 1 (0 - 5 percent); and Psychophysiological Reactions, Class 1 (0 - 5 percent). (Ex. 22). The Referee assigned the highest percentage for each disorder (10 percent, 5 percent, 5 percent, 5 percent) for a total of 25 percent.

SAIF argues that the evidence does not support the Referee's award of the maximum 10 percent for claimant's personality disorder. Former OAR 436-35-400(3)(c)(A) provides the standard for class 1 permanent personality disorders and lists five factors. Dr. Yospe identified claimant as having only two of the five factors listed. In light of this fact, we rate claimant's personality disorder at 6 percent rather than 10 percent.

SAIF further argues that the Referee erred in rating claimant at 5 percent for each of his three diagnosed psychoneuroses. Former OAR 436-35-440(4)(a) states: "Class 1: 0-5% A worker belongs in Class 1 when one or more of the following reactions is noted by a psychiatrist or psychologist. . . ." The rule proceeds to list six reactions, including anxiety, depressive and psychophysiological. As we read the rule, the maximum rating for class 1 is 5 percent, whether claimant has one or all six of the listed reactions. Therefore, claimant is entitled to a total value of 5 percent.

Claimant's psychological impairment (6 percent, 5 percent) is combined, not added, for a total of 11 percent. Former OAR 436-35-005(4).

Total Impairment

The impairment values for claimant's shoulder (33 percent), cervical spine (5.34 percent), and psychological conditions (11 percent) are combined, not added, for a total impairment value of 43.6 percent. Former OAR 436-35-005(4).

Computation of Unscheduled Permanent 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 6, the product is 30. When that value is added to claimant's impairment value 43.6, the result is 73.6 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, 74 percent.

Clear and Convincing Evidence

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". Former 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 argues that he has presented clear and convincing evidence that he is entitled to a greater award than provided under the standards. Although claimant is able to read at a twelfth grade level, he has a 1.9 grade equivalent in language mechanics and a 4.5 grade equivalent in language expression. (Exs. 32-2, 32-3, Tr. 69). Mr. Ross, claimant's vocational expert, testified that claimant is limited to one to seven percent of the labor market due to his physical limitations and his language deficiency. (Tr. 71). Claimant argues that these would be entry level, minimum wage positions, whereas he was earning $8.00 per hour at the time of his 1981 injury.

The standards have the overall affect of providing some compensation for a claimant's limited wage potential and decreased access to the labor market. Further, Mr. Ross does not specify to what degree claimant's decreased access to the labor market is attributable to his writing problems, as opposed to his physical limitations, which are adequately compensated under the standards. 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.

Offset

The Referee authorized SAIF to offset $3,686.79 in overpaid temporary total disability compensation (TTD) against his award of additional permanent partial disability. Claimant argues that the insurer did not produce sufficient data at hearing to establish the overpayment. We disagree.

Mr. Bibelheimer, senior adjuster for SAIF, testified that an audit was performed on the basis of what was ordered paid by the October 24, 1989 Determination Order. (Tr. 86, 89). Mr. Bibelheimer testified that the claim audit submitted as Exhibit 35 was a record kept in the normal course of business and was a record that would be relied on in an external audit. (Tr. 88, 92). This audit supports the offset authorized by the Referee.

Claimant did not deny that he had received the payments identified in the audit. Instead, claimant argues that some of the overpayments listed on the audit are for periods for which he is entitled to TTD. However, claimant did not raise the issue of entitlement to additional TTD at hearing; therefore, this issue cannot be raised as a defense to the offset on review. See Anderson v. West Union Village Square, 44 Or App 687 (1980); Theodore W. Lincicum, 40 Van Natta 1760 (1988).

Under these circumstances, we find that the Referee correctly authorized an offset of $3,686.79.

ORDER

The Referee's order dated December 29, 1989 is affirmed in part and reversed in part. In lieu of the Referee's award of unscheduled permanent disability, and in addition to the Determination Order award of 37 percent (118.4 degrees), claimant is awarded 37 percent (118.4 degrees) unscheduled permanent disability for a total award to date of 74 percent (236.8 degrees) for his right shoulder, cervical spine and psychological conditions. Claimant's attorney fee shall be adjusted accordingly. The remainder of the Referee's order is affirmed.

February 26, 1991 Cite as 43 Van Natta 399 (1991)

In the Matter of the Compensation of
GERALD L. BILLINGS, Claimant
Own Motion No. 89-0442M
OWN MOTION ORDER
Brownstein, et al., Claimant Attorneys
Meyers & Radler, Defense Attorney

The self-insured employer submitted to the Board claimant's claims for an alleged worsening of either one of his industrial injuries of November 2, 1978, and April 6, 1979. Claimant's aggravation rights for both injuries have expired. The employer recommended against reopening either claim for the proposed surgery, contending that there had not been a worsening of his compensable

condition and that surgery is neither reasonable nor necessary. The employer apparently also issued a denial of the proposed surgery.

By order dated September 27, 1989, as amended November 15, 1989, we referred this own motion matter for consolidation with claimant's hearing request then pending before the Hearings Division (WCB Case Nos. 89-16012 & 89-11986). We instructed the Referee to take evidence on whether the disputed treatment is related to either of the 1978 or 1979 industrial injuries and whether claimant's condition has worsened so as to justify own motion reopening, and to forward to the Board his recommendation and a copy of his Opinion and Order in WCB Case Nos. 89-16012 and 89-11986.

On December 15, 1989, the parties entered a stipulated settlement whereby the employer agreed to rescind its denial of the proposed surgery and to reopen voluntarily claimant's 1979 injury claim with temporary total disability benefits beginning on the date of the proposed surgery. The parties also agreed to allow the Referee to determine what, if any, attorney fees to approve or assess as a result of the stipulated settlement. Following arguments by the attorneys, the Referee dismissed the attorney fee requests for lack of jurisdiction and referred those requests to the Board for consideration under our own motion jurisdiction. Claimant has requested Board review of the order. By Order on Review issued this date, the Board affirms the Referee's order.

Claimant underwent the proposed surgery on January 9, 1990. The employer voluntarily reopened the 1979 claim with temporary disability benefits beginning on that date. The claim was closed by Notice of Closure on June 12, 1990, which terminated temporary disability benefits as of May 30, 1990. The employer now requests Board authorization of reimbursement from the Reopened Claims Reserve for temporary disability benefits it paid claimant pursuant to its voluntary reopening.

After reviewing the record, we find that claimant's condition had worsened requiring surgery. Therefore, we have the authority to award temporary disability benefits beginning January 9, 1990, the date of surgery. See ORS 656.278(1)(a). Moreover, inasmuch as Dr. Johnson declared claimant medically stationary on May 30, 1990, temporary disability benefits were properly terminated as of that date. Accordingly, reimbursement of those monies from the Reopened Claims Reserve to the employer is authorized. See ORS 656.625.

Claimant's attorney requests an assessed (i.e., carrier-paid) fee for services which ultimately resulted in the employer's acceptance of responsibility for the surgery. We conclude, however, that we lack own motion jurisdiction to award an assessed fee under these circumstances. ORS 656.386(1) authorizes the Board to award an assessed fee only if claimant finally prevails in a rejected case "in a review by the [B]oard itself." Accordingly, we may award an assessed fee under ORS 656.386(1) only in the exercise of our reviewing authority pursuant to ORS 656.295. When exercising our own motion authority pursuant to ORS 656.278, we may only award claimant's attorney a fee payable out of claimant's compensation. See ORS 656.386(2); OAR 438-15-080. Additionally, we may allow an out-of-compensation fee exceeding $1,050 only upon a finding that extraordinary services were rendered. See OAR 438-15-080. Here, we find that claimant's attorney rendered extraordinary services to obtain further compensation. Accordingly, claimant's attorney is entitled to an attorney fee equal to 25 percent of the additional temporary disability benefits paid by the employer, not to exceed $3,000. It appears, however, that the employer has voluntarily paid all temporary disability benefits directly to claimant. In that event, the employer is not obligated to reimburse claimant's attorney for the attorney fee. See Mohammad Zarifi, 42 Van Natta 670, 672 (1990).

IT IS SO ORDERED.

In the Matter of the Compensation of
GERALD L. BILLINGS, Claimant
WCB Case Nos. 89-16012 & 89-11986
ORDER ON REVIEW
Brownstein, et al, Claimant Attorneys
Meyers & Radler, Defense Attorneys
Shelly McIntyre (Saif), Defense Attorney

Reviewed by Board Members Cushing and Myers.

Claimant requests review of that portion of Referee Harri's order that declined to award his attorney an assessed or approved fee. On review, the issue is attorney fees.

We affirm and adopt the Referee's order with the following supplement. In order to qualify for an assessed (i.e., carrier-paid) fee under ORS 656.386(1), claimant must finally prevail in a rejected case in a hearing before the referee. See Greenslitt v. City of Lake Oswego, 305 Or 530, 533 (1988); Shoulders v. SAIF, 300 Or 606, 611 (1986). We have interpreted the phrase "in a hearing before the referee" to mean in an administrative proceeding (trial) before a referee where the record is opened, testimony, evidence and/or stipulations are taken, and the merits are litigated. Duane L. Jones, 42 Van Natta 875, 877 (1990). We further held that claimant does not "prevail finally" in a hearing before the referee until the referee enters an order upholding claimant's right to compensation and that order is not timely appealed. Id. at 877-78.

Here, the parties did not litigate the merits of claimant's medical services claim for low back surgery. Instead, the parties entered a stipulated settlement whereby the self-insured employer agreed to accept responsibility for the surgery. The Referee did not enter an order upholding claimant's right to compensation. Accordingly, we do not find that claimant finally prevailed in a rejected case in a hearing before a referee. Claimant's attorney does not qualify for an assessed fee under ORS 656.386(1). See id.

Additionally, the Referee did not have jurisdiction to approve an attorney fee payable out of claimant's temporary disability benefits pursuant to ORS 656.386(2). Inasmuch as claimant's 1979 injury claim is subject to the Board's own motion authority under ORS 656.278, only the Board has the authority to approve an attorney fee payable out of temporary disability benefits. See OAR 438-15-080. Accordingly, we resolve the attorney fee issue by Own Motion Order issued this date.

ORDER

The Referee's order dated January 12, 1990 is affirmed.

In the Matter of the Compensation of
LARRY D. CUTBURTH, Claimant
WCB Case Nos. 89-12991 & 89-21308
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
Yturri, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of that portion of Referee Daron's order that upheld the insurer's denial of claimant's aggravation claim for his neck, low back and hip conditions. The issue on review is aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that there had been no worsening of claimant's condition, relying in part on the administrative expertise of the agency and of himself personally in determining that degenerative spinal conditions are present in most persons of claimant's age. The Referee, as a result, upheld the denial of aggravation. We agree that the denial should be upheld but for different reasons. In particular, we do not rely upon the administrative expertise of the Referee in this matter.

To establish an aggravation, claimant must show a worsening of his compensable conditions since the last arrangement of compensation in September 1987. "Worsening" within this context means increased symptoms, or a worsened underlying condition, resulting in a diminishment of earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989).

In this matter, claimant needs to show that since September 1987 his condition has worsened. In July 1988 claimant was seen by his treating physician, Dr. Turnbull. At that time claimant had increased symptoms and the doctor noted muscle spasms on examination. In January 1989, claimant was seen by Dr. Eisler who took a history of blackout spells occurring within the last four months. These increased symptoms are sufficient to prove the first element of a worsening; however, in order for claimant to prove that his condition has aggravated, he must also prove that these increased symptoms have resulted in a diminishment of his earning capacity.

Dr. Ford, who began treating claimant in January 1989, reported in February 1989 that claimant's recent headaches were becoming disabling. However, since September 1987, no doctor has restricted claimant from working. Claimant, who is self-employed as a landscaper, has seen his business steadily grow, and at the time of the hearing he had over 100 customers. He has had to hire additional help, but the record is not clear that claimant has hired these people because he is less able to do the work. The record does support a finding that claimant has had to hire additional help to handle the increase in the volume of his business. We find, on this record, that claimant has failed to show that there has been a diminishment of his earning capacity. Thus, we do not believe claimant has carried his burden of proving an aggravation of his condition.

ORDER

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

In the Matter of the Compensation of
CHARLES R. FRITZ, Claimant
WCB Case No. 89-20255
ORDER ON REVIEW
Sellers & Jacobs, Claimant Attorneys
Parks, et al., Attorneys
Robert J. Jackson (Saif), Defense Attorney

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Seifert's order that held that claimant's request for hearing was filed untimely and that the late filing was not excused by good cause. In its brief, the SAIF Corporation contends that, if the dismissal of the request for hearing was not appropriate, claimant was an out-of-state employee not covered by the Oregon Workers' Compensation Law. On review, the issues are timeliness of claimant's hearing request and, if timely, subjectivity.

FINDINGS OF FACT

Claimant, a long-haul truck driver, worked for Czyhold Truck Lines, one of four truck companies doing business under Quality Transportation Services. Czyhold is based in Yakima, Washington and holds intrastate authority only in that state. It has authority to haul goods on an interstate basis using federal highways that lie in Oregon, but such operations are incidental to its primary intrastate business in Washington.

Czyhold employs approximately 80 truck drivers, about 10 of whom live in Oregon. Czyhold has no base of operation in Oregon. Its trucks do receive routine maintenance at a leased facility operated by Quality Transportation Services in Portland, where its Oregon drivers also park their trucks. However, the facility is not operated by Czyhold, and is used by several other sister companies for a similar purpose. Claimant is an Oregon resident and had Washington compensation insurance withheld from his paycheck.

On February 2, 1989, in Portland, Oregon, claimant suffered a broken neck when a tractor-trailer moved while he was under the rig releasing a frozen brake. He was hospitalized and underwent treatment for a cervical condition. He subsequently filed an accident report in the state of Washington. The claim was accepted and benefits were paid.

On April 18, 1989, claimant filed an injury claim in Oregon seeking additional benefits. SAIF received the Compliance Division's investigation report on July 24, 1989, at which time SAIF was aware that claimant was represented by an attorney on his Washington claim. However, no retainer agreement had been filed with regard to any Oregon claim.

SAIF denied the claim on July 31, 1989, asserting that claimant was not covered by the Oregon Workers' Compensation Law. The denial was sent by certified mail to claimant's last known address, listed as Milwaukie, Oregon. The letter was returned unclaimed and indicated that claimant had moved to Cottage Grove, Oregon. On August 31, 1989, SAIF remailed the denial to claimant's new address. Claimant received it in early September, 1989. He filed a request for hearing on October 11, 1989, 72 days after the denial was issued.

CONCLUSIONS OF LAW AND OPINION

Timeliness of Hearing Request

Claimant acknowledges that a request for hearing must be filed within 60 days after notification of the insurer's denial, unless good cause for failure to file within that time is shown. ORS 656.319(1). He contends, however, that

his request for hearing was timely because the time for filing the request did not begin to run until he actually received notice of the denial.

The court answered that argument in Cowart v. SAIF, 86 Or App 748 (1987). The date of mailing, not receipt, starts the running of the 60 day period under ORS 656.319. Id. at 750. Because the notice of denial was mailed on July 31, 1989, claimant's request for hearing was not filed within 60 days of the denial.

In the alternative, claimant argues that he had good cause for filing a late request for hearing. The test for determining whether 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).

Claimant first contends that the fact that the notice was sent to his prior address constitutes good cause, as recognized by the court in Burkholder v. SAIF, 11 Or App 334 (1972). In Burkholder, the insurer had mailed a denial to an address at which the claimant had never lived and, consequently, the claimant did not receive notice of it before the expiration of 60 days. Under those facts, the court held that claimant had shown good cause for the late filing and that the request, although filed more than 60 days after the notice was mailed, was nevertheless valid. Id. at 339.

We conclude that the reasoning in Burkholder does not apply here. The claimant in Burkholder, through no fault of his own, was not notified of the denial before the 60 day deadline. In this case, however, the reason that the notice was sent to an incorrect address was, in fact, due to the fault of claimant, i.e., he did not promptly notify SAIF that he had moved to a new address in Cottage Grove, Oregon. Moreover, unlike the claimant in Burkholder, claimant here did receive the notice of denial before the expiration of 60 days. He could have filed a timely request with reasonable diligence. See Cowart v. SAIF, supra, 86 Or App at 750.

We are not persuaded by claimant's assertion that he notified SAIF of his relocation by telephone. At hearing, he could not state the date of the call or identify the person with whom he allegedly spoke. He produced no long distance phone records to support his contention. In fact, when asked if he had notified SAIF, he testified: "I should assume. I won't swear I did it. I won't swear I didn't." (Tr. 25).

Claimant next argues that he had good cause, because his untimely filing was based on his inaccurate belief that SAIF had sent a copy of the notice to his attorney. He relies on Cowart v. SAIF, 94 Or App 288 (1988). In that case, the claimant's attorney had been in contact with the insurer and had asked it to mail all documents related to the claim to him. Additionally, the claimant had left instructions with his attorney to challenge all denials. The claimant assumed, therefore, that when he received the insurer's denial his attorney had also received a copy and had taken action as instructed.

Noting that the insurer was not statutorily required to serve a copy of the denial on the claimant's attorney, the Cowart court found that, given the insurer's regular correspondence with him, the claimant had reason to expect that the insurer would notify his attorney if it had taken any significant action on the claim. Accordingly, the court concluded that the claimant's failure to seek a hearing was excusable neglect and that he therefore had good cause under former ORS 656.319(1)(b). Id. at 291.

In this case, however, there is no evidence in the record to suggest that SAIF was in regular correspondence with claimant's attorney. To the contrary,

at the time it issued the denial, SAIF had no indication of qualified representation by a member of the Oregon State Bar with respect to any rights claimant might possess under the Oregon Workers' Compensation Law. No retainer agreement had been filed with regard to any Oregon claim. SAIF was only aware that claimant was represented by Washington counsel with respect to his Washington claim. Thus, we do not believe that claimant had reason to expect that his attorney had received a copy of the notice and had taken appropriate action. Accordingly, we conclude that claimant has not shown good cause for his failure to file a timely request for hearing.

Subjectivity

We add that, as SAIF points out, even if claimant's request for hearing was filed timely or was filed with good cause, claimant was not a subject worker under Oregon law. ORS 656.027 provides that all workers are subject to the Oregon Workers' Compensation Act except those specifically excluded under the law. Among those excluded is "[a] worker engaged in the transportation in interstate commerce of goods, persons or property for hire by [motor vehicle], and whose employer has no fixed place of business in this state." ORS 656.027(5).

Claimant argues that ORS 656.027(5) does not apply here, because the leased facility in Portland is a "fixed place of business in this state." He relies on Wright v. Industrial Indemnity Co., 68 Or App 302 (1984). In that case, the evidence established that the employer had opened a truck terminal in Brooks, Oregon, where several full-time employees worked. Because the employer repaired and serviced a large number of trucks based at that terminal, and because all trips originating from Oregon were dispatched from Brooks, the court held that the terminal was a "fixed place of business" in Oregon. Id. at 305.

In this case, however, Czyhold has no terminal or full time employees in the state of Oregon. While its trucks do receive routine maintenance at a facility in Portland, the facility is leased and operated by Quality Transportation Services. It is not operated by Czyhold and is used by several other sister companies for a similar purpose. Additionally, major maintenance and repair is strictly done at the Yakima, Washington terminal, or under contract at various truck stops in Oregon and Washington. Moreover, while Czyhold operates about 60 trucks, only four or five are parked at the Portland facility. During the course of claimant's employment, dispatch has been accomplished only through Yakima, Washington. Claimant was never dispatched from the state of Oregon.

After our review of the record, we conclude that, had claimant filed his request for review within 60 days, or shown good cause for failure to file within that time, SAIF's denial would be upheld on the basis that claimant is, by definition, not a subject worker for whom compensation is available under Oregon law. Accordingly, the Referee's order is affirmed.

ORDER

The Referee's order dated April 27, 1990 is affirmed.

In the Matter of the Compensation of
NEAL B. HOAGLAND, Claimant
WCB Case No. 88-14837
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Podnar's order that upheld the self-insured employer's denial of claimant's medical services claim for chiropractic treatment for his neck and mid back in excess of the Director's guidelines. On review the issues are res judicata, the procedural propriety of the denial and frequency of medical treatment. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Res Judicata

In support of its denial, the employer argues that claimant's current condition does not require treatment in excess of the Director's guidelines. In the alternative, the employer contends that claimant has not established that his alleged need for treatment in excess of the guidelines results from the compensable injury, rather than his preexisting degenerative condition.

Claimant argues on review that a prior Referee's Opinion and Order, issued April 15, 1987, precludes the denial under the doctrine of res judicata. In that order, the prior Referee found that claimant's 1984 compensable motor vehicle accident contributed to a permanent syptomatic worsening of claimant's condition. Based on this finding, the Referee awarded claimant permanent partial disability. We disagree with claimant's contention that the 1987 order precludes the employer's denial.

The doctrine of res judicata precludes litigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, 50, modified 305 Or 468 (1988). We first determine whether the denial is barred under the res judicata doctrine of "issue preclusion."

"Issue preclusion" may involve the same claim (direct estoppel) or entirely different claims (collateral estoppel). Under the doctrine of "issue preclusion," if a claim is litigated to a 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 District v. White, Id. Key elements of issue preclusion include: 1) the same parties; 2) a valid and final judgment; 3) actual litigation of an issue of fact or law; and 4) a determination of such issue which is essential to the judgment.

Here, the issue of the reasonableness of the frequency of claimant's chiropractic treatment has not been "actually litigated." The Referee's Opinion and Order of April 15, 1987 does not address the issue of frequency of medical treatments. The Referee's ruling was limited to a finding that claimant's injury caused a permanent increase in symptoms so that he was entitled to a permanent disability award. The August 1988 denial, the November 1988 hearing and the Referee's December 1988 Opinion and Order put the frequency of treatments at issue for the first time. Therefore, the employer is not precluded

from denying treatment on reasonable and necessary grounds under the doctrine of issue preclusion.

Nor is a denial on causation grounds barred by issue preclusion. The prior Referee found that the injury resulted in some permanent impairment, not that the condition was totally attributable to the injury. The employer is not denying all further treatment on the ground that the condition is not related to the injury. Rather, it is only contending that the need for treatment in excess of the guidelines is not due to the injury. The injury could have contributed to increased symptoms, but not to the extent excess treatment was required. Accordingly, the employer's causation argument is not barred by the prior Referee's order.

Claimant argues in the alternative that the denial is barred under the doctrine of "claim preclusion." The rule of claim preclusion is that if a claim is litigated to final judgment, the judgment precludes a subsequent action between the same parties on the same claim or any part thereof. Id. Sections 17-19, 24. See also Carr v. Allied Plating Co., 81 Or App 306, 309 (1986); Million v. SAIF, 45 Or App 1097, 1102, rev den 289 Or 337 (1980). A claim or cause of action is an aggregate of operative facts which compose a single occasion for judicial relief. Restatement (Second) of Judgments, Section 24(2) (1982). See also Dean v. Exotic Veneers, Inc., 271 Or 188, 192-93 (1975); Carr v. Allied Plating Co., supra, 81 Or App at 310.

Claimant contends that the denial is barred because the frequency issue could have been raised by the employer at the time of the 1987 litigation. We disagree. The number of operative facts within a single cause of action must be determined pragmatically, based primarily on practical trial convenience consideration. Carr v. Allied Plating Co., supra. Here, we conclude, the issue of the frequency of chiropractic treatment, a medical service issue, does not arise from the same set of operative facts as did the question of the extent of claimant's permanent disability addressed in the 1987 litigation. See Tana Wilson, 40 Van Natta 476 (1988).

Accordingly, we conclude that the employer's denial is not precluded by res judicata.

Procedural Propriety of the Denial/Reasonableness and Necessity of Chiropractic Treatments

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

The Referee upheld the employer's August 18, 1988 denial of claimant's "further" chiropractic treatment. The Referee did not make specific findings or conclusions as to whether such treatment was reasonable and necessary. On review, claimant argues that the denial is prospective and, therefore, void.

It is well settled that prospective denials are impermissible. A carrier may not deny its future responsibility for payment of medical services for a previously accepted claim. ORS 656.245(1); Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989). Here, the employer denied all "further" chiropractic treatment. Such a denial is prospective and, therefore, invalid. However, since the record indicates that claimant continued to receive chiropractic treatments subsequent to the denial and prior to hearing, the reasonableness and necessity of these post-denial treatments are also at issue. Holly J. Rahim, 42 Van Natta 415 (1990); See Rater v. Pacific Motor Trucking Co., 77 Or App 418 (1986); Vandehey v. Pumilite Glass & Building Co., 35 Or App 187 (1978). We evaluate whether the treatments until the date of the hearing were reasonable and necessary.

An injured worker is entitled to all reasonable and necessary curative or palliative medical care required for a compensable injury. See ORS 656.245(1); West v. SAIF, 74 Or App 317, 320 (1985); Wetzel v. Goodwin Bros., 50 Or App 101 (1981); McGarry v. SAIF, 24 Or App 883, 888 (1976). Claimant has the burden of proving that the treatment is reasonable and necessary. McGarry v. SAIF, supra.

Overly frequent and extensive services for conditions arising from a compensable injury will be found unreasonable and unnecessary. James v. Kemper Insurance Co., 81 Or 80, 84 (1986). The Workers' Compensation Department has promulgated a rule indicating that the usual range of the utilization of medical services does not exceed two visits per month after the initial 60 days. OAR 436-10-040(2)(a). The rule does not constitute an arbitrary limitation of services, but is a guideline to be used concerning requirements of accountability for the services provided. Kemp v. Workers' Compensation Dept., 65 Or App 659 (1983), modified on other grounds, 67 Or App 270, rev den 297 Or 227 (1984). Thus, while we may find that a claimant is entitled to receive some chiropractic treatments, he may not expect to receive any number of treatments without showing that the treatments are reasonable and necessary. James v. Kemper Ins. Co., supra.

Here, the evidence does not support claimant's contention that he has a need for more than two treatments per month. The Western Medical Consultants reviewed claimant's file on October 18, 1988. The panel included Dr. Tilden, D.C., who had examined claimant on February 10, 1987. The Consultants opined that the medical evidence did not substantiate the need for treatment beyond the guidelines. They further opined that claimant's symptoms were attributable to his preexisting degenerative joint disease. Their opinion regarding causation is contrary to the law in this case. Nevertheless, their opinion that claimant's symptoms, no matter what their cause, no longer require care beyond the guidelines is independent of their causation opinion and entitled to weight. The Consultants' opinion is supported by the Independent Chiropractic Consultants, who noted that claimant has a home care program which would help his condition and reduce his need for treatment.

Dr. Graffeo opined that claimant requires ongoing chiropractic care as a result of his injury at the rate of three to four treatments per month. He based this conclusion on his assertion that at the time of the August 6, 1984 injury, claimant had not received treatment for his neck for the previous nine months. However, the record indicates that claimant saw Dr. Graffeo on June 13, 1984, when he complained of cervical problems. Therefore, Dr. Graffeo based his opinion on an incorrect history. Accordingly, we give his opinion that claimant requires chiropractic care in excess of the guidelines less weight.

Consulting chiropractor Bussanich did not recommend an unvarying weekly schedule, but felt that claimant should be treated from one to four times per month. Dr. Bussanich also opined that claimant could benefit from a more comprehensive home exercise program. Therefore, we do not find Dr. Bussanich's equivocal opinion persuasive evidence that claimant requires treatment in excess of the guidelines on a routine basis.

In light of these facts, we find that claimant has not established that medical treatment in excess of that provided for by OAR 436-10-040 is reasonable and necessary.

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 prospective denial issue is $1,500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case, as represented by the hearing record and claimant's respondent's brief, and the complexity of the issue.

ORDER

The Referee's order dated December 16, 1988 is affirmed in part and reversed in part. Claimant's hearing request is reinstated. The self-insured employer's denial is set aside, in part, as prospective. The remainder of the order is affirmed. For services at hearing and on review regarding the prospective portion of the denial, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the employer.

February 26, 1991 Cite as 43 Van Natta 409 (1991)

In the Matter of the Compensation of
RODNEY L. KOSTA, Claimant
WCB Case No. 90-11571
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Myers and Cushing.

The insurer requests review of Referee McCullough's order that awarded 10 percent (15 degrees) scheduled permanent partial disability for the right wrist, whereas a Determination Order had awarded no permanent disability. On review, the issue is jurisdiction and extent of scheduled disability.

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

The insurer contends that the 1990 amendments to the Oregon Workers' Compensation Law should be applied to the analysis of claimant's impairment. Specifically, it contends that amended ORS 656.268(7) applies, which requires "objective findings" to support an award of permanent disability. We disagree.

According to section 54, paragraph (1) of the 1990 Act, the general rule is that all amendments apply to all claims existing or arising on or after July 1, 1990, regardless of the date of injury. However, section 54, paragraph (3) provides that the amendments to certain statutes, including ORS 656.268(7), apply to all claims which become medically stationary after July 1, 1990. In this case, claimant became medically stationary in August 1988. Accordingly, amended ORS 656.268(7) does not apply.

After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that $300 is a reasonable assessed fee for claimant's counsel's efforts on review. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues presented, and the value of the interest involved.

ORDER

The Referee's order dated September 12, 1990 is affirmed. For services on Board review, claimant's attorney is awarded $300, to be paid by the insurer.

In the Matter of the Compensation of
JERRY A. MCCORMACK, Claimant
WCB Case No. 89-14597
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Ronald Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Fink's order that granted an award of 26 percent (83.2 degrees) unscheduled permanent disability for a low back condition whereas the Determination Order granted none. The issue on review is extent of unscheduled permanent partial disability.

The Board affirms and adopts the order of the Referee with the following comment and corrections. Claimant argues that the Referee erred in two ways in calculating his disability.

Claimant first contends that since he has no documented training he should have received a value of +1 for training. We disagree. Whether claimant is entitled to a value for training under former OAR 436-35-300(5) is dependent upon whether or not claimant has demonstrated competence in some specific vocational pursuit. Competence in some "specific vocational pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off the job to perform other than an entry level position. Larry L. McDougal, 42 Van Natta 1544 (1990). Here, claimant has acquired on-the-job training sufficient to perform something other than entry-level employment, thus demonstrating competence in a specific vocational pursuit. Therefore, the appropriate training value is 0. Former OAR 436-35-300(5).

Claimant further argues that the Referee erred in not giving him a value for adaptability. We agree.

Under former OAR 436-35-310, adaptability values range from 0 to 10. No adaptability value is given to a claimant who has returned to his usual and customary work or accepted a work offer for usual and customary work, or who has received a "work offer" for usual and customary work but who has refused or has not responded to the "work offer." Former OAR 436-35-310(2)(a) & (b). An adaptability value for a claimant who is unable to return to his 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). If, as a result of the injury, a claimant is not working and no employment has been offered, the adaptability factor shall be based on residual physical capacity according to the table in former OAR 436-35-310(4).

Pursuant to former OAR 436-35-270(3)(d), a "work offer" as used in former OAR 436-35-290 through 436-35-310 means delivery in person or by certified mail, return receipt requested, of a written offer of work by the employer to which there is a physician's release. A "physician's release" refers to a release by claimant's "attending physician." Former OAR 436-35-270 (3)(c).

In this case, claimant has made it extremely difficult to obtain information regarding his physical capacity to work. His vocational assistance was terminated because he failed to cooperate with the program. He has failed to appear for a physical capacity evaluation which was requested by his treating physician. He failed to appear at the hearing so that his testimony could be elicited regarding his ability to carry out certain physical activities.

Claimant cites four exhibits which he believes support his burden to prove his level of adaptability. Claimant contends that these exhibits show he is limited to light work. Two of those exhibits indicate that claimant needs to have a physical capacities exam. (Exs. 23, 30). One report was made prior to claimant's 1988 surgery. (Ex. 6-1). The final exhibit is a report from a vocational counselor who merely restates what claimant tells him are his limitations. We do not find these reports to be persuasive evidence on claimant's current level of adaptability.

There is no contention that claimant has returned to his regular job, to a modified job or that he has been released by his physician to return to his regular job; nor is there evidence that claimant has been offered a job by this employer. Thus, neither former OAR 436-35-310(2) nor (3) is applicable here.

Claimant's treating surgeon, Dr. Campagna, does believe that claimant has definite limitations, and the Referee found that there was some question of whether claimant could return to his regular job. Nevertheless, there is not sufficient evidence to determine that claimant's failure to return to work is due to the compensable injury. Thus, we are unable to determine his adaptability value under former OAR 436-35-310(4). In certain cases where the evidence regarding one aspect of rating disability is absent, remand is appropriate. See Hattie L. Goodrich, 42 Van Natta 1752 (1990). In this matter, even though there is insufficient evidence to determine adaptability under former OAR 436-35-310, we do not believe remand is appropriate. The lack of evidence in this case is due to claimant's failure to cooperate with vocational assistance and his failure to appear for his physical capacities exam.

In this case, we instead assign a value of +1 for adaptability. Under the "standards" the adaptability value is a multiplier on the value for age and education. Failure to give a value for adaptability would in effect cancel out the value claimant is entitled to receive for age and education. Former OAR 436-35-319(2). Using a value of +1 for adaptability allows claimant to receive his full value for age and education, but does not otherwise modify the rating of disability due to his adaptability value. Accordingly, we assign an adaptability value of +1, rather than the 0 value assigned by the Referee.

Notwithstanding this modification, we conclude the Referee correctly awarded claimant 26 percent unscheduled permanent disability under the "standards". The Referee multiplied the +3 value for age/education by the 0 value he assigned for adaptability, and incorrectly arrived at a product of 3, rather than 0. He then added the product 3 to the 23 percent impairment value for a total of 26 percent. We instead multiply the +3 age/education value by a +1 adaptability value for a product of 3, and add this product to the 23 percent impairment value. Thus, like the Referee, we calculate a total award of 26 percent unscheduled permanent disability.

ORDER

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

In the Matter of the Compensation of
JAVIER MENDOZA, (Deceased), Claimant
WCB Case No. 89-16779
ORDER ON REVIEW
Glenn D. Ramirez, Claimant Attorney
Jerry Larkin (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The beneficiaries of the deceased claimant request review of Referee Peterson's order that dismissed a request for hearing as not timely filed. The issues on review are jurisdiction and entitlement to survivor benefits. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings with the following additional findings and corrections.

Tina Mendoza and Javier Mendoza were married in November 1981, not November 1982.

Attorney Charles D. Burt, on behalf of Tina Mendoza, requested benefits for Joey Mendoza on November 8, 1988.

No request for benefits was filed on behalf of Rosa Mendoza prior to the August 24, 1989 letter requesting a hearing.

The birth certificate for Rosa Mendoza, who was born on March 14, 1982, identifies the father as Javier Hernandez Mendoza. The birth certificate for Joey Allen Mendoza, who was born on February 13, 1986, does not list the name of the father.

Tina Mendoza and Javier Mendoza had lived apart since September 1984. In the Decree of Dissolution of Marriage, dated October 22, 1986, only one minor child, Melissa Lynette Mendoza, is identified as child of issue of this marriage. Javier Mendoza was ordered to pay child support for that child.

Blood testing done on Joey and Rosa Mendoza and Javier Mendoza's parents exclude Javier Mendoza as the children's father.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The Referee dismissed the request for hearing because he found that the request was not timely filed after the SAIF Corporation's denial was issued in March 1988. SAIF argues that the dismissal was proper because more than 180 days elapsed between the issuance of the denial and the request for hearing.

Claimant argues that the denial of benefits for Rosa and Joey was premature and thus void because no request for benefits had been made prior to the August 24, 1989 letter requesting a hearing. He further argues that, on the merits, since the marriage was not dissolved until after the birth of these children, there is a presumption that children born in wedlock are the children of the mother's husband. We agree with claimant that the request for hearing should not have been dismissed.

No request for benefits was made on behalf of Rosa prior to August 24, 1989; however, we do find that a request had been made on behalf of Joey in November 1988. Survivor benefits are independent and not derivative of the injured worker's rights. Fossum v. SAIF 289 Or 787 (1980). Therefore, each survivor has rights that are independent, and Joey and Rosa each needed to request

those benefits before they could be denied. The March 1988 denial of those benefits was premature and thus invalid.

Additionally, because SAIF had knowledge of the accident and has shown no prejudice, we find that the November 1988 and August 1989 claims should not be dismissed because of late filing. SAIF made no response to the November 1988 claim. Further, once 60 days had passed after the August 24, 1989 letter, a "de facto" denial as to both children existed. Since the hearing was held in December 1989, the claims for both children were in denied status at the time of hearing. The issue then of entitlement to benefits for both children was properly before the Referee, although he failed to reach the merits on that question. We find the record has been fully developed on the issue of entitlement, and thus, on de novo review we address that issue on the merits.

Entitlement to Survivor Benefits

To prove entitlement to benefits under ORS 656.204, Joey and Rosa need to prove that they are children of the deceased. They argue that there is a conclusive presumption under ORS 109.070 that they are the children of Javier.

The applicable portions of ORS 109.070 are:

> "(1) The child of a wife cohabiting with her husband who was not impotent or sterile at the time of the conception of the child, shall be conclusively presumed to be the child of her husband, whether or not the marriage of the husband or wife may be void."
>
> "(2) A child born in wedlock, there being no decree of separation from bed or board, shall be presumed to be the child of the mother's husband, whether or not the marriage of the husband or wife may be void. This shall be a disputable presumption."

Joey was born on February 13, 1986. The divorce was not effective until after that date, although Tina and Javier Mendoza had been living apart since 1984. The presumption as it relates to Joey is disputable. ORS 109.070(2). Blood tests were done on Javier's parents and on Joey and his mother. The results of these tests indicate that Javier would be excluded as the father of Joey. The test results, as well as other evidence in this record which indicates that the parties did not believe that Joey was Javier's child, lead us to conclude that Joey is not the child of Javier, and that he is not entitled to survivor benefits under ORS 656.204.

Rosa, although born during the time when the parties cohabited, was conceived prior to the marriage. There is no evidence in this record that when she was conceived, the parties were cohabiting. Therefore, the presumption that Rosa is the child of Javier can only be a disputable presumption as ORS 109.070(2) applies. The blood tests which were done to establish paternity of Rosa likewise exclude Javier as her father. We find that the only evidence of paternity in this record which would support a finding that Rosa is entitled to benefits is the child's birth certificate which lists Javier as the father. This is not persuasive evidence on that issue, however, in light of the blood test results which are further supported by the documents filed in the divorce proceedings which indicate that the only child of the marriage of Javier and Tina Mendoza was Melissa. Therefore, we find that Rosa is not entitled to survivor benefits under ORS 656.204.

ORDER

The Referee's order dated January 16, 1990 is reversed. The request for hearing is reinstated. The "de facto" denial of the SAIF Corporation is upheld.

In the Matter of the Compensation of
BRYAN G. OGDEN, Claimant
WCB Case Nos. 88-17878 & 88-14296
ORDER ON RECONSIDERATION
Max Rae, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

The SAIF Corporation has requested reconsideration of that portion of our December 11, 1990 Order on Review which declined to address responsibility for claimant's low back condition after April 7, 1988. In order to allow claimant to respond to SAIF's argument, we abated our order. We have received claimant's response and SAIF's supplemental authorities and now proceed with our reconsideration.

If we correctly interpret SAIF's Motion for Reconsideration, it is arguing, in part, that claimant's April 7, 1988 claim is barred by application of the doctrine of res judicata (claim preclusion) because claimant never contested its denial of his July 29, 1987 injury claim. However, as we have previously held, an uncontested denial only bars further litigation concerning the compensability of claimant's back condition as it existed at the time of the first denial. See Anna M. Turner, 41 Van Natta 1956 (1989); Howard W. Lankin, 35 Van Natta 849 (1983), aff'd mem 68 Or App 53, rev den 298 Or 470 (1984). Claimant is not precluded from proving any contribution his employment may have had to the worsening or development of his low back condition following the denial of the July 29, 1987 injury.

As we have previously found, claimant's claim for a new occupational disease is based on different operative facts than existed at the time of the prior injury claim. The new operative facts included a series of traumatic events that occurred after the judgment on the first claim became final and while claimant was limbing trees. That series of traumatic events resulted in increased symptoms which required medical treatment or resulted in disability. Because all of these operative facts occurred after the earlier final judgment, claimant could not have asserted this occupational disease claim at the time of his first injury claim. Thus, this claim is not barred by claim preclusion.

SAIF also argues that we must determine "responsibility" between claimant's original injury and his subsequent occupational disease. However, this is a case that involves only one insurer/employer. It is not a case of responsibility between various employers/insurers, where holdings in cases such as E.C.D, Inc. v. Snider Electronic Control Design, 105 Or App 416 (1991) or John A. Tallant, 42 Van Natta 939 (1990) would apply. Neither is this a case in which a concededly compensable condition involving a single employer/ insurer must be classified as either a new occupational disease or the aggravation of a prior injury with the same employer/insurer. See Teresa L. Walker, 41 Van Natta 2283 (1989). Claimant had no compensable injury or disease before the development of the instant occupational disease. Here, the only question is that of compensability of a new occupational disease claim under former ORS 656.802(1)(c). The fact that claimant experienced a preexisting, non-compensable back condition does not alter our analysis of the case.

Accordingly, our December 11, 1990 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our December 11, 1990 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
VERL E. SMITH, Claimant
WCB Case No. 89-19352
ORDER ON REVIEW
Dobbins & McCurdy, Claimant Attorneys
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of that portion of Referee Crumme's order which declined to grant permanent total disability. Additionally, in his brief, claimant contends that the Referee erred in admitting into the record Exhibit 13A which contains information pertaining to settlement negotiations. On review, the issues are evidence and permanent total disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Facts" with the following corrections and supplementation.

Findings of fact numbers 10 and 12 contain a clerical error. Claimant declined the modified job offer of December 2, 1989, not September 26, 1989.

Claimant became medically stationary on August 10, 1989.

Claimant is not currently "regularly" employed at gainful and suitable employment.

The modified job offered by the employer is not a job available in the hypothetically normal labor market.

FINDINGS OF ULTIMATE FACT

Claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation due to a combination of medical and nonmedical factors.

Claimant is willing to work; although a work search would be futile, claimant has made reasonable efforts to find work.

CONCLUSIONS OF LAW AND OPINION

Evidence

At the hearing, claimant objected to the admission of Exhibit 13A which contains information relative to settlement negotiations between claimant and the insurer. Finding that claimant's argument went more to the weight to be given the questionable portion of the report than to its admissibility, the Referee concluded that the goal of substantial justice would be furthered by the admission of the exhibit. On review, claimant requests that the entire exhibit be excluded from the record. The insurer argues that the Board need not remove the entire exhibit which contains relevant and material evidence on the permanent total disability issue, but rather only the objectionable portion of the exhibit should be deleted. We agree with the insurer.

A Referee is not bound by common law or statutory rules of evidence and may conduct a hearing in any manner that will achieve substantial justice. ORS 656.283(7); see Jackson P. Shull, 42 Van Natta 1206 (1990). On the other hand, under Oregon Evidence Code 403, relevant evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice. The

commentary to the Code indicates that "unfair prejudice" means an undue tendency to suggest decisions on an improper basis.

The portion of the exhibit which contains information relative to settlement negotiations between claimant and the insurer was prejudicial and outweighed its probative value. Consequently, that portion of Exhibit 13A shall not be considered. We note that the Referee recognized the questionable admissibility of the challenged portion of the exhibit when he admitted it. Although the Referee admitted the entire report, he did not rely on the offensive portion of the report. On review, we do not consider the second and third sentences of the first paragraph on page two of Exhibit 13A as part of the record.

Permanent Total Disability

The Referee found that claimant had not proven that the job the employer offered him on December 2, 1989 was not available in a hypothetically normal labor market. Therefore, he concluded that claimant is not entitled to a permanent total disability award. We disagree.

In order to establish permanent total disability, claimant must prove that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Permanent total disability may be established through evidence of complete physical incapacity, or by establishing that the physical impairment, combined with a number of social and vocational factors, effectively prohibits gainful employment under the "odd-lot" doctrine. Welch v. Bannister Pipeline, 70 Or Ap 699 (1984), rev den 298 Or 470 (1985).

Claimant has severe degenerative arthritis of the right glenohumeral joint. A total shoulder replacement, an operation with a low success rate, is the only treatment for claimant's condition. All the treating, examining, and consulting physicians have opined that claimant has a severe physical impairment that precludes essentially all useful function of the right upper extremity such that claimant is capable of performing only non-physical work using his non-dominant left hand. There is no contrary medical opinion.

Thus, claimant is severely disabled as a consequence of his compensable injury; he is not capable of returning to work as a drywall finisher, the job he performed for the 40 years prior to his injury. Nevertheless, claimant is not precluded from performing all work activity. Accordingly, we conclude that claimant is not completely physically disabled and not totally precluded from employment on medical grounds alone. We must, therefore, determine whether claimant is permanently and totally disabled under the "odd-lot" doctrine.

The nonmedical factors to be considered in an "odd-lot" analysis include age, education, work experiences, adaptability to non-physical labor, mental capacity and emotional condition, as well as the conditions of the labor market. Clark v. Boise Cascade Co., 72 Or App 397 (1985); Welch v. Bannister Pipeline, supra at 701. Additionally, in evaluating permanent total disability, we consider preexisting disabilities and their impact on performing work at a gainful and suitable occupation. See ORS 656.206(1). Because application of an "odd-lot" analysis presupposes some capacity for employment, an injured worker is statutorily required to be willing to work and to make reasonable efforts to find work, although he need not engage in job seeking activities that, in all practicality, would be futile. ORS 656.206(30); SAIF v. Stephen, 308 Or 41 (1989); SAIF v. Orr, 101 Or App 612 (1990).

In addition to his severe physical limitations as a result of his compensable right shoulder injury, claimant is further restricted by preexisting hearing loss and a prior compensable injury to the left leg resulting in a 30 percent loss of use or function. Claimant wears hearing aids; while he does under

stand most conversational speech, at the hearing, claimant needed to have some questions repeated. Claimant also has difficulty using the phone because it "whistles" in his ears. Finally, claimant cannot stand in one place more than five to ten minutes due to his prior leg injury.

At the time of the hearing, claimant was 61 years old, had an eighth grade education with no other formal training, and no transferable skills from his highly specialized prior job. Gary Culbertson, a vocational expert, persuasively testified that for all of the foregoing reasons, claimant is not employable.

Nevertheless, the insurer makes several arguments which we must address. Specifically, the insurer contends that claimant is not entitled to an award of permanent total disability because claimant is regularly working part-time for wages and because claimant is not motivated to work.

Claimant testified that he is willing to seek work, but is unsure what he could do. Given his age, lack of transferable skills, and severe physical limitations, we find a work search would be futile for this claimant. See SAIF v. Scholl, 92 Or App 594, 597 (1988); Butcher v. SAIF, 45 Or App 318 (1983). Nevertheless, since his compensable injury, claimant has applied to twenty employers either directly or through the state employment offices. Claimant was working part-time at a modified job as of the hearing. We are persuaded by claimant's testimony and his continued efforts to find work that he is indeed willing to work.

The insurer contends that "[c]laimant has a job. He is actually performing work for wages. The employer needs him . . . to perform the job . . . ." The insurer relies on Georgia-Pacific v. Perry, 92 Or App 56 (1988). We are not persuaded by the insurer's argument that claimant is working regularly for wages. As of the hearing, claimant was working for the employer for one hour each morning. On many days, the employer sends claimant home because there is nothing for him to do. We do not read Perry to say that the ability to do any part-time job, no matter how few the hours, precludes a finding of permanent total disability. See Homer B. Hartman, 42 Van Natta 276 (1990).

Finally, we address claimant's contention that, contrary to the Referee's finding, the job offered December 2, 1989 does not exist in a hypothetically normal labor market. A copy of the job offer is not in the record. Claimant testified that the job was part-time, and paid an hourly wage equal to 80 percent of his prior wage. Claimant and the employer both testified that the job was one that was created for claimant, and included miscellaneous bits and pieces of other jobs, such as opening up the office, turning on the heat, answering the phone before the receptionist arrived, ordering material, and instructing other employees as needed.

Claimant and the employer agree that there is no other job like this in the remodeling construction business. The employer's vocational expert testified that this was a special job offered to a loyal employee. Moreover, both claimant's and the employer's vocational experts agree that the job offered to claimant is not one that is available in a hypothetically normal labor market. Under these circumstances, we find that the job offered to claimant is not persuasive evidence that he is currently employable or able to sell his services on a regular basis in a competitive labor market. Harris v. SAIF, 292 Or 683, 695 (1982).

In sum, claimant's impairment attributable to the compensable injury, in combination with his preexisting disabling conditions, prevent him from returning to his regular employment. His age, lack of transferable skills and

severely limited physical capabilities prevent claimant from finding suitable and gainful employment. Neither claimant's current modified job nor the offered modified job demonstrates that claimant is capable of selling his services in a competitive labor market. Finally, although it would be futile for claimant to seek regular employment, he has demonstrated his willingness to work.

Consequently, we conclude that claimant is unable to perform any work at a gainful and suitable occupation and, therefore, is entitled to an award of permanent total disability.

A permanent total disability award is effective as of the date the evidence establishes the disability status. See Adams v. Edwards Heavy Equipment, Inc., 90 Or App 365, 370-71 1988); Morris v. Denny's, 50 Or App 533, modified 53 Or App 863 (1981). Claimant became medically stationary on August 10, 1989. Therefore, we conclude that the award of compensation for permanent total disability shall commence as of August 10, 1989. The insurer is authorized to offset any temporary or permanent partial disability compensation paid to claimant after that date against the permanent total disability award. See Pacific Motor Trucking Co. v. Yeager, 64 Or App 28, 32 (1983); Paul D. Rasmussen, 38 Van Natta 1310 (1986).

ORDER

The Referee's order dated March 12, 1990 is reversed. In lieu of the Referee's award of 33 percent (105.6 degrees) unscheduled permanent disability, claimant is granted permanent total disability effective August 10, 1989. The insurer is authorized to offset temporary or permanent partial disability compensation paid subsequent to that date, if any, against claimant's permanent total disability award. 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. However, the total fees awarded by the Referee and Board orders shall not exceed $6,000.

In the Matter of the Compensation of
ROBERT L. TODD, Claimant
WCB Case Nos. 89-16230 & 89-16229
ORDER ON REVIEW
Aspell, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

The insurer requests review of that portion of Referee Brown's order that increased claimant's unscheduled permanent disability award for a back injury from 11 percent (35.2 degrees), as awarded by a Determination Order, to 45 percent (144 degrees). On review, the issue is extent of unscheduled permanent partial disability. We modify.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the exception of finding 7. We make the following additional findings. Claimant is limited to light/sedentary work. He has sustained a 23 percent loss of earning capacity as a result of his compensable back injury.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant has an unscheduled permanent partial disability equal to 45 percent. Although the Referee did not specify which standards he applied, he apparently applied former OAR 436-35-001 et seq, which was effective at the time of claimant's August 10, 1989 Determination Order. These are the rules which we apply as well. ORS 656.283(7) and 656.295(5); OAR 438-10-010. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent disability.

Former OAR 436-35-270(2) provides that impairment is to be modified by various social and vocational factors to arrive at unscheduled permanent disability. The insurer argues that claimant is not entitled to any social or vocational values because he has no "measurable impairment" within the meaning of former OAR 436-35-270(2) and 436-35-320(1) since his only impairment is the loss of repetitive use of his back. To support his argument, the insurer relies on (1) an unsigned letter from the manager of the Evaluation Section of the Department of Insurance and Finance, which the insurer attached to its brief; and (2) former 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." We do not find this argument persuasive.

We first note that our review is limited to the record developed at hearing. Former ORS 656.295(5). Therefore, we are not authorized to consider the evidence submitted by the insurer on review. However, we may remand to the Referee if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." Id. Therefore, we treat the insurer's submission as a motion to remand; we review the submission only for purposes of ruling on that motion.

To merit remand, it must be shown that material evidence was not obtainable with due diligence before the hearing. Bernard L. Osborn, 37 Van Natta 1054, 1055, aff'd mem 80 Or App 152 (1986). Here, the letter which the insurer submits is dated more than six weeks prior to the date of the hearing in this matter. Therefore, we are not persuaded that the proffered evidence was unobtainable with due diligence prior to the hearing. Moreover, even if the letter was unobtainable prior to hearing, we are not persuaded that the record is improperly, incompletely or otherwise insufficiently developed in its absence. In this regard, in similar circumstances we have declined to find a letter from the Department to be a legally-binding interpretive rule. See James H. Wiley, 43 Van Natta 86 (1991). Therefore, we decline to remand and do not consider the submission on review.

We turn to the insurer's reliance on former OAR 436-35-005. The introductory material in former OAR 436-35-005 provides that the definition of "impairment" found in former OAR 436-35-005(1) applies "unless the context requires otherwise." Here, the context requires otherwise. Former OAR 436-35-320(1) expressly provides for an impairment value for the loss of repetitive use. That rule appears in the section entitled "Impairments Rated as Unscheduled Disability." The other provisions of that section are addressed to the calculation of impairment. We find no limiting language in the section indicating that a medically verified loss of repetitive use is not a measurable impairment. Therefore, we conclude that loss of repetitive use is a "measurable impairment" within the meaning of former OAR 436-35-270(2). Cf. Larry L. McDougal, 42 Van Natta 1544 (1990). Accordingly, claimant is entitled to a value under the "standards" for social and vocational factors.

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.

Aside from the insurer's argument, as discussed above, the parties do not challenge the following values assigned by the Referee: Age (0); Formal Education (0); Skills (+3); and Impairment (+5). We, therefore, adopt those values without further discussions.

Training

Whether claimant is entitled to a value for training under former OAR 436-35-300(5) is dependent upon whether or not claimant has demonstrated competence in some specific vocational pursuit. Competence in some "specific vocational pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off the job to perform other than an entry level position. Larry L. McDougal, supra.

The Referee assigned a value of +1 for training, finding that claimant's three months of training in the Navy as a boiler room helper did not give claimant competence in that area. We do not need to address the question of whether claimant has competence as a boiler room helper because we find that claimant has competence as a veneer grader, his at injury job. The job of veneer grader has a SVP of 3, and claimant worked at this job for one and a half years before his injury. We find that his work as a veneer grader gives claimant competence to perform other than an entry level position.

Claimant argues that competence in a specific vocational pursuit requires the worker to be presently physically capable of performing the job. However, because the administrative rule contains no such qualification, the Board rejected that argument in Jimmie L. Wilson, 42 Van Natta 2526 (1990). Thus, we find that claimant has demonstrated competence in a specific vocational pursuit. Therefore, the appropriate training value is a 0. Former OAR 436-35-300(5).

Adaptability

The Referee assigned a value of +10 for adaptability based on the February 17, 1988 report of Dr. Bennett, claimant's original treating physician. The Referee found that, since Dr. Bennett was correct about claimant's diagnosis of chronic lumbar strain, he was inferentially correct about claimant's limitations. We disagree.

Claimant did not become medically stationary until March 17, 1989, more than a year after Dr. Bennett's report limited claimant to sedentary work with limits on standing, walking, bending, and lifting. Although Dr. Bennett opined that these limits were permanent, the record shows that claimant's condition improved significantly over this time period. Dr. Bennett referred claimant to Dr. Campagna, neurologist, who examined claimant three times in the period from June 13, 1988 to March 17, 1989. (Exs. 27, 32, 36). Dr. Bennett did not treat claimant during this period. Dr. Campagna noted that claimant's condition had improved. (Exs. 32).

Moreover, claimant's at injury job was in the light category, and Dr. Campagna recommended that claimant continue his vocational rehabilitation

efforts. (Ex. 32). On this basis, we find that Dr. Campagna judged claimant capable of doing less than light work. We defer to his opinion because he examined claimant at the time he became medically stationary.

The adaptability value for a claimant who is not working as a result of his or her compensable injury/condition 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 not working as a result of his injury/condition and has not been offered work. Based on Dr. Campagna's report, claimant has established that his physical capacity falls between the light and sedentary categories as defined in former OAR 436-35-310(4). In such cases, the values for the two categories are averaged to obtain the appropriate adaptability value. Former OAR 436-35-310(4). The average of 4, the value for light physical capacity, and 8, the value for sedentary physical capacity, is 6. Therefore, the appropriate adaptability value is 6.

Computation of Unscheduled Permanent 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 6, the product is 18. When that value is added to claimant's impairment value 5, the result is 23 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 23 percent.

ORDER

The Referee's order dated December 18, 1989, as reconsidered January 24, 1990, is modified in part and affirmed in part. In lieu of the Referee's award and in addition to the 11 percent (35.2 degrees) awarded by Determination Order, claimant is awarded 12 percent (38.4 degrees) unscheduled permanent disability, for a total award of 23 percent (73.6 degrees). The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
BETTY S. FRANKLIN, Claimant
WCB Case No. 89-13985
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Nelson, et al., Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

The insurer requests review of Referee Craine's order that: (1) set aside its denial of claimant's low back aggravation claim; (2) set aside its denial of certain medical services as not reasonable and necessary; and (3) awarded an assessed attorney fee. On review, the issues are aggravation, medical services and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "FINDINGS OF FACT".

CONCLUSIONS OF LAW AND OPINION

AGGRAVATION/ATTORNEY FEE

We adopt the Referee's opinion regarding the aggravation and attorney fee issues.

MEDICAL SERVICES

The Referee held that treatment by a physician in addition to the three attending physicians allowed by former ORS 656.245(3) was reasonable and necessary, and ordered the insurer to pay for the costs of that treatment. The Referee found that the insurer's refusal to allow claimant to change to a new physician, who happens to be an osteopath, effectively precluded her from this type of treatment which she had never tried before. We disagree.

The worker may choose her initial attending doctor and two subsequent doctors without approval from the director. If the worker thereafter selects another attending physician, the insurer may require that the director approve a new selection. The director, when requested, shall determine whether the selection shall be approved. ORS 656.245(3); OAR 436-10-060(4).

Here, the insurer gave claimant notice after she had had three attending physicians, as required by the rule, that she needed to seek the insurer's approval of any additional change. OAR 436-10-060(4). Claimant then sought treatment from Dr. Heatherington and he subsequently referred her to Dr. Aversano for consultation. The insurer did not give approval. Approval to change attending physician was then requested from the director; however, the director refused to grant the requested change.

The well-reasoned opinions of her additional doctors, especially Dr. Heatherington, may be crucial to claimant's aggravation claim. However, claimant is not entitled to have the insurer pay for services rendered by those doctors unless the insurer or the director approve.

Although we have reversed that portion of the Referee's order that found the insurer responsible for medical services, we do not disturb the Referee's attorney fee award for services at the hearing level concerning the aggravation and medical service issues. After considering the factors set forth in OAR 438-15-010(4), we find that $1,825 is a reasonable fee for services at hearing concerning the aggravation issue. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issue, and the value of the issue involved.

Finally inasmuch as claimant has not submitted a brief on review, she is not entitled to an attorney fee for services on review. See Shirley M. Brown 40 Van Natta 879 (1988).

ORDER

The Referee's order dated April 26, 1990 is reversed in part and affirmed in part. We reverse that part of the order that set aside the insurer's denial of medical services rendered by Dr. Heatherington and Dr. Aversano. The insurer's denial is reinstated and upheld. We affirm the remainder of the order.

In the Matter of the Compensation of
BUCK E. JOHNSON, Claimant
WCB Case No. 89-07415
ORDER ON REVIEW
Max Rae, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Nichols, Brittingham and Crider.

Claimant requests review of Referee M. Johnson's order that: (1) declined to grant permanent total disability; (2) awarded claimant 25 percent (80 degrees) unscheduled permanent disability for his mental illness, neck, brachial plexus, and low back conditions, whereas a Determination Order had awarded no permanent disability; (3) declined to award claimant scheduled permanent disability for his left knee; and (4) declined to assess a penalty and related attorney fee for the SAIF Corporation's allegedly unreasonable failure to provide exhibits. On review, the issues are the extent of permanent disability, including permanent total disability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

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

Upon discharge from the Oregon State Hospital in 1983, claimant's mental disorder was diagnosed by Dr. McNutt, M.D., as Axis I 302.20 Pedophilia. (Ex. 3).

Dr. Schwartz, psychologist, began treating claimant in September 1986 for severe emotional distress related to his experiences at the employer. At that time Dr. Schwartz diagnosed claimant's mental disorder as Axis I 309.89 post-traumatic stress disorder. (Ex. 10, 23). Dr. Schwartz was still treating claimant in June 1989, at which time he added the diagnoses of Axis I 300.02 generalized anxiety disorder and depression. (Ex. 83). In June 1989, Dr. Schwartz reported to vocational rehabilitation that claimant was physically and mentally incapable of working, and that it would be futile for him to be required to participate in a vocational assistance program. As a result, vocational rehabilitation discontinued its services.

Dr. Wittkopp, psychiatrist, examined claimant for SAIF in 1986 and again in January 1989. (Ex. 77).

Claimant began treating with Dr. Palmer, chiropractor, in November 1987. Palmer referred him to a physical rehabilitation program. (Ex. 56).

Claimant was examined by Dr. Pitchford, Ph.D., psychologist, in December 1987. (Ex. 49).

Western Medical Consultants performed an independent medical examination of claimant in April 1988 which included an exam by Dr. Glass, psychiatrist. (Ex. 61).

Claimant has an IQ of 82 and a mental/emotional age of 10 years.

Claimant has approximately a 4th grade education. He cannot calculate or spell. He has no specific training.

Claimant worked for two and a half years as a steam cleaner in a car wash, six years as a garbage collector, and nine years on a green chain. (Ex. 32-1).

FINDINGS OF ULTIMATE FACT

Claimant suffers from chronic mental disorders diagnosed as Axis I 309.89 post-traumatic stress disorder and 300.02 generalized anxiety disorder and depression. These conditions were caused by the compensable injury.

Claimant is unable to regularly perform any type of work because of the combined effect of his chronic mental disorders, his permanent physical impairment, his age of 52, his mental/emotional age of 10, his IQ of 82, his 4th grade education, his inability to calculate or spell, and his inability to follow directions.

Claimant is willing to work. He has made reasonable efforts to obtain employment. A further work search would be futile.

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Disability

The Referee found that claimant was employable and, therefore, concluded that he is not permanently and totally disabled. We disagree.

To establish his entitlement to permanent total disability, claimant must prove that he is completely physically disabled and therefore unable to regularly perform work at a gainful and suitable occupation. ORS 656.206(1)(a); Harris v. SAIF, 292 Or 683, 695 (1982). Psychological conditions which are due to the compensable injury are considered with physical impairment in determining if an injured worker is permanently and totally disabled. Gornick v. SAIF, 92 Or App 303 (1988); Ferguson v. Industrial Indemnity Co., 70 Or App 46 (1984). The same is true if a compensable injury materially contributes to a permanent worsening of a preexisting psychological condition. Allen v. Fireman's Fund Insurance Co., 71 Or App 40 (1984); Haugen v. Beautique a Go-Go, 18 Or App 132 (1974). Alternatively, permanent total disability may be established by evidence that the physical impairment, combined with certain social and vocational factors, effectively prevents gainful employment under the "odd-lot" doctrine. Welch v. Bannister Pipeline, 70 Or App 699 (1984), rev den 298 Or 470 (1985).

The physicians who examined claimant found only mild physical impairment of claimant's neck, low back and knees. Western Medical Consultants performed an independent medical examination in April 1988. Dr. Snodgrass, M.D., neurologist, found no impairment of the cervical and lumbar areas or the right knee at that time. Dr. Palmer, chiropractor, evaluated claimant's physical condition in July 1989. His lifting and carrying evaluations are confusing. He stated claimant could lift 30 pounds from floor to waist height, 20 pounds from waist to overhead, and could carry 30 pounds occasionally. He also limited claimant to no more than 50 pounds lifting and 20 pounds carrying because of his low back, and 20 pounds lifting and 10 pounds carrying because of his neck. He also limited repetitive use of the arms in extension, pushing and pulling that require repetitive turning and twisting of the cervical spine. Palmer did not release claimant to regular work. Claimant himself testified that he could lift 20 pounds. He also testified that he might be able to work 3 hours a day, but that he could not handle "responsibility," i.e., mildly complex instructions. This evidence indicates that claimant is not permanently totally disabled as a result of his neck, back, brachial plexus or left knee condition.

However, claimant's inability to handle responsibility raises the issue of his psychological limitations. The consensus of the medical evidence indicates that claimant's most severe problem is his psychiatric condition. We first address the diagnosis of the condition and whether it is due to the accepted injury.

In 1986, Dr. Wittkopp diagnosed claimant with, inter alia: Axis I dysthymic disorder (depressive neurosis) with anxious features, agoraphobia with panic attacks, suspected borderline mental retardation, psychological factors affecting physical condition--abdominal pain and spastic torticollis; Axis II mixed personality disorder with paranoid, explosive, and dependent features; Axis IV severe job-related stress; Axis V highest level of functioning in the last year--fair with impaired vocational and social relationships. Dr. Wittkopp stated that the stresses in the workplace were the major contributing cause of the dysthymic disorder and anxiety symptoms, and that the stress reactivated and exacerbated the agoraphobia. He did not think that the stress worsened claimant's underlying personality disorder, but only caused an increase in symptoms. Dr. Wittkopp gave claimant a year to recover from the stress. (Ex. 24).

In 1987, Dr. Pitchford diagnosed, inter alia: Axis I post-traumatic stress disorder from medical records, dysthymic disorder, psychological factors affecting physical condition--extreme tension is probably worsening neck pain, adjustment disorder with atypical features, and adjustment to late middle-age with mixed emotional features; and Axis II borderline personality disorder. She recommended a return to work, noting that claimant had a stable work history. Although she assessed claimant as an individual with a lifetime of severe social and personal pathology that preceded his work-related injury, she opined that the sadistic nature of the events at the employer were adequate to induce post-traumatic stress disorder.

In 1988, Dr. Glass diagnosed, inter alia: Axis I adjustment reaction of adult life with mixed emotional features, now resolved; Axis II mixed personality disorder with antisocial and passive dependent features. Glass stated that the personality disorder was claimant's major problem and was the result of his traumatic childhood, and that the stress from the car wash job had resolved.

In 1988, Dr. Wittkopp changed his diagnosis to Axis I bipolar disorder (manic depressive), psychogenic pain disorder (neck, shoulder & low back), borderline mental retardation; Axis II same as in 1986; Axis IV stress minimal; Axis V same as in 1986. He opined that claimant's compensable condition from the car wash job was no longer the cause of his disability, but that claimant was a manic-depressive who needed to have his condition controlled by medication, that claimant had been repeatedly exploited because of his mental disorder and retardation, and that claimant needed to have a guardian of his person and finances.

Dr. Schwartz diagnosed claimant with Axis I post-traumatic stress disorder in 1986, related to the compensable injury. He continued to make that diagnosis in 1989. In 1989, he also diagnosed claimant with Axis I generalized anxiety disorder, and depression.

Where there is a dispute between medical experts, we will give more weight to opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). In this case, we give less weight to Dr. Glass' opinion because he had seen claimant only once, after claimant had been released to work by Dr. Schwartz but prior to claimant's unsuccessful work attempts later in 1988. Drs. Schwartz and Wittkopp each saw claimant over a period of time. Of these two, we find Dr. Schwartz to be more persuasive than Wittkopp for the following reasons. Dr. Wittkopp did not provide any reasoning as to why he now diagnoses claimant with manic-depression rather than dysthymic disorder. Furthermore, his statement that he finds no evidence of continuing post-traumatic stress from the car wash job, since "most psychiatric disorders begin in childhood trauma" begs the question of causation.

Dr. Schwartz, on the other hand, contrasted his current diagnosis with the diagnosis made by Dr. McNutt at the time claimant was discharged from the Oregon State Hospital program. At that time claimant had no mental disorders other than pedophilia. Dr. Schwartz also compared claimant's behavior and physical and mental health while in the program with the debilitating anxiety and depression that prevented him from a successful return to work in 1988. Furthermore, Schwartz contrasted claimant's current inability to cope with the pressures of a job with claimant's former ability to hold a job successfully for five years. We also find Schwartz' opinion more persuasive because he has been treating claimant since the onset of the compensable condition. In addition, Schwartz' opinion is reinforced by that of Dr. Pitchford, who, although recognizing that claimant had a lifetime of severe pathology, opined as well that the sadistic nature of the events at the car wash were adequate to induce post-traumatic stress disorder. Accordingly, we are persuaded that claimant has post-traumatic stress disorder, generalized anxiety disorder and depression that are a result of his compensable injury. We thus consider claimant's psychological condition with his physical impairment in determining whether claimant is permanently totally disabled. Gornick v. SAIF, supra.

Claimant is severely disabled as a consequence of his compensable injury. We also consider claimant's severe, preexisting hearing loss, which resulted from conditions at the employer's car wash. See ORS 656.206(1). However, claimant testified that he could lift 20 pounds and could work 3 hours a day, provided he was not required to handle mildly complex instructions. Thus, despite his physical and psychological limitations, claimant is not precluded from performing all work activity. Accordingly, we conclude that claimant is not completely physically disabled and not totally precluded from employment on medical grounds alone. Therefore, we must 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, work experiences, adaptability to nonphysical labor, mental capacity and emotional condition, as well as the conditions of the labor market. Clark v. Boise Cascade Co., 72 Or App 397 (1985); Welch v. Bannister Pipeline, supra. Because application of an "odd-lot" analysis presupposes some capacity for employment, an injured worker is statutorily required to be willing to work and to make reasonable efforts to find work, although he need not engage in job seeking activities that, in all practicality, would be futile. ORS 656.206(3); SAIF V. Stephen, 308 Or 41 (1989); SAIF v. Orr, 101 Or App 612 (1990).

In addition to his physical limitations and severe mental disorder, claimant is further restricted by intellectual, social and vocational factors. He has an intellect that borders on mental retardation. He is uneducated and is unable to calculate or write. He has a mental/emotional age of 10 years. He is 52 years of age with no specific training.

Claimant has demonstrated his willingness to work. In 1988, he made three unsuccessful attempts to return to work as a laundry worker, service station attendant and cannery worker. He was unable to perform these jobs because of his physical and mental limitations.

Moreover, claimant participated in vocational assistance. However, vocational assistance was stopped on the authority of Dr. Schwartz after claimant had tried and failed to perform three jobs, each of which lasted a shorter time than the last. Dr. Schwartz stated that vocational assistance would be futile because of claimant's psychological condition. There is no contrary current medical evidence in the file that indicates claimant can work. Claimant's age, lack of basic reading and writing skills, low intellect, subnormal mental/emotional age, lack of transferable skills and severe psychological impairment

prevent him from finding suitable and gainful employment. Considering claimant's physical and psychological limitations and lack of transferable skills, we find that additional efforts to seek employment would be futile.

Consequently, we conclude that claimant is permanently and totally disabled as a result of his compensable injury and, therefore, is entitled to an award of permanent total disability.

A permanent total disability award is effective as of the date the evidence establishes the disability status. See Adams v. Edwards Heavy Equipment, Inc., 90 Or App 365, 370-71 (1988); Morris v. Denny's, 50 Or App 533, modified 53 Or App 863 (1981). Claimant became medically stationary on January 23, 1989. Therefore, we conclude that the award of compensation for permanent total disability shall commence as of January 23, 1989. The SAIF Corporation is authorized to offset any permanent partial disability compensation paid after January 23, 1989 as a prepayment of claimant's permanent total disability compensation. See Pacific Motor Trucking Co. v. Yeager, 64/Or/App/28 (1983).

Penalty and Attorney Fees for Failure to Submit Documents

We affirm the Referee, but with different reasoning.

The Referee denied claimant's request for penalties and related attorney fees based upon SAIF's failure to provide exhibits as required by OAR 438-07-018(1). The Referee concluded that because there is no provision for claimant or his attorney to receive compensation because of SAIF's failure to provide exhibits, no compensation could be awarded.

Claimant admits that no compensation was delayed because of SAIF's violation of the rule. Although SAIF violated the rule, and although we assume without deciding that the violation was unreasonable, the violation, nevertheless, did not result in an unreasonable delay or refusal to pay compensation. Thus, no penalty may be awarded. ORS 656.262(10). Further, ORS 656.382(1) allows an attorney fee if an insurer "unreasonably resists the payment of compensation." Absent a showing that SAIF's inaction affected some obligation to pay compensation due in the past, present or future, it cannot be said that there was any resistance to such payment. An insurer cannot unreasonably resist paying compensation for which it is never liable. Accordingly, an attorney fee is not authorized by ORS 656.382(1).

ORDER

The Referee's order dated August 18, 1989 is reversed in part and affirmed in part. In lieu of the Referee's award of permanent partial disability, claimant is granted permanent total disability, effective January 23, 1989. The SAIF Corporation is permitted to offset permanent partial disability payments paid subsequent to that date against claimant's permanent total disability benefits. The remainder of the order is affirmed. Claimant's attorney is awarded a fee equal to 25 percent of the increased compensation created by this order, payable by the SAIF Corporation, except that total out-of-compensation fees awarded by the Referee and the Board shall not exceed $6,000.

Board Member Brittingham, concurring in part and dissenting in part:

I concur in that portion of the majority opinion that declines to award a penalty and attorney fee for SAIF's alleged unreasonable delay or refusal to pay compensation. I would uphold the Referee's permanent partial disability award.

Board Member Crider, concurring in part and dissenting in part:

I join in that portion of the lead opinion that finds that claimant is permanently and totally disabled. I agree that claimant is not entitled to a penalty for violation of OAR 438-07-018 because there were no amounts then due at the time of the violation. I dissent, however, from that portion of the opinion that holds that claimant is not entitled to a carrier-paid attorney fee as a result of SAIF's violation of the Board's rules regarding the submission of exhibits.

OAR 438-07-018 governs the submission of exhibits at hearing. It provides that the insurer has primary responsibility for preparing exhibits. The rule reads in relevant part as follows:

> "(1) Not later than twenty (20) days before the hearing, the insurer or self-insured employer shall provide the claimant documents that are relevant and material to the matters in dispute in the hearing, together with an index. The documents shall be arranged in chronological order and numbered, in Arabic numerals, in the lower right corner of each page, beginning with the document of earliest date. The numbers shall be preceded by the designation 'Ex,' and pagination of multiple page documents shall be designated by a hyphen followed by the page number. For example, page two of document two shall be designated 'Ex 2-2.' The index shall include the document numbers, description of each document, author, number of pages and date of the document.
>
> "(2) Not less than ten (10) days before the hearing, or within seven (7) days of receipt of the insurer document index and documents, whichever is later, the claimant shall provide the insurer(s) or self-insured employer(s) legible copies of any additional documents"that are relevant and material to the matters in dispute in the hearing. The additional documents shall be marked and accompanied by a supplemental document index, prepared in the same manner as the insurer documents and index and numbered to coincide in chronological order with the insurer's documents. Letter subdesignations shall be used to insure chronological numbering. For example, a document which is chronologically between documents six and seven of the insurer documents shall be designated 'Ex. 6A.'"
>
> "(3) Before the hearing, the parties shall delete from their indexes and packets of documents those documents which are cumulative, or which no party can in good faith represent to be relevant and material to the issues, and the revised indexes and packets of documents shall be submitted to the referee...." (Emphasis added.)

Counsel for SAIF submitted no exhibits--within the time provided for by the rule or at any other time. Therefore, claimant's attorney, after ascertaining that SAIF was taking the position that it had no obligation to submit exhibits, prepared a complete set of exhibits with an index. In submitting the

exhibits to the Referee, he also amended his hearing request to seek penalties and attorney fees for SAIF's failure to submit exhibits as required by the rule.

The Referee ruled that there is no basis for the award of a fee under these circumstances. The Board affirms, stating that because claimant has not proved that compensation was delayed by SAIF's violation of the rule, claimant is entitled to neither a penalty nor a fee. There was no compensation due at the time of the violation. Therefore, the Board correctly holds that no penalty may be levied. ORS 656.262(10). Nevertheless, SAIF, by seeking to impede the litigation process, has resisted the payment of compensation; a fee should be assessed.

On review, SAIF contends that it had no duty to submit any exhibits because it did not intend to rely on any exhibits. In fact, under the Board rules, unlike the rules in civil court, it is the insurer and not the party requesting the hearing, which must first submit exhibits. In making its initial submission, again unlike the rules applicable in civil court, the Board rules require the insurer to include all documents "relevant and material to the matters in dispute," not simply the documents on which the insurer will rely to prove its side of the case. In short, the insurer does have an affirmative duty to prepare a complete set of exhibits that will enable the referee to insure that the record is complete. Hence, SAIF is wrong when it contends that it had no duty to prepare a set of exhibits and index in this case.

An attorney fee is appropriate, even in the absence of amounts then due, if the evidence establishes that SAIF unreasonably resisted the payment of compensation. ORS 656.382(1); Ellis v. McCall Insulation, 308 Or 74 (1989).

OAR 438-07-018(1) is crystal clear. Therefore, SAIF's deliberate violation of the rule was unreasonable.

In this case, the violation also constituted a resistance to the payment of compensation. First, SAIF's failure to submit exhibits was capable of and calculated to either delay the hearing or to put the burden on claimant to prepare the exhibits and index whereas the rule placed the burden on the insurer. SAIF's conduct thus put an additional roadblock between claimant and the permanent total disability award which claimant sought. Second, we have found that claimant was in fact entitled to the compensation which he sought. Consequently, although SAIF did not successfully delay the payment of compensation, it did unreasonably resist the payment thereof. The Board errs in holding that an insurer does not resist the payment of compensation, within the meaning of ORS 656.382(2), unless it is actually successful in delaying compensation. In ordinary English usage, the word "resist" means "to exert force in opposition to." Webster's Ninth Collegiate Dictionary (1985). It does not mean to successfully exert force in opposition to. There is no reason to read the term as employed in ORS 656.382(2) more narrowly than the ordinary usage requires. Claimant's attorney, who was forced by SAIF's conduct to prepare the exhibits in SAIF's stead in order that the hearing not be delayed, is entitled to an assessed fee for prevailing on this issue.

In the Matter of the Compensation of
FRED LOTFI, Claimant
Own Motion No. 91-0047M
OWN MOTION ORDER ON RECONSIDERATION
Stebbins & Coffey, Claimant Attorneys

Claimant requests reconsideration of the Board's February 6, 1991, Own Motion Order which dismissed his claim for temporary disability benefits on res judicata grounds. Claimant contends that res judicata does not bar his claim.

The relevant facts of this case follow. In January, 1989, claimant submitted a claim for an alleged worsening of his compensable low back injury. Because his aggravation rights had expired, the claim is subject to the Board's own motion authority under ORS 656.278. Claimant requested authorization for low back surgery and the payment of temporary disability benefits. The self-insured employer denied the compensability of surgery and referred the own motion request for temporary disability benefits to the Board. Claimant requested a hearing on the surgery denial (WCB Case No. 89-02669), and the Board postponed action on the own motion request.

The Referee in WCB Case No. 89-02669 set aside the denial of surgery on November 13, 1989. By letter dated December 20, 1989, the Board requested evidence that claimant was in the work force "at the time the compensable condition worsened" so as to qualify for temporary disability benefits. By Own Motion Order dated April 26, 1990, the Board denied claimant's request for temporary disability benefits. Finding no evidence that claimant was working or making reasonable efforts to obtain work before his low back condition worsened, the Board concluded that claimant was not a "worker" and, therefore, did not lose wages as a result of the worsening. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Cutright v. Weyerhaeuser, 299 Or 290 (1985). That order was not appealed and is now final.

After low back surgery was performed in October, 1990, claimant filed a "new application" for temporary disability benefits. He also submitted evidence that he had been working for several months after his condition worsened in January, 1989, but before issuance of the April 26, 1990, order. By order dated February 6, 1991, the Board found that the "new application" is the same claim for temporary disability benefits which was denied by the April 26, 1990, order, and concluded the claim was barred by res judicata. See, e.g., Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560 (1989).

Pursuant to ORS 656.278(1)(a), the Board may reopen a claim for the payment of temporary disability benefits when there is a worsening of a compensable injury that requires surgery or hospitalization. In such cases, the Board may authorize the payment of benefits beginning on the date of surgery or hospitalization.

In order to qualify for temporary disability benefits, however, claimant must prove that he is in the work force. See Cutright v. Weyerhaeuser, supra; Dawkins v. Pacific Motor Trucking, supra. In aggravation cases, the Supreme Court has held that the critical time at which claimant must be in the work force in order to qualify for temporary disability benefits is at the "time of disability." Weyerhaeuser Co. v. Kepford, 100 Or App 410, 414, rev den 310 Or 71 (1990). In own motion cases, on the other hand, the onset of disability alone does not trigger claimant's substantive entitlement to the payment of temporary disability benefits. Claimant must undergo surgery or hospitalization for the worsened condition before claimant's substantive entitlement to temporary disability benefits is triggered. See ORS 656.278(1)(a). Inasmuch as

surgery or hospitalization is a prerequisite to the payment of temporary disability benefits under the Board's own motion authority, we are persuaded that the critical time at which claimant be in the work force in order to qualify for temporary disability benefits is the date of surgery or hospitalization. Insofar as the Board's prior own motion orders are inconsistent with this holding, they are disavowed.

Here, in our February 6, 1991, order, we concluded that claimant's current claim for temporary disability benefits arose from the same operative facts which composed the earlier claim we denied by final order on April 26, 1990. Accordingly, we concluded that the claim was barred by the "claim preclusion" branch of res judicata. See Drews v. EBI Companies, 310 Or 134 (1990); North Clackamas School Dist v. White, 305 Or 48, modified 305 Or 468 (1988); Dean v. Exotic Veneers, Inc., 271 Or 188, 193 (1975); Liberty Northwest Ins. Corp. v. Bird, supra; Carr v. Allied Plating Co., 81 Or App 306, 310 (1986).

Claimant notes that, prior to the issuance of our April 26, 1990, order, the Board only requested evidence of his work efforts prior to or at the time of his worsening in January, 1989. The Board did not request evidence of his subsequent work efforts. Claimant contends, therefore, that the operative facts of the earlier claim should not preclude his current claim. We agree.

The number of operative facts viewed as part of the same claim should be determined by practical considerations such as whether the facts are related in time, space, origin, or motivation, whether they form a convenient trial unit, and whether their treatment as a unit conforms to the parties' expectations. Restatement (Second) of Judgments 26 (1982); see also Dean v. Exotic Veneers, Inc., supra; Carr v. Allied Plating Co., supra. Here, before denying claimant's earlier claim for temporary disability benefits by final order on April 26, 1990, we requested evidence of his work efforts at the time of his worsening only. Therefore, the parties could not reasonably expect that the April 26 order would preclude a subsequent claim for temporary disability benefits based on evidence of his work efforts after the worsening. Accordingly, we are persuaded that the current claim does not arise from the same operative facts which composed the earlier claim. The doctrine of res judicata does not apply to preclude the current claim.

On the merits, we find that claimant was working from September, 1989, through March, 1990. That is sufficient to prove that claimant is in the work force so as to qualify for temporary disability benefits. Additionally, we are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, claimant's claim is reopened with temporary disability benefits to commence October 16, 1990, the date he was hospitalized for the surgery. The self-insured employer shall continue paying temporary total disability benefits until one of the following events 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. Claimant's attorney is awarded a reasonable attorney fee equal to 25 percent of the additional compensation created by this order, not to exceed $600. When appropriate, the claim shall be closed by the employer pursuant to OAR 438-12-055.

Our February 6, 1991, order is abated and withdrawn. On reconsideration, we issue this order in its stead.

IT IS SO ORDERED.

In the Matter of the Compensation of
LYLE L. SMITH, Claimant
WCB Case No. 89-20618
ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
Kenneth Russell (Saif), Defense Attorney

The Board has received the SAIF Corporation's motion for abatement and reconsideration of our Order on Review dated January 29, 1991.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and withdrawn. Claimant is requested to file a response to the motion within 10 days from the date of this order. Thereafter, the Board shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
TIMOTHY D. BEARD, Claimant
WCB Case No. 89-05535
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Peterson's order that: (1) found he lacked jurisdiction to address claimant's entitlement to temporary disability compensation commencing January 25, 1989, the SAIF Corporation's denial of claimant's aggravation claim for a low back condition, and penalties and attorney fees for an allegedly unreasonable denial of that aggravation claim, and for failure to commence payment of temporary disability benefits on January 25, 1989; (2) affirmed a September 16, 1988, Determination Order which awarded no unscheduled permanent partial disability beyond the 30 percent (96 degrees) previously awarded; (3) declined to award additional temporary disability compensation commencing August 25, 1988; and (4) found that claimant's back injury claim was not prematurely closed by the September 16, 1988, Determination Order. In his brief, claimant also requests penalties and attorney fees for SAIF's failure to pay temporary total disability benefits after August 12, 1988. On review, the issues are jurisdiction, aggravation, premature closure, temporary total disability compensation, extent of permanent partial disability including permanent total disability, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact. In addition, we find that the aggravation claim culminating in the September 16, 1988, Determination Order was filed on April 5, 1988.

FINDING OF ULTIMATE FACT

Claimant's aggravation rights expired on June 28, 1987.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's injury was nondisabling for the first year after his low back injury and, therefore, the statutory period of

claimant's aggravation rights commenced to run on June 28, 1982, the date of the injury. Accordingly, the Referee concluded that "all of the aggravation issues raised by claimant" were beyond his jurisdiction. We interpret the Referee's language as referring to the issues of temporary disability compensation commencing January 25, 1989, SAIF's March 24, 1989, aggravation denial, and penalties and attorney fees for unreasonable denial of that aggravation claim and for failure to pay temporary disability benefits commencing January 25, 1989. On review, claimant argues that his aggravation rights have not expired because, on June 8, 1984, in a Disputed Claim Settlement (DCS), SAIF constructively acknowledged that claimant's injury was disabling by paying temporary disability benefits and, therefore, the aggravation rights should run from October 7, 1985, the date the first Determination Order issued in this claim.

By Disputed Claim Settlement dated June 8, 1984, claimant agreed that his compensable condition remained nondisabling. That DCS was entered into more than one year after the date of his June 1982 injury. Thus, he cannot now argue that the injury was disabling from the outset. Therefore, claimant's claim must be treated as an aggravation claim under ORS 656.273, because it is made on the basis that his previously nondisabling injury has become disabling more than one year after the date of injury. Smith v. Ridgepine, Inc., 88 Or App 147, 149 (1987); Denise A. Robinson, 42 Van Natta 2514 (1990). The crucial question, then, is did claimant file his claim within five years of June 28, 1982.

In his brief, claimant contends that he filed aggravation claims on both December 29, 1988 and January 25, 1989. Both of these dates are beyond five years of June 28, 1982. Therefore, we agree with the Referee's conclusion that claimant's aggravation claims were not timely filed.

We also agree with the Referee's conclusion that the expiration of claimant's aggravation rights was not affected by the fact an October 7, 1985, Determination Order was wrong in stating that the aggravation period began to run on October 7, 1985. The Referee cited Miltenberger v. Howard's Plumbing and SAIF, 93 Or App 475 (1988), for the proposition that an incorrect date on a Determination Order does not change the correct date from which the aggravation rights run. Claimant contends that he detrimentally relied on the October 7, 1985, date and, therefore, SAIF is estopped from denying that this was the date when the aggravation rights began to run.

Although the Miltenberger court did not specifically rule that a statement on an administrative form cannot modify the express language of controlling statutes, it affirmed a Board order which so held. See Bert E. Miltenberger, 39 Van Natta 68 (1987); See Also Margarette I. Schaffer-Wright, 39 Van Natta 1113 (1987). Further, on this record, we find no evidence that claimant actually relied on the October 7, 1985, date which the Determination Order incorrectly identified as the date from which claimant's aggravation rights began to run. Moreover, claimant's aggravation did not occur until 1988, after the expiration of his aggravation rights. Therefore, even if the Determination Order had stated the correct date from which those rights ran, claimant's claim would not have have been timely filed. Accordingly, we affirm the Referee's finding that he lacked jurisdiction over the issues emanating from the March 24, 1989, denial.

We next consider the Referee's rulings concerning the September 16, 1988, Determination Order and the related aggravation claim. The Referee found that claimant was not entitled to temporary disability compensation after August 25, 1988, that his claim was not prematurely closed and that he is not entitled to permanent disability greater than the 30 percent already awarded. In addition to requesting review of these rulings, claimant also asks the Board to assess a

penalty and related attorney fee for SAIF's failure to pay temporary disability compensation after August 12, 1988.

Claimant filed his aggravation claim when, on April 5, 1988, Dr. Newby requested that claimant's low back claim be reopened. As we have determined that claimant's aggravation rights expired on June 28, 1987, we conclude that this claim was not filed timely. In light of the fact that the aggravation claim culminating in the September 16, 1988, Determination Order was not filed within the statutory five-year aggravation period, we find that the Referee lacked jurisdiction over the premature closure, extent of permanent disability, temporary disability compensation, penalties and attorney fee issues discussed in the previous paragraph. The issuance of the September 16, 1988, Determination Order, which closes a claim that was voluntarily reopened by the insurer after claimant's aggravation rights had run, does not give the Hearings Division authority it would not otherwise have. Moreover, the September 16, 1988, Determination Order itself is invalid for the same reasons. Instead of seeking claim closure for the 1988 voluntary reopening through the Evaluation Section, the claim should be processed to closure pursuant to "Own Motion" procedures. See OAR 438-12-055; 438-12-060.

ORDER

The Referee's order dated November 24, 1989 is affirmed in part and reversed in part. The Referee's jurisdictional ruling regarding review of the SAIF Corporation's March 24, 1989, aggravation denial and related issues is affirmed. The remainder of the Referee's order is reversed. The September 16, 1988, Determination Order is set aside as invalid.

February 28, 1991 Cite as 43 Van Natta 434 (1991)

In the Matter of the Compensation of
RONALD R. BUDDENBERG, Claimant
WCB Case No. 89-19242
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of those portions of Referee McWilliams' order that: (1) declined to grant permanent total disability; and (2) affirmed a Determination Order that awarded no additional scheduled permanent disability beyond the 60 percent (81 degrees) previously awarded by a Referee's order for loss of use or function of each foot. The issue on review is extent of scheduled permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

We adopt the Referee's discussion of the permanent total disability issue subject to the following supplementation.

The Referee noted that claimant's inability to find employment in the Harbor/Brookings area where he lived, as opposed to Portland, does not render him permanently and totally disabled. We agree with that statement to the extent that claimant's "normal" labor market is not necessarily confined to the Harbor/Brookings area. However, we do not agree with the finding insofar as it suggests that Portland would be within claimant's "normal" labor market. Nevertheless, we agree with the Referee's ultimate conclusion that claimant has not proven that he has made reasonable efforts to seek suitable and gainful employment since his last surgery or that such efforts would be futile.

Extent of Scheduled Permanent Disability

In order for claimant to qualify for a permanent disability award, upon closure of his aggravation claim, he must show that he has suffered a permanent worsening of his shoulder condition since the last award or arrangement of compensation. Stepp v. SAIF, 304 Or 375 (1987). The Referee concluded that the May 6, 1987 Determination Order was the last award of compensation. We agree and adopt her reasoning on this issue.

Claimant argues that the Referee incorrectly found that he had not experienced a permanent worsening of his compensable condition since the May 1987 Determination Order. We do not agree with claimant's characterization of the Referee's order. While the Referee did conclude that claimant was entitled to no additional permanent disability, her conclusion was not premised upon a finding that claimant's condition had not permanently worsened. Instead, the Referee concluded that claimant had failed to establish entitlement to an additional award in excess of that which he had previously received on this claim, i.e., 60 percent scheduled permanent disability for each foot as awarded by a Referee's December 1982 order. We agree with the Referee.

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. Because claimant's condition became medically stationary on August 21, 1989, and his claim was closed by Determination Order on September 18, 1989, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Additionally, either party may establish by clear and convincing evidence that claimant's disability is more or less than determined by application of the standards. Former ORS 656.283(7); 656.295(5). Once the total disability is arrived at by application of the "standards" or by clear and convincing evidence, we reduce the award by the amount of previous awards of permanent disability made as a result of the same compensable injury. This is true even though the prior awards may have been determined by application of longstanding guidelines rather than disability rating standards adopted pursuant to ORS 656.726(3)(f). Gary A. Koch, 42 Van Natta 2777 (1990). See also ORS 656.222; American Building Maintenance v. Molees, 296 Or 772 (1984).

The Evaluation Section assigned impairment values of 10 percent bilaterally for claimant's surgeries, and 15 percent bilaterally for calcaneous deformities. The Referee utilized these values in reaching her conclusion that claimant was entitled to no additional permanent disability. Neither party has contested these values. Although the record in support of these values is sparse, we accept those values for purposes of determining whether, in fact, claimant's current permanent disability rating exceeds that which he has previously received as a result of the same compensable injury. In addition to the above values, we find that claimant is entitled to a 5 percent impairment value

for chronic conditions limiting repetitive use of both feet. Former OAR 436-35-010(7). In this regard, claimant credibly testified that he is forced to periodically rest and elevate his feet due to pain and swelling when he is active on his feet. This testimony is supported by the medical evidence.

For purposes of computing claimant's total disability, the impairment values listed above are combined, not added. Former OAR 436-35-240(5). Claimant's bilateral impairment values of 10 percent, 15 percent, and 5 percent are combined for a total value of 28 percent. Therefore, claimant's permanent disability under the "standards" is 28 percent. Because this amount is less than that previously awarded to claimant, we conclude that he is entitled to no additional award under the "standards" upon the most recent closure of his claim. See Gary A. Koch, supra.

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". Former 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).

Although not expressly stated, claimant's argument concerning his entitlement to additional permanent disability could be interpreted as a contention that he has established, by clear and convincing evidence, entitlement to a permanent disability award in excess of that indicated by the "standards." We find the record as a whole does establish that claimant suffers greater permanent disability than the 28 percent value indicated by the "standards." However, we are not persuaded that the record establishes that it is "highly probable" that claimant's permanent disability exceeds the 60 percent value previously awarded to claimant under the longstanding guidelines. Therefore, claimant is entitled to no additional award of permanent disability.

ORDER

The Referee's order dated February 22, 1990 is affirmed.

February 28, 1991 Cite as 43 Van Natta 436 (1991)

In the Matter of the Compensation of
IRA G. EDDINGTON, Claimant
WCB Case Nos. 88-14604 & 88-13382
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Nelson, et al., Defense Attorneys
Norman Cole (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation requests review of those portions of Referee Menashe's order that: (1) set aside its denial of claimant's asthma condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of claimant's occupational disease claim for the same condition. SAIF does not object to the overturning of its denial. However, it contends that the Referee erred in upholding Liberty Northwest's denial. In his brief on review, claimant requests a higher assessed fee than the $1,500 awarded by the Referee. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Reasoning that SAIF had never closed claimant's 1983 claim, the Referee concluded that its July 1988 denial was an invalid preclosure denial. Thus, SAIF's denial was set aside and the claim remanded for further processing. Inasmuch as his decision was based on procedural grounds, the Referee noted that the merits of claimant's occupational disease claim with Liberty Northwest had not been considered. Under such circumstances, the Referee upheld Liberty Northwest's August 1988 denial.

On review, SAIF does not contest the Referee's reasoning in concluding that its denial was improper and that it is responsible for processing the claim to closure. However, it objects to the Referee's decision to uphold Liberty Northwest's denial. Specifically, SAIF contends that, if Liberty Northwest's denial stands, Liberty Northwest would forever avoid responsibility for claimant's condition. We disagree.

The decision to set aside SAIF's denial has been expressly based on the impropriety of its denial. Although the merits of claimant's occupational disease claim existing at the time of the October 1988 hearing have not been addressed, Liberty Northwest's denial has nonetheless been upheld because it is not responsible for the claim. The Referee's, as well as our, determination of responsibility solely pertains to disability and medical services arising from the claim as it existed at the time of hearing. Such a determination will have neither prospective nor preclusive effect upon the merits of any subsequent claim should one arise following closure of the SAIF claim.

We further disagree with SAIF's contention that Liberty Northwest is absolved of future claim processing obligations by this decision. Should subsequent claims arise following closure of the SAIF claim, whether directly from claimant or indirectly from SAIF via OAR 436-60-180, Liberty Northwest would remain responsible for processing them. Moreover, in the event of a denial and a timely hearing request, Liberty Northwest would be required to defend its denial with no preclusive effect from our decision today regarding the merits of that future claim.

Finally, after considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree with the Referee that a reasonable fee for claimant's counsel's services at hearing is $1,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's counsel's statement of services), the complexity of the issues, the value of the interest involved, and the risk that counsel's efforts may go uncompensated.

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 is $500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, the value of the interest involved, and the nature of the proceedings.

ORDER

The Referee's order dated November 23, 1988, as amended January 20, 1989, is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $500, payable by the SAIF Corporation.

In the Matter of the Compensation of
ALMER R. ENGLISH, Claimant
WCB Case No. 89-24327
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Darryl Nelson, Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Brown's order that increased claimant's unscheduled permanent disability award for a low back injury from 25 percent (80 degrees), as awarded by Determination Order, to 28 percent (89.6 degrees). On review, the issue is extent of unscheduled permanent partial disability. We modify.

FINDINGS OF FACT

We adopt the Referee's "Findings," with the exception of #6, which we replace as follows.

Claimant was not working at hearing, for reasons related to his compensable injury.

CONCLUSIONS OF LAW AND OPINION

Claimant's sole argument on review is that his adaptability factor should be determined under former OAR 436-35-310(4), rather than former OAR 436-35-310(3). We agree.

Claimant was not working at hearing. He testified that he is trained and licensed to sell real estate. However, due to his compensable back condition, he is physically unable to show property with stairs or uneven ground or to stand long enough to participate in "open house" activities. Therefore, claimant cannot perform the modified work for which he is trained. There is no evidence to the contrary. On this basis, we conclude that claimant is not working for reasons related to his compensable injury.

The adaptability value for a claimant who is not working as a result of his or her compensable injury 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); Donna Bartruff, 42 Van Natta 2784, 2786 (1990).

Claimant's treating physician has limited him to lifting no more than 10 pounds, with additional restrictions on bending, twisting, crawling and climbing ladders. Because claimant's residual physical capacity is "sedentary," with additional restrictions, the proper adaptability factor is 9. Former OAR 436-35-310(4).

Inasmuch as the remaining values under the "standards" are not contested or improperly analyzed, we adopt those values assigned by the Referee and proceed to the calculation of claimant's permanent disability.

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, 9, the product is 45. When that value is added to claimant's impairment value, 13, the result is 58 percent unscheduled permanent partial disability. Claimant's permanent disability under the "standards" is, therefore, 58 percent.

We do not find clear and convincing evidence of greater or lesser permanent disability than that determined by application of the "standards."

ORDER

The Referee's order dated May 5, 1990 is modified. In addition to the Referee's award and Determination Order award claimant is awarded 30 percent (96 degrees) unscheduled permanent disability, giving him a total award to date of 58 percent (185.6 degrees) unscheduled permanent disability for his low back condition. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total attorney fees awarded by the Referee and the Board orders shall not exceed $3,800.

February 28, 1991 Cite as 43 Van Natta 439 (1991)

In the Matter of the Compensation of
DENNIS S. JACOBSEN, Claimant
WCB Case No. 87-16343
ORDER ON REVIEW
Scott McNutt, Claimant Attorney
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Crider, Speer and Howell.

The SAIF Corporation requests review of that portion of Referee Higashi's order that set aside its partial denial of claimant's alcohol-related condition. The issue is compensability. We affirm.

FINDINGS OF FACT

Claimant, 53 years of age at hearing, compensably injured his low back on November 4, 1981, in a lifting incident while employed by SAIF's insured. He subsequently underwent lumbar surgery. A referee's Opinion and Order dated March 5, 1984 awarded claimant 30 percent unscheduled permanent disability for his low back, and 5 percent scheduled permanent disability for his right leg.

In 1984, claimant began working as a heavy equipment operator for a different employer. He was operating a dump truck on October 4, 1985, when he suffered a jarring incident resulting in worsened low back and leg symptoms. Claimant continued to work with the new employer for another week, until October 11, 1985, when his job ended. He subsequently filed an aggravation claim with SAIF and a "new injury" claim with the new employer. Pursuant to a June 1986 referee's order, responsibility for claimant's condition was assigned to SAIF on an aggravation theory.

As a result of the October 1985 aggravation, claimant was unable to return to work as a heavy equipment operator. He remained physically and vocationally capable of certain medium level work including driving some types of trucks, as well as working as a purchasing agent or supply clerk. He searched for employment within his limitations. However, other than some volunteer work for the

Oregon All Terrain Vehicle Association, claimant was unemployed from October 1985 until early 1988, at which time he obtained work as a federal purchasing agent.

During the late spring or early summer of 1987, claimant began to consume one fifth of whiskey per day. His increased alcohol consumption was in response to feelings of frustration and depression associated with his inability to locate new employment. For a number of years previously, he had consumed a lesser, undetermined amount of alcohol.

Claimant was subsequently hospitalized in July 1987 for acute pancreatitis and alcoholism. The pancreatitis condition was caused by excessive consumption of alcohol. Following stabilization of his pancreatitis, he was treated at the VA hospital in Roseburg, Oregon for alcohol dependency. By letter dated April 25, 1988, SAIF denied payment of benefits related to claimant's alcoholism.

Claimant did not suffer from a preexisting symptomatic alcoholism condition prior to his compensable 1985 aggravation.

CONCLUSIONS OF LAW AND OPINION

Claimant argues that his alcohol-related condition arose as a sequela of his compensable injury and subsequent aggravation. Therefore, treatment for claimant's alcoholism is compensable if the injury caused it to become symptomatic, or caused a preexisting psychological condition to become symptomatic in the form of alcoholism. Hansen v. Weyerhaeuser Company, 89 Or App 349 (1988). The court in Hansen concluded that the injured worker suffered from a preexisting alcoholism condition. The court noted in this regard that claimant had previously been treated for alcoholism, that he had once been active in Alcoholics Anonymous, and that he had participated in a diversion program after being charged with driving under the influence. Here, by contrast, the record does not support such a finding. To the contrary, there is no evidence of prior treatment, missed work, drunk driving charges, or any other evidence of a preexisting alcoholism condition. The only evidence supporting a finding of a preexisting condition is a statement in a report generated during claimant's hospitalization which refers to claimant's "chronic alcoholism." To the extent this statement suggests that claimant suffered from alcoholism prior to his 1985 aggravation, it is unsupported elsewhere in the record. We conclude that claimant did not suffer from alcoholism prior to his 1985 aggravation and ensuing period off work. Therefore, the next question we must address is whether claimant's October 1985 aggravation played a material role in the development of his alcoholism.

Relying upon the opinion of Dr. Martin, a consulting psychiatrist, the Referee found a causal relationship between the industrial injury and claimant's problem of alcohol abuse. Dr. Martin stated in this regard that there was a direct relationship between claimant's October 1985 aggravation and his markedly escalating alcohol consumption thereafter. The Referee rejected the conclusion of Dr. Turco, an independent psychiatrist, who opined that claimant's alcoholism was not due to his compensable injury or its aggravation. We conclude, however, that while their ultimate conclusions are superficially contradictory, Drs. Martin and Turco actually agree on the cause of claimant's increased alcohol use. In this regard, Dr. Martin finds that claimant's "enforced layoff" resulted in increased discouragement, frustration and depression. Similarly, Dr. Turco found that "the temporary exacerbation necessitating the hospitalization appears to be associated with [claimant's] being out of work."

In this regard, SAIF contends that claimant did not leave his job because of his aggravated back condition, but instead he left work when the job ended

and he was laid off. The record supports SAIF's contention. However, the question remains whether claimant was off work thereafter, at least in material part, as a result of his injury-related condition. In this regard, the Orthopaedic Consultants reported to SAIF on October 9, 1986, that claimant was "getting along satisfactorily and working" until his 1985 aggravation. Since that time, claimant had continued to experience low back symptoms. The Consultants suggested that claimant could return to "some other occupation." They further suggested that claimant might need vocational job placement assistance.

Claimant both cooperated with vocational assistance and undertook his own job search. However, he was unable for an extended period of time to locate new employment in a field other than that he was engaged in at the time of his aggravation. Under these circumstances, claimant has established that he was off work in material part due to his aggravated condition. As noted above, he has also established that his alcoholism and resulting hospitalization in 1987 was due to his frustrations and depression from being out of work. Accordingly, claimant has established a prima facie compensable claim.

Relying upon the opinion of Dr. Turco, SAIF asserts that claimant should nevertheless be denied benefits because his drinking was "volitional." ORS 656.154 denies benefits to a worker if injury results from "the deliberate intention of the worker to produce such injury or death." Accepting arguendo SAIF's assertion that claimant's drinking was volitional, there is nonetheless no evidence supporting the proposition that he drank excessively "with the deliberate intention" of putting himself in the hospital for pancreatitis. Therefore, ORS 656.154 does not apply.

SAIF also argues that claimant should be denied benefits pursuant to ORS 656.325(2). That provision operates to suspend the payment of benefits to a worker who "commits insanitary or injurious practices which tend to either imperil or retard recovery of the worker." ORS 656.325(2) may have some application under facts such as are found here. However, if we were to find that claimant's excessive drinking amounted to an injurious practice which tended to retard his recovery, nevertheless, SAIF's recourse under ORS 656.325(2) was to seek the Director's approval to suspend benefits. SAIF has not done so.

In sum, we conclude that, on these facts, claimant has established compensability of his claim for benefits resulting from his hospitalization in 1987.

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 $800, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value to the interest involved to claimant.

ORDER

The Referee's order dated June 24, 1988 is affirmed. For services on Board review, claimant's counsel is awarded a reasonable assessed attorney fee of $800, payable by the SAIF Corporation.

Board Member Howell dissenting.

This case involves conditions which resulted from claimant's alcohol consumption and which have some causal connection with his original compensable injury. The majority has followed the result obtained in the majority of reported cases. See e.g., South Carolina Dep't of Highways & Pub Transp. v.

Higgins, 284 S.C. 359, 326 S.E.2d 425 (Ct App 1985). However, few, if any, cases have developed a complete and cogent approach for analyzing such cases. 1 Larson, Workmen's Compensation Law, 13.11(d), 3-382 (1985). Professor Larson has developed such an overall analytical framework. Because I believe the Board should now adopt that framework, and because the result would be different in this case if that framework was adopted, I respectfully dissent.

Larson places subsequent consequences of compensable injuries into two categories. The first such category consists of those injury consequences which arise out of activities performed in the "quasi-course of employment." Larson states:

> "By this expression is meant activities undertaken by the employee following upon his injury which, although they take place outside the time and space limits of the employment, and would not be considered employment activities for normal purposes, are nevertheless related to the employment in the sense that they are necessary or reasonable activities that would not have been undertaken but for the compensable injury. 'Reasonable' at this point relates not to the method used, but to the category of activity itself."1 Larson, Workmen's Compensation Law, 13.11(d), 3-379 (1985).

Oregon has expressly adopted the above-quoted "quasi-course of employment" portion of Larson's analytical framework for range of consequences cases. Fenton v. SAIF, 87 Or App 78, 82 (1987).

Larson's second category of range of consequences cases consists of cases in which the consequences of a compensable injury do not arise out of the "quasi-course of employment." Neither this Board nor the courts have expressly considered, as a separate class, this remaining portion of Larson's overall analytical approach.

The significance of Larson's categories is that, taken together, they provide a complete and rational basis for determining the compensability of consequences of compensable injuries. Larson's approach allows one to determine whether a sufficient causal relationship exists between the original, compensable injury and two fundamentally different types of consequences. Such a complete framework is now lacking, since Oregon has adopted only one portion of Larson's overall analytical approach.

I would adopt the remainder of Larson's analytical approach, that portion dealing with consequences of injuries which do not arise out of "quasi-course of employment" activities, and apply that analysis to the present case. Larson states:

> "Once we recognize that we are dealing with a dual rather than a single problem, we are ready to go on to the next task, which is to identify an appropriate rule on range of consequences separately for each of the two categories of subsequently [sic] activity.
>
> "It is submitted that an appropriate pair of principles would be as follows:
>
> "When the injury following the initial compensable injury arises out of a quasi-course activity, such as a trip to the doctor's office, the claim of causation

claimant has not objected to the insurer's contentions within the time granted her in our abatement order, we have proceeded with our review.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The sole question on review is whether a referral for a psychiatric evaluation is compensable. The Referee concluded that it was and set aside the insurer's denial accordingly. We disagree.

For her compensable injury, claimant is entitled to medical services "for such period as the nature of the injury or the process of recovery requires." ORS 656.245(1). Claimant carries the burden of proving by a preponderance of the evidence that the proposed treatment is reasonable and necessary. West v. SAIF, 74 Or App 317 (1985).

The difficulty in this case arises because it is unclear why the referral was made. Dr. Hulse, the treating physician who requested the referral, is silent on the matter. Because claimant testified that she was not interested in psychiatric treatment, the Referee assumed that the referral was made for an evaluation for pain management treatment and, under the circumstances, concluded that it was reasonable and necessary medical treatment.

Even assuming that the referral was made for an evaluation for pain management, we are not persuaded that a preponderance of the evidence establishes that such treatment is reasonable and necessary. There is no evidence in the record that claimant would benefit from pain center treatment. If Dr. Hulse considered claimant a candidate for such treatment, he failed to explain the basis of his opinion. Moreover, in August and December 1989, the Orthopaedic Consultants found claimant medically stationary and in need of no further therapy or treatment. The Western Medical Consultants reached the same conclusion in February 1990. Consequently, we conclude that, on this record, claimant has failed to carry her burden of proof that a referral made for an evaluation for pain management treatment is a compensable medical service.

Claimant also has failed to carry her burden of proof if Dr. Hulse referred her for treatment for a psychological condition. It is undisputed that claimant suffers from a personality disorder. However, Dr. Hulse concurred with Dr. Turco's opinion that claimant's psychological problems are not related to her compensable injury. Thus, there is no medical evidence that the injury was a material contributing cause of that condition, or that the injury aggravated the preexisting psychological weakness. See Jordan v. SAIF, 86 Or App 29 (1987); Jeld-Wen Inc. v. Page, 73 Or App 136 (1985).

ORDER

The Referee's order dated April 19, 1990 is reversed. The insurer's denial is reinstated and upheld. The Referee's $1,200 attorney fee to claimant's counsel for services at hearing regarding the denial is reversed.

In the Matter of the Compensation of
DARRELL G. MCCLURE, Claimant
WCB Case No. 88-16863
ORDER ON REVIEW
Goldberg, et al., Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Menashe's order which increased claimant's unscheduled permanent disability award for a 1980 low back injury from 10 percent (32 degrees), as awarded by Determination Order, to 20 percent (64 degrees). On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact." In addition, we supplement with the following findings.

This case arises from claimant's February 13, 1980 compensable low back injury. A Determination Order issued October 6, 1981, awarding claimant 10 percent unscheduled permanent partial disability. Claimant's 1980 injury became medically stationary prior to October 6, 1981, and has remained medically stationary since that time.

On September 18, 1986, claimant sustained a second compensable low back injury with a different employer. That condition became medically stationary on January 6, 1987, and a Determination Order issued October 5, 1987, awarding claimant 10 percent unscheduled permanent partial disability.

In November 1987, the insurer for the February 1980 injury referred claimant for vocational training. After claimant completed an Authorized Training Program, his claim was reclosed by a September 21, 1989 Determination Order. Upon redetermination, claimant was awarded no additional unscheduled permanent partial disability.

FINDINGS OF ULTIMATE FACT

Claimant has sustained a 20 percent loss of earning capacity as a result of his 1980 low back injury.

CONCLUSIONS OF LAW AND OPINION

The Referee applied the "standards" in effect at the time the last Determination Order (September 21, 1989) issued. However, 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. (Emphasis provided). Here, claimant's February 1980 claim was initially closed by a Determination Order issued in October 1981. The claim was reopened for vocational assistance and reclosed by a Determination Order issued in September 1989. Although claimant's permanent impairment from the 1980 injury was reconsidered in a subsequent Determination Order issued after July 1, 1988, claimant has been medically stationary from this injury since prior to October 1981, when this claim was first closed. Therefore, we find that claimant's 1980 injury did not last became medically stationary on or after

January 1, 1988. Accordingly, we apply the "guidelines" rather than the "standards" in evaluating claimant's permanent partial disability attributable to the 1980 injury.

The criterion for rating unscheduled permanent partial disability under the guidelines 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); Barrett v. D & H Drywall, 300 Or 553, 555 (1986). The rules for rating unscheduled disability are 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.

Claimant's compensable back injury restricts his ability to perform work-related activities such as walking, standing, and lifting; claimant is only employable in sedentary and restricted light level jobs. As of the date of the hearing, claimant was 50 years old and precluded from returning to his prior work. Claimant has a high school education, has completed one and one-half years of college, and is successfully working at a sedentary job.

On review, claimant contends that because he could be earning $16.00 an hour performing unrestricted heavy labor, as compared to $7.25 an hour that he is now earning in sedentary work as a draftsman, he has lost at least fifty percent of his earning capacity. We disagree. Although we consider wage differential, we also must consider such factors as access to the labor market, the absolute number of jobs that claimant remains capable of performing, the wages obtainable in those jobs, and the like. A worker's post-injury earnings alone are not determinative in assessing loss of earning capacity. Jacobs v. Louisiana-Pacific, 59 Or App 1 (1982); Ford v. SAIF, 549 Or App 549 (1972); Daniel Mercado-Nuno, 42 Van Natta 2812 (1990); Richard A. Gonsalves, 42 Van Natta 1787 (1990).

After considering these factors, along with claimant's physical limitations and other relevant social and vocational factors, we conclude that an award of 30 percent (96 degrees) unscheduled permanent disability adequately and appropriately compensates claimant for his loss of earning capacity.

The Referee reduced claimant's 30 percent unscheduled permanent partial disability award by 10 percent as awarded for a separate compensable injury to the same body part. We concur. Former ORS 656.214(5) provides that an injured worker is entitled to that unscheduled permanent disability which results from the injury in question. However, the worker is not entitled to be doubly compensated for a permanent loss of earning capacity which would have resulted from the injury in question, but which was produced by another accident and compensated by a prior award. Frederick Fox, 43 Van Natta 197 (1991); Alberta M. Lakey, 43 Van Natta 30 (1991); Mary A. Vogelaar, 42 Van Natta 2846 (1990). See Thomason v. SAIF, 73 Or App 319, 322 (1985); Lawrence W. Scott, 40 Van Natta 1721 (1988).

Consequently, to avoid doubly compensating claimant for the same loss of earning capacity, we reduce claimant's total disability of 30 percent by the 10 percent award he received for the September 1986 injury to his low back. Accordingly, we conclude that a 20 percent unscheduled permanent partial disability award represents claimant's permanent disability as a result of the February 1980 injury.

As discussed above, claimant received an award of 10 percent permanent disability pursuant to a 1981 Determination Order under the 1980 claim, and an

award of 10 percent permanent disability pursuant to a 1987 Determination Order under the 1986 claim. The Referee assumed that both awards were made under the 1980 injury claim. Consequently, he awarded claimant an additional 10 percent (32 degrees) unscheduled permanent disability, for a total award of 30 percent. In fact, the 10 percent disability awarded in 1987 was for claimant's separate 1986 injury. To date, claimant has received a total of 20 percent unscheduled permanent disability for the 1980 injury, not the 30 percent assumed by the Referee. Consequently, although the Referee correctly awarded an additional 10 percent permanent disability, the total award to date for the 1980 injury is 20 percent, rather than 30 percent.

ORDER

The Referee's order dated March 6, 1990 is affirmed.

February 28, 1991 Cite as 43 Van Natta 448 (1991)

In the Matter of the Compensation of
CHRISTOPHER P. MURCHIE, Claimant
WCB Case No. 90-11882
ORDER ON REVIEW
Ronald M. Somers, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

The SAIF Corporation requests review of Referee Galton's order that: (1) awarded 8 percent (10.8 degrees) scheduled permanent disability for a left foot injury, whereas a Determination Order awarded no permanent disability; and (2) ordered the disability award to be paid at $305 per degree. On review, the issue are extent and rate of scheduled permanent partial disability. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's FINDINGS OF FACT.

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Disability

We defer to the Referee's finding that claimant was credible based on his demeanor as a witness. In light of the credible testimony by claimant that he can no longer repetitively perform certain tasks both at work and off work, we conclude that he is entitled to an award of 5 percent because of chronic conditions limiting repetitive use of his left foot. Former OAR 436-35-010(7).

Claimant argues that he is entitled to an additional award for pain. We disagree. Because claimant's claim was closed by a Determination Order on December 15, 1989, the "standards" that were effective January 1, 1989 are applicable. Unlike previous versions of the rule, former OAR 436-35-010(2) allows an award for pain only if the pain results in measurable impairment. The record here does not support measurable impairment. Therefore, we decline to make an additional award for pain.

Consequently, we conclude that claimant is entitled to an award of 5 percent scheduled permanent disability under the "standards".

Degree Dollar Amount

The Referee concluded that permanent partial disability must be paid at $305 per degree. We agree.

We have recently held that, regardless of the date of injury, all scheduled permanent disability awards made on or after May 7, 1989, must be paid at the rate of $305 per degree. Alan G. Herron 43 Van Natta 267 (1991).

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 dollars per degree issue is $500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to his unsuccessful defense of the Referee's permanent disability award.

ORDER

The Referee's order dated October 25, 1990 is modified in part and affirmed in part. In lieu of the Referee's award of 8 percent (10.8 degrees) scheduled permanent partial disability, claimant is awarded 5 percent (6.75 degrees) scheduled permanent partial disability, for a total of 5 percent to date for loss of use or function of his left foot. Claimant's out-of-compensation attorney fee shall be adjusted accordingly. The remainder of the order is affirmed. For services on review, regarding the rate of permanent disability issue, claimant's attorney is awarded an assessed fee of $500, to be paid by the SAIF Corporation.

February 28, 1991 Cite as 43 Van Natta 449 (1991)

In the Matter of the Compensation of
MARY A. NAGEL, Claimant
WCB Case No. 90-09577
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Speer and Howell.

The insurer requests review of that portion of Referee Seifert's order which increased claimant's unscheduled permanent disability award for a low back injury from 15 percent (48 degrees), as awarded by a Determination Order, to 45 percent (144 degrees). On review, the issue is extent of permanent disability. We reverse.

FINDINGS OF FACT

Claimant was 33 years old at the time of hearing. She has 13.5 years of formal education, including a high school diploma. For the ten years preceding hearing, claimant worked as an order filler (DOT # 222.487-014), SVP 3. (Ex. 3). Claimant has competence in a specific vocational pursuit.

Claimant is able to perform all but heavy lifting. She had not returned to work at the time of the hearing.

Claimant has a chronic injury-related condition that limits repetitive use of her low back.

Claimant became medically stationary on February 15, 1990. A Determination Order issued on April 5, 1990, awarding 15 percent unscheduled permanent disability.

CONCLUSIONS OF LAW AND OPINION

Because claimant's condition became medically stationary on February 15, 1990, and her claim was closed by Determination Order on April 5, 1990, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq.

Age and Education

The appropriate value for claimant's age of 33 years is 0. Former OAR 436-35-290.

The appropriate value for claimant's 13.5 years of formal education, including a high school diploma, is 0. Former OAR 436-35-300(3).

The highest specific vocational pursuit (SVP) level demonstrated by a claimant during the ten years preceding the date of determination is used to determine a value for skills. Former OAR 436-35-300(4). For our purposes, permanent disability is determined on the date of hearing. The position which claimant successfully performed during the ten years preceding the date of hearing, which has the highest specific vocational pursuit (SVP) level, was, 3, as an order filler (DOT # 222.487-014). Therefore, the appropriate value for skills is 3. Former OAR 436-35-300(4). We are not persuaded by claimant's argument that, because some of her duties overlap the description of warehouse worker in the DOT, that warehouse worker is the appropriate SVP level. According to the 801 that the employer filled out three days after the injury, claimant's occupation was order filler. (Ex. 3).

Whether claimant is entitled to a value for training under former OAR 436-35-300(5) is dependent upon whether or not claimant has demonstrated competence in some specific vocational pursuit. Competence in some "specific vocational pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off the job to perform other than an entry-level position. Larry L. McDougal, 42 Van Natta 1544 (1990).

Here, claimant has demonstrated competence in a specific vocational pursuit. Therefore, the appropriate training value is 0. Former OAR 436-35-300(5).

Adaptability

The adaptability value for a claimant who is not working as a result of his or her compensable injury/condition is determined by the claimant's residual physical capacity, without regard to the claimant's physical capacity prior to the injury. Former OAR 436-35-310(4).

Here, the insurer argues that the Referee erred in assigning an adaptability value of 8 for sedentary work. We agree.

Claimant relies on a check-the-box chart where Dr. Koester, her treating physician, had checked that claimant could never lift 20 pounds and could occasionally lift 10 pounds. However, that form is contrary to the written reports of Dr. Koester and other physicians who have examined claimant.

On February 10, 1989, Dr. Koester released claimant to work with the restriction that she perform no heavy lifting. In December 1989, Dr. Koester reported that claimant was not cooperating in her vocational rehabilitation classes and had been issued warnings. Dr. Holland, a psychiatrist, examined claimant and noted that, although she was in her sixteenth month of disablement, there was not one objectively demonstrable physical finding in her medical record. (See Exs. 4, 5). He recommended that her claim be closed as quickly as possible. (Ex. 15-16, 19). He also noted that claimant was in some conflict with her supervisor at the time of her injury. (Ex. 15-17). Dr. Koester concurred with Dr. Holland.

Here, claimant is not working as a result of her compensable injury and no offer of employment has been made. However, we are not persuaded by Dr. Koester's check-the-box form concerning claimant's physical capacity. After a review of all of the medical evidence, we conclude that claimant has failed to prove that she is precluded from more than heavy lifting. That limitation places her physical capacity in the medium category. Therefore, the appropriate adaptability value is 1. Former OAR 436-35-310(4)(b).

Impairment

The physicians' reports and tests indicate no loss of range of motion nor any other spinal findings upon which to make an award of permanent impairment. However, we find that claimant suffers from a chronic condition that limits repetitive use of her back. Former OAR 436-35-320(4). Accordingly, claimant is entitled to an impairment rating of 5 percent.

Computation of Unscheduled Permanent 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, 1, the product is 3. When that value is added to claimant's impairment value, 5, the result is 8 percent unscheduled permanent partial disability. Former OAR 436-35-280(7).

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". Former 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).

Here, the record fails to establish that claimant suffers injury-related permanent disability in excess of that awarded under the standards. Therefore, we do not find clear and convincing evidence that claimant suffers more than 8 percent unscheduled permanent disability. However, because the insurer did not request reduction of the award made by Determination Order, we affirm that award.

ORDER

The Referee's order dated August 9, 1990 is reversed. The award made by the Determination Order is reinstated and affirmed.

In the Matter of the Compensation of
PETER O. ODIGHIZUWA, Claimant
WCB Case Nos. 89-11253 & 89-11254
ORDER ON RECONSIDERATION
Goldberg & Mechanic, Claimant Attorneys
Roberts, et al., Defense Attorneys

The self-insured employer requested reconsideration of those portions of our Order on Review which assessed a penalty and attorney fee for an unreasonable denial. On February 14, 1991, we abated our order to give claimant an opportunity to respond and to give us an opportunity to reconsider. Claimant has now responded. On reconsideration, we adhere to our order with the following clarification.

The gist of this case is that under claimant's version of the events in question, he sustained a compensable injury; under his supervisors' version of the events in question, the injury is not compensable. The Referee, in his order, acknowledged that the case had to be resolved based on credibility. He specifically found claimant credible based on claimant's demeanor. In contrast, he found the supervisors not credible. In other words, he found that the supervisors were lying and claimant was telling the truth.

The denial was based on the supervisors' version of the facts. Because the supervisors were not telling the truth, there was no reasonable basis for the denial. As the Court of Appeals recently said of an attorney who was the employer's agent:

> "Employer contends that it had a legitimate doubt, because it relied on the advice of counsel. We disagree. Employer's attorney is its agent, and employer, as principal, cannot hide behind the incorrect advice of its agent." International Paper Company v. Huntley, 106 Or App 107 (1991).

Similarly, the employer must be charged with the actions of its agents who were claimant's supervisors and who, presumably, knew that the claim was compensable.

As amended, we hereby adhere to and republish our order of February 4, 1991. Appeal rights shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MILTON PORTER, JR., Claimant
WCB Case No. 89-23281
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Daryll E. Klein, Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of that portion of Referee Crumme's order that affirmed a Determination Order which awarded no unscheduled permanent disability

for a back injury beyond the 40 percent (128 degrees) awarded by a prior Determination Order and Stipulation. 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 correction. The next to the last sentence in Finding of Fact 12 should read: "Claimant usually works two to three hours per day, five to six days per week, collecting and selling recyclable cardboard and earns between $16 and $20 a day."

CONCLUSIONS OF LAW AND OPINION

The Referee rated claimant's disability under the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). He concluded that claimant is entitled to 28 percent unscheduled permanent disability under the "standards." Because claimant had already received awards totalling 40 percent in this claim, he affirmed a Determination Order awarding no additional permanent disability. Neither party challenges the Referee's calculation under the "standards." Therefore, we assume it is correct. Nevertheless, each party raises issues about claimant's entitlement given the 28 percent allowable under the "standards." We address the issues serially.

Applicability of the "Standards"

Claimant contends that the "standards" should not be applied to his claim because it was not first closed after July 1, 1988. Instead, claimant argues that the guidelines set forth in former OAR 436-30-380 et seq. should be applied.

We disagree. As the Referee noted, 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 "the standards." OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988).

The dispositive date is when claimant last became medically stationary and the claim was last closed, not when the claim was first closed. See Susannah Rateau, 43 Van Natta 135 (1991); Wade A. Webster, 42 Van Natta 1707 (1990). Claimant's condition last became medically stationary on September 21, 1989, and his claim was last closed by Determination Order on October 23, 1989. Thus, the Referee properly rated claimant's disability under the "standards."

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 the claimant is more or less than the entitlement indicated by the "standards." Former ORS 656.283(7) and 656.295(5).

The Referee found that claimant had not established by clear and convincing evidence that his disability is greater than that indicated by application of the standards. We disagree.

Claimant received the following values under the "standards:" age (+1 for workers 40 years and older); formal education (+1 for no high school diploma/GED); SVP (+3); training (+1); adaptability (+2.5); and impairment (+13). The 2.5 adaptability value was based on claimant's return to modified light work,

recycling cardboard 10 to 18 hours each week, whereas his job at injury involved heavy work. Former OAR 436-35-310(3).

Claimant asserts his race is one of the factors that places him outside the "standards," but he presents no evidence in support of his assertion. However, the "standards" do not adequately consider the fact that all of claimant's prior work experience is in heavy work he can no longer perform. Nor do the "standards" adequately consider the fact the modified work, to which claimant has returned, is work he created for himself, for less than 20 hours per week, rather than gainful employment within the meaning of former ORS 656.214(5). Considering claimant's total preclusion from his performing prior work activities, his lack of transferable skills, his age of 54 years and his sixth grade education with third grade reading ability, we find the evidence clear and convincing.

We find the evidence clear and convincing--that is, highly persuasive, free from confusion and distinct--that claimant suffers 50 percent permanent loss of earning capacity due to his compensable injury. See Riley Hill General Contractor Corp., 303 Or 390, 407 (1987).

Reduction of Current Award Due to Prior Awards

The insurer argues that if claimant is awarded additional permanent partial disability beyond that awarded by the Referee, then claimant's prior awards for separate 1975 and 1978 injuries should be considered. We disagree. There is no evidence of such prior awards in the record. Furthermore, even if there were evidence of such prior awards, immediately prior to his August 1985 injury claimant had returned to heavy work. The significance of any prior award under ORS 656.222 is accordingly reduced.

The record does establish that claimant has received prior awards in this claim. Claimant argues that any additional permanent partial disability should not be arithmetically reduced by the 40 percent which has been awarded for this injury, before the standards became applicable. We disagree. In support of his argument, claimant cites Ronald J. James, 41 Van Natta 561 (1989), Cascade Rolling Mills v. Madril, 57 Or App 398 (1982), and Norby v. SAIF, 303 Or 536 (1987). However, these cases are inapposite because they involve prior awards for separate injuries and interpret ORS 656.222.

Here, claimant has an accepted aggravation claim involving the same compensable injury for which he has received a total of 40 percent unscheduled permanent disability. In such cases, we reduce the total disability by the amount of previous awards of permanent disability made as a result of the same compensable injury, even though the prior awards may have been determined by application of guidelines rather than "standards". See Gary A. Koch, 42 Van Natta 2777, 2778 (1990). Therefore, we reduce claimant's total impairment of 50 percent under the "standards" by his previous awards totaling 40 percent, leaving claimant entitled to an additional 10 percent unscheduled permanent partial disability.

ORDER

The Referee's order dated April 20, 1990 is affirmed in part and reversed in part. In addition to claimant's prior awards of 40 percent (128 degrees) unscheduled permanent disability, claimant is awarded 10 percent (32 degrees), giving him a total award to date of 50 percent (160 degrees) for his lower back condition. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded 25 percent of the additional compensation granted by this order, not to exceed $3,800, to be paid directly to claimant's attorney.

In the Matter of the Compensation of
CLANCY WHITTEN, Claimant
WCB Case No. 89-23237
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

The SAIF Corporation requests review of those portions of Referee Davis' order that: (1) awarded claimant interim compensation from September 14, 1989 to December 5, 1989; (2) assessed a penalty and attorney for failure to pay interim compensation; and (3) assessed a penalty and attorney fee for an allegedly untimely denial. On review, the issues are interim compensation, penalties 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".

CONCLUSIONS OF LAW AND OPINION

Interim Compensation

We agree with the Referee that the employer must be on notice or have knowledge of a claim before it has the duty to pay interim compensation. The Referee concluded that the first question to be answered was when SAIF received notice that claimant was making a claim. The Referee found that a September 14, 1989 letter from claimant's attorney to SAIF was a claim. The Referee then concluded that because the letter was mailed, the presumption of delivery exists in this case so that September 14, 1989 is the date of notice to SAIF. We disagree.

Counsel for claimant wrote a letter to SAIF and it is dated September 14, 1989. That letter states that claimant "hereby files an occupational disease claim . . ." SAIF denies receipt of the letter before November 20, 1989. A letter duly directed and mailed is presumed received in the regular course of the mail. ORS 40.135 (1) (q). Here, the only evidence from which we can determine if or when SAIF received claimant's attorney's letter is the date stamp on that letter of November 20, 1989. Claimant has not established when the letter was mailed in order to be able to take advantage of the aforementioned presumption. Claimant has not submitted an affidavit of mailing nor offered testimony regarding the date of mailing. The court has already held that there is no presumption that a letter is mailed on the day it is dated or on the day it was written. Madewell v. Salvation Army, 49 Or App 713 (1980). Thus, we conclude, absent this presumption, that SAIF had notice of claimant's claim on November 20, 1989.

The next question is whether the notice sent by claimant's attorney satisfies the requirements of the law to trigger SAIF's duty to pay interim compensation. The insurer must begin paying temporary disability benefits no later than the 14th day after the subject employer has notice or knowledge that the claimant has left work due to the industrial claim. Bono v. SAIF, 298 Or 405 (1984). Under the circumstances of this case, we conclude that claimant's attorney's letter dated September 14, 1989 and received by SAIF on November 20, 1989 is sufficient medical verification to trigger SAIF's duty to pay interim compensation. That letter informed SAIF that claimant's treating physician had restricted claimant to modified work as a result of an exacerbation of his back condition while working for SAIF's insured in May 1989. SAIF must either deny

or commence payments with 14 days from that notice. In this case, the first payment was due December 4, 1989 and SAIF neither denied the claim nor commenced payment on that date. Claimant is entitled to interim compensation from November 20, 1989 to the date of denial.

Penalty and Attorney Fees

Because no payment of interim compensation was made on the due date and the record contains no explanation by SAIF for its failure to make the payment, we find this failure to pay to be unreasonable. Therefore, we agree with the Referee that claimant is entitled to a penalty. Counsel for claimant is entitled to a reasonable fee on that issue. After considering the factors set forth in OAR 438-15-010(4), we affirm the Referee's award of $300. In reaching this conclusion, we have considered the time devoted to the issue as represented by the record, the complexity of the issue, and the value of the interest involved.

The insurer has 60 days from the date of notice of the claim within which to accept or deny. ORS 656.262 (6). Since we have found that SAIF had notice of claimant's claim on November 20, 1989, an acceptance or denial was due within 60 days of that date. The December 5, 1989 denial was timely. Because we find the denial timely, the issue of penalties and attorney fees for untimely denial is moot. Consequently, we reverse the Referee's assessment of a 10 percent penalty and $300 attorney fee on this basis.

ORDER

The Referee's May 21, 1990 order, as amended on May 29, 1990, is reversed in part, modified in part and affirmed in part. Those parts of the Referee's order assessing a 10 percent penalty and a $300 attorney fee for a late denial are reversed. That part of the Referee's order awarding interim compensation is modified to award interim compensation from November 20, 1989 to the date of the SAIF Corporation's denial. The 15 percent penalty assessed by the Referee for failure to pay interim compensation will be adjusted accordingly. Claimant's attorney fee as awarded by the Referee, payable from this interim compensation award, shall be adjusted accordingly. The rest of the Referee's order is affirmed.

In the Matter of the Compensation of
JOSE R. VALDEZ, Claimant
WCB Case No. 89-04510
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
David Lillig (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Mulder's order that increased claimant's scheduled permanent disability award for loss of use or function of the right arm from 20 percent (38.4 degrees), as awarded by a Determination Order, to 30 percent (57.6 degrees). On review, the sole issue is extent of scheduled permanent partial disability. We modify.

FINDINGS OF FACT

The Board adopts the Referee's "Findings" with the exception of the last paragraph of those findings.

FINDING OF ULTIMATE FACT

Claimant has sustained a 31 percent loss of use or function as a result of his right arm injury.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant has suffered a 30 percent loss of use of the right arm. In so doing, he indicated that the 30 percent scheduled disability award was made pursuant to his authority to make an award outside the standards when there is clear and convincing evidence of a greater (or lesser) loss than is indicated by the standards. On review, claimant seeks a greater award.

Claimant was medically stationary on August 31, 1988; his claim was closed by a November 7, 1988 Determination Order.

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 version of former OAR 436-35-001 et seq. effective July 1, 1988 as amended by temporary rules effective August 19, 1988, the rules in effect at the time of the November 7, 1988 Determination Order.

The most current medical report is Dr. Soot's report following his May 3, 1989 examination of claimant. Dr. Soot reported that claimant's elbow flexed to 135 degrees. Claimant is therefore entitled to 4 percent for loss of flexion. Former OAR 436-35-100(1).

In his March 17, 1989 chart note, Dr. Soot reported that claimant's right hand strength was noticeably diminished. In his May 1989 report, Dr. Soot stated that this was caused by loss of strength in the right elbow due to muscular avulsion. Soot opined that claimant would lose 40 percent of the strength in his elbow. The loss of grip strength is caused by a loss of elbow strength which in turn is caused by "loss of continuity of the biceps tendon and the injury to the brachialis muscle." Consequently, we find that the 40 percent loss of grip strength is due to anatomical changes in the forearm. Therefore, claimant is entitled to an impairment value of 20 percent. Former OAR 436-35-110(3)(d).

Claimant credibly testified that lifting causes pain in his elbow, pain in his wrist, and pain and numbness in his forearm. Dr. Soot reported on May 3, 1989 that pain prevented claimant from doing heavy work. We find this evidence persuasive and award claimant 10 percent for his loss of use or function due to pain. Former OAR 436-35-010(2)(a).

Having determined the values necessary to compute claimant's permanent disability under the standards, we proceed to that calculation. Combining the 4 percent for lost range of motion with the 20 percent for loss of grip strength yields 23.2. Combining that figure with the 10 percent for loss of use or function due to pain yields 30.8 percent. This figure is then rounded up to the next higher one percent step. Former OAR 436-35-010(6). Therefore, we conclude that claimant is entitled to a 31 percent disability rating.

Claimant argues that Dr. Soot's May 1989 report is clear and convincing evidence that he should receive an award for general weakness associated with the use of the wrist and elbow.

We read Dr. Soot's opinion as saying that this weakness is the cause of the loss of claimant's grip strength, for which we have compensated him under former OAR 436-35-110(3)(d). Moreover, we conclude that claimant's weakness has been adequately addressed by the standards and we grant no further award.

ORDER

The Referee's order dated July 5, 1989 is modified. In addition to the Referee and Determination Order awards of 30 percent (57.6 degrees) scheduled permanent disability, for loss of use or function of the right arm, claimant is awarded 1 percent (1.92 degrees) scheduled permanent disability, giving him a total award to date of 31 percent (59.52 degrees) for loss of use or function of the right arm. 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
LONNIE K. REED, Claimant
WCB Case No. C1-00111
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Allen, Stortz, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

On February 22, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

A proposed disposition must be set aside 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 a fact-finder could only conclude that the agreement is unreasonable as a matter of fact. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990).

Here, the proposed disposition releases claimant's entitlement to past, present, or future vocational rehabilitation benefits. Further, the proposed disposition also provides that the "...subject claim shall remain in accepted status in all other respects...". However, the attached summary sheet indicates that claimant will release temporary disability, permanent disability, vocational rehabilitation, survivor benefits, along with all rights under the Worker's Compensation Act, with the exception of medical services. These two provisions are inconsistent. Inasmuch as we are unable to discern the parties intent with regard to the payment of consideration, we are persuaded that a reasonable fact-finder could only conclude that the proposed disposition is unreasonable as a matter of fact. Accordingly, we find that the agreement is unreasonable as a matter of law and set it aside. Anaya, supra.

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

March 5, 1991 Cite as 43 Van Natta 459 (1991)

In the Matter of the Compensation of
JAMES G. CANNON, Claimant
WCB Case No. C1-00200
ORDER DENYING RECONSIDERATION
S. David Eves, PC, Claimant Attorneys
Roberts, et al., Defense Attorneys

Claimant requests reconsideration of our February 13, 1991 Order Disapproving Claim Disposition Agreement (CDA). Specifically, claimant contends that the CDA's terms regarding the payment of the consideration in the event of claimant's death is not inconsistent, and thus, the agreement should be approved. In support of his motion, claimant provides an explanation of the agreement's terms.

We note that claimant's motion does provide clarification of the agreement's terms regarding the nature of the consideration. Nonetheless, that understanding has not been memorialized in the agreement. Because the nature of the consideration is an essential element of the CDA, we decline to approve an agreement that we find is either unclear or inconsistent on this point.

If the parties are in agreement as to the terms of the CDA as explained by claimant's motion or otherwise, they need to document such an understanding per a revised CDA, signed by all the relevant parties, including claimant. Upon receipt of a revised CDA, we will follow our standard acknowledgment procedures.

IT IS SO ORDERED.

In the Matter of the Compensation of
RUSSELL C. GUTENDORF, Claimant
WCB Case Nos. 90-02058, 89-17179, 90-00344, 90-02056 & 90-02057
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Saif Legal Department, Defense Attorney
David Jorling, Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review, and the SAIF Corporation cross-requests review, of Referee Bethlahmy's order which: (1) set aside SAIF's denial of claimant's claim for a cervical condition; (2) upheld the self-insured employer's denial of the same condition; (3) declined to award claimant an assessed attorney fee; (4) did not award claimant interim compensation from July 5, 1989 to September 1, 1989; (5) did not assess penalties and associated attorney fees for SAIF's failure to pay interim compensation; and (6) did not assess a penalty and associated attorney fees for SAIF's failure to timely accept or deny his aggravation claim. On review, the issues are responsibility, interim compensation and penalties and attorney fees. We affirm in part, modify in part, and reverse in part.

FINDINGS OF FACT

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

The City of Portland, Bureau of Risk Management, accepted claimant's October 2, 1986 injury as a disabling neck strain.

SAIF accepted claimant's May 14, 1986 injury as a disabling cervicothoracic strain.

Claimant was employed by Clackamas County Fire District since 1975. Prior to July 1, 1986, SAIF was the insurer. The City of Portland began coverage on July 1, 1986.

CONCLUSIONS OF LAW AND OPINION

Responsibility

In cases such as this one, where there are successive employments and successive accepted injuries to the same body part, there is a "rebuttable presumption" that the carrier on the risk at the time of the last work-related injury is responsible. To avoid responsibility, that carrier has the burden of proving that the injury for which it is responsible did not contribute independently to the worsened condition which gives rise to the present claim for compensation. Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984). The fact that SAIF had an open claim at the time of the latest injury (the one for which the City of Portland is responsible) does not alter that presumption.

The City also argues that because the claims that SAIF accepted as nondisabling in 1984 and 1985 were not closed, SAIF is precluded, under Roller v. Weyerhaeuser, 67 Or App 583 (1984), from issuing a "partial denial." We do not agree. SAIF may issue a preclosure denial on the two nondisabling claims on the basis of its assertion that the City of Portland had become responsible for claimant's condition. See Stephen Kenyon, 42 Van Natta 1134 (1990); Jimmy C. Lay, 37 Van Natta 583 (1985).

Here, the City was the carrier on the risk at the time of the most recent compensable injury. The Referee concluded that the City had met its burden of proving that claimant's injury, while it was on the risk, did not independently

contribute to claimant's worsened cervical condition. She found that a previously accepted injury, while SAIF was on the risk, remained a contributing cause. We agree.

Claimant has suffered several neck injuries in his work as a firefighter. The first injury of concern in this case was November 29, 1984. Claimant treated with Dr. Cichoke, D.C. In February 1985, claimant began treating with Dr. Clark, D.C., after a mid-back and neck injury suffered on January 31, 1985. In response to a request from SAIF, Clark noted, on November 22, 1985, that he was continuing to treat claimant on an as-needed basis because claimant continued to aggravate his condition due to the nature of his work.

Claimant treated with Clark through two subsequent injuries, one on May 14, 1986 while SAIF was still on the risk, and one on October 2, 1986, after the City of Portland came on the risk.

In a report dated February 9, 1987, Dr. Clark noted that he was treating claimant for the two abovementioned injuries. He stated that it was one injury overlapping the other which has left claimant in his current condition.

At SAIF's request, claimant was examined by Dr. Simpson, D.C., on March 12, 1987. (Ex. 19). Dr. Simpson states, in the "History of Present Injury" portion of his report, that claimant injured his neck on May 14, 1986 and that he experienced an aggravation on October 2, 1986 while cutting a hole in a floor with a chainsaw during a training drill. Dr. Simpson stated that, "with both episodes" claimant had been released to regular work by Dr. Clark, and Simpson found him medically stationary, with "no PPI [sic] from the 5-14-86 injury."

On February 1, 1988, claimant signed a change of attending physician form whereby Dr. Quinn, D.C., became claimant's attending physician. The date of injury was listed on the form as May 14, 1986. No mention was made of the October 1986 injury. In late October 1988, Dr. Quinn sent a letter to SAIF stating that claimant had reported to his office on October 14, 1988 with pain in his left cervicothoracic/shoulder area. Claimant told the doctor that his work routine had been more vigorous than usual. The doctor concluded that claimant had incurred an aggravation of his previous injury of May 14, 1986. Again, no mention was made of the October 2, 1988 injury. From the record, we are not able to discern whether claimant did or did not report the October 1986 injury to Dr. Quinn when he first began treatment with him.

On December 4, 1989, claimant underwent an independent medical examination with Medical Consultants Northwest, at the request of the City of Portland. (Ex. 45). It is evident from that record that claimant reported to the examiners that he had suffered an injury while cutting a hole in a floor with a chainsaw. He reported that the injury occurred after his job was merged into the fire department of the City of Portland. However, he reported that he did not recall whether a claim was filed or accepted for his injury. (Id at 2).

The Medical Consultants Northwest stated that it appeared clear to them that claimant first reported a compensable neck injury in 1985, and has been almost continuously under chiropractic treatment since that time, having exacerbations and remissions of the same symptoms. It was their opinion that claimant has had waxing and waning of symptoms ever since his original 1985 injury.

Claimant argues that Dr. Clark's opinion is persuasive because he is claimant's treating physician and because of his statement in February 1987 that both SAIF's and the City of Portland's injuries contributed to claimant's "current" condition. However, the issue here is not claimant's condition in 1987 but, rather, in July 1989. Because Dr. Clark did not see claimant after

claimant changed physicians in February 1988, we do not find his opinion relevant.

Dr. Quinn began treating claimant in 1988 and did treat him after July 4, 1989. Quinn consistently relates claimant's condition in 1989 to his May 14, 1986 injury. However, because there is no evidence in the record that Quinn was aware of the October 1986 injury, we also are not persuaded by Dr. Quinn's opinion as to the relationship of the 1989 incident to the May 1986 compensable injury.

The only report in the record which can be determined to have been based upon an accurate history of claimant's numerous neck injuries is the report from the Medical Consultants Northwest. As noted above, the Consultants state that claimant's continuing neck problems are a result of continuing exacerbations of his first compensable injury. They diagnosed the result of the July 4, 1989 injury as a "temporary worsening of symptoms resulting from January 31, 1985, injury." (Ex 45-5). Because the Consultants obtained a complete history from claimant of his injuries since 1984, we are persuaded by their opinion and conclude that the City of Portland has met its burden of proving that claimant's injury while they were on the risk did not independently contribute to the July 1989 worsening of his condition. Accordingly, we agree with the Referee that responsibility for claimant's condition after July 1989 lies with the previous insurer, SAIF.

Regarding the issue of a fee for claimant's attorney's services at hearing, the Referee declined to award such a fee because claimant's attorney took the position that the City of Portland was responsible for claimant's July 1989 incident, whereas the Referee found that SAIF was responsible. However, based upon our holding in a recent Board case, Riley E. Lott, Jr., 43 Van Natta 209 (1991), we conclude that an attorney fee is appropriate.

Here, an order designating a paying agent under ORS 656.307 had not issued by the time of hearing. Under such circumstances, a claimant is entitled to an attorney fee, even where his counsel actively argues responsibility against a carrier ultimately found not responsible. Lott, supra. We reach such a conclusion because, even though responsibility is the only issue litigated at hearing, claimant's counsel is nonetheless required to protect against possible reassertions of compensability because the carriers have not obtained a .307 order. Lott, supra.

Therefore, claimant's counsel is awarded a reasonable assessed attorney fee of $350. In determining the amount of the fee, we do consider, in addition to those factors at OAR 438-15-010(4), the nature of claimant's attorney's services at hearing, as well as the fact that compensability was only potentially at risk.

Interim Compensation

Claimant contends that he is entitled to interim compensation from July 5, 1989 to September 1, 1989 and associated penalties and attorney fees for SAIF's unreasonable resistance to the payment of that compensation. We agree.

On July 18, 1989, Dr. Quinn wrote a letter to SAIF stating that claimant had experienced a worsening of his condition and that he was taken off work for two months. A date stamp indicates that SAIF received the letter on July 20, 1989. SAIF was required to begin payment of interim compensation within 14 days of that date, when it received notice of a medically verified inability of claimant to work resulting from a worsening of his condition. ORS 656.273(6). Dr. Quinn's letter adequately provides such notice to SAIF. Accordingly, we conclude that claimant was entitled to receive interim compensation benefits between

July 20, 1989 and September 1, 1989, when claimant returned to normal work duties. (Tr. 31).

Penalty and Attorney Fee

Because SAIF provides no explanation for its failure to pay interim compensation, we find that SAIF unreasonably refused payment of compensation, thus entitling claimant to a penalty. ORS 656.262(10).

As noted above, SAIF had notice of an aggravation claim on July 20, 1989, but failed to issue a formal response. After receiving a notice of an aggravation, an insurer has 60 days to issue an acceptance or a denial. ORS 656.262(6). Here, it was not until the day of hearing, February 27, 1990, that SAIF issued an oral denial of responsibility for the July 1989 incident. We conclude that SAIF's failure to timely accept or deny claimant's claim was unreasonable. Claimant is entitled to a penalty. Additionally, SAIF's conduct in those regards amount to an unreasonable resistance to the payment of compensation entitling claimant to an associated attorney fee pursuant to ORS 656.382(1). 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 concerning the penalty issue is $500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the value of the interest involved.

ORDER

The Referee's order dated March 30, 1990 is affirmed in part, modified in part and reversed in part. That portion which set aside the SAIF Corporation's denial and upheld the self-insured employer's denial of claimant's cervical condition is affirmed. That portion of the order which declined to award claimant an attorney fee is reversed. For services at hearing, claimant's attorney is awarded an assessed fee of $350, payable by SAIF. Claimant is awarded temporary disability benefits in the form of interim compensation between July 20, 1989 and September 1, 1989, payable by SAIF. Claimant's counsel is awarded an approved attorney fee of 25 percent of the interim compensation payable as a result of this order, in an amount not to exceed $3,800, payable by SAIF directly to claimant's counsel. For the SAIF Corporation's unreasonable failure to pay interim compensation and to timely accept or deny claimant's claim, claimant is awarded a penalty equal to 25 percent of the interim compensation due and claimant's attorney is awarded an assessed fee of $500.

March 6, 1991 Cite as 43 Van Natta 463 (1991)

In the Matter of the Compensation of
CHARLES M. ANDERSEN, Claimant
WCB Case No. 89-12008
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Myers, Cushing and Crider.

The insurer requests review of Referee Daron's order that: (1) set aside its partial denial of claimant's travel expenses claim; and (2) assessed penalties and related attorney fees for an allegedly unreasonable denial. On review, the issues are travel expenses and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Travel expenses

The question posed in this case is whether claimant is entitled to travel expenses associated with medical services received from a Portland surgeon although the insurer notified claimant, in accordance with OAR 436-60-050, that travel expenses would be limited to the local area and provided him with a list of physicians who practice in the area. The Referee found former OAR 436-60-050(4) invalid because it limited the right of claimants to choose their treating physicians. He relied on Pyle v. SAIF, 55 Or App 965 (1982) and SAIF v. Holston, 63 Or App 348 (1983) which, in his view, had determined that an earlier version of the administrative rule was inconsistent with ORS 656.245. Consequently, the Referee set aside the insurer's partial denial of travel expenses.

We disagree with the Referee's view that the Court of Appeals has declared the administrative rule invalid. Rather, in SAIF v. Holston, supra, 63 Or App at 352, note 2, the court specifically reserved the issue posed here: Whether any reasonableness limitation may be imposed on the distance a claimant may travel within the State of Oregon, at the insurer's expense, to receive medical services from his chosen physician. Nevertheless, we agree with the Referee's conclusion that no such limitation may be imposed; that the administrative rule is inconsistent with the statute; and that the denial must be set aside.

Under former ORS 656.245(1), a claimant is entitled to all medical services that "the nature of the injury or the process of recovery requires." The statute thus authorizes reasonable and necessary medical services for compensable conditions. Travel expenses are "other related services" within the meaning of medical services under ORS 656.245. See ORS 656.245(1); Stritt v. SAIF, 37 Or App 893 (1978); Francoeur v. SAIF, 17 Or App 37 (1974). Travel expenses include meals, lodging, public transportation or use of a private vehicle required to seek medical services. Former OAR 436-60-070(1). Former ORS 656.245(3) also provides that the claimant may select any physician in the state of Oregon to provide those services as treating physician.

The Court of Appeals held, in Smith v. Chase Bag Company, 54 Or App 261 (1981), that a worker who relocates within the State of Oregon is entitled to reimbursement of travel expenses to continue to see his former treating physician. To do otherwise, the court held, would infringe upon the claimant's right to choose his treating physician.

Former OAR 436-60-050(4) recognizes the right of relocated workers to travel reimbursement under Smith. The rule, however, provides that in all other circumstances the insurer may decline to reimburse travel beyond the area where the claimant resides if it provides the claimant with a list of physicians who can provide like services to those offered by claimant's chosen physician. The rule reads as follows:

> "The worker may choose an attending physician within the state of Oregon. Reimbursement to the worker of transportation costs to visit the attending physician, however, may be limited to within a city, or metropolitan area, or the distance to the nearest city or metropolitan area, from where the worker resides and where a physician providing like services is available. A worker who relocates within the State of Oregon may continue treating with the attending physician and be reimbursed for transportation costs accordingly. If an insurer or self-insured employer chooses to limit reimbursement to

> the nearest available city, or metropolitan area, a written explanation shall be provided the worker along with a list of physicians who provide the like services within an acceptable distance of the worker. The worker shall be made aware of the fact treatment may continue with any attending physician within the state of Oregon of the worker's choice, but the reimbursement of transportation costs will be limited as described."

Claimant sustained a compensable low back injury in August 1987. The claim was closed in January 1988. However, claimant continued to have back problems and sought treatment from Dr. Gorman, who in turn referred claimant to Dr. Gallo, a neurosurgeon. Dr. Gallo recommended surgery. Claimant did not wish to treat further with Dr. Gallo. He sought another referral from Dr. Gorman and was referred to Dr. Smith, a Portland neurosurgeon. Dr. Smith performed surgery on claimant's back. Between December 1988 and July 1989 claimant received medical services from Dr. Smith.

On July 31, 1989, the insurer issued a partial denial of travel expenses for travel from claimant's home in Eugene to Dr. Smith's office in Portland. The denial indicated that there were physicians in the Eugene area qualified to treat claimant's low back condition and listed four such doctors by name. After issuance of the denial, claimant incurred additional travel expenses for follow up medical services with Dr. Smith in August 1989 and September 1989. In the course of obtaining medical care, claimant incurred travel expenses; these expenses consisted of mileage and meals. The insurer declined to reimburse claimant for these expenses.

As an initial matter, we note that the insurer denied future reimbursements for traveling beyond the Eugene area for medical treatment. The travel expenses for which claimant seeks reimbursement occurred post-denial. Nevertheless, the parties clearly have chosen to litigate the compensability of the post-denial expenses. For that reason, we decide that issue. Weyerhaeuser Company v. Bryant, 102 Or App 432 (1990); See Hollie J. Rahim, 42 Van Natta 415 (1990). We further note that under this administrative rule, which requires advance notice of intent not to reimburse, post-denial claims are merged into the original denial for processing purposes. For that reason also, we may decide the issue at this time. We turn to the merits.

We find that the insurer's partial denial complied with the procedural requirements of former OAR 436-60-050. Therefore, the question is whether the Referee properly set aside the denial. We are bound by the rules promulgated by the Director insofar as they are consistent with the workers' compensation act. See Miller v. Employment Division, 290 Or 285 (19980); McPherson v. Employment Division, 285 Or 541, 551 n.8 (1979). Where there is a conflict between a rule and the statute, however, we must follow the statute. Employment Division v. Ring and Central City Concern, 104 Or App 713 (1990).

The Director is empowered to make rules for the effective and efficient administration of medical services, but that authority does not reach so far as to limit medical services that are reasonable and necessary. Kemp v. Workers' Comp. Dept., 65 Or App 659 (1983), on recon, 67 Or App 270 (1984), rev den, 297 Or 227 (1984). The application of an administrative rule which limits the right of a claimant to obtain reasonable and necessary medical services causally related to a compensable claim is not enforceable. Kemp, supra.

In Smith v. Chase Bag, supra, the court held that travel reimbursement could not be denied to relocated workers who choose to treat with a physician in

the State. We find no basis in the statute for distinguishing between relocated workers and other injured workers. Therefore, we hold that to deny reimbursement for travel expenses associated with reasonable and necessary services with a physician selected in accordance with ORS 656.245(3) is inconsistent with the statute. Because the administrative rule authorizes denial of certain reasonable and necessary medical services to workers, it is inconsistent with the statute and we give it no effect. Claimant is entitled to reimbursement of reasonable travel expenses, the rule notwithstanding.

Penalties and related attorney fees

Based upon the uncertainty as to whether or not reimbursement of travel expenses was subject to a test of reasonableness in accordance with ORS 656.245, former OAR 436-60-050(4), and relevant case law, we find that the insurer had a legitimate doubt as to its obligation to reimburse claimant for travel expenses. We therefore conclude that the insurer did not issue an unreasonable denial. See Norgard v. Rawlings, 30 Or App 999 (1977). Consequently, we reverse the Referee's assessment of a penalty and related attorney fee.

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 Board review concerning the travel expenses issue is $1,200, 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 November 3, 1989 is affirmed in part and reversed in part. That portion of the Referee's order that assessed a 25 percent penalty for an unreasonable denial is reversed. Insofar as the Referee's order assesses a penalty-related attorney fee for the same denial, that portion is reversed. The remainder of the order is affirmed. For services on Board review concerning the compensability of travel expenses, claimant's counsel is awarded an assessed fee of $1,200, payable by the insurer.

In the Matter of the Compensation of
JERRY H. FOSS, Claimant
WCB Case No. C0-00439
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Roger D. Wallingford, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

On January 30, 1991, 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 $2,000 by Louisiana-Pacific, claimant fully releases his right to future workers' compensation benefits, except medical services, for his November 28, 1979 compensable injury. Additionally, if further consideration of the payment of $8,000 by Louisiana-Pacific, claimant fully release his right to future workers' compensation benefits, except medical services, for his December 18, 1981 compensable injury.

The agreement is in accordance with the terms and conditions prescribed by the Director. 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.

Parenthetically, the agreement provides that Louisiana-Pacific shall advance claimant a payment of $2,000 upon submission of the agreement to the Board. The agreement further provides that, if the agreement is disapproved by the Board, Louisiana-Pacific shall be entitled to recapture the amount by deducting 25 percent of "any disability payment."

An agreement which allows the recovery of prepaid disapproved CDA proceeds against future compensation is permissable. Julian H. Combs, 43 Van Natta 327 (1991), amended 43 Van Natta 503 (1991). Thus, to the extent that the provision permits such a recovery it is not contrary to law. However, overpayments may be recovered only from future permanent disability benefits, not temporary disability benefits. Buddy Tillman, 41 Van Natta 239 (1989); Harold D. Bates, 38 Van Natta 992 (1986). Inasmuch as the "offset" provision could be interpreted to encompass future temporary, as well as permanent disability, benefits, it would be contrary to law.

In any event, since the Board finds no basis for disapproving the agreement, this objectionable language is harmless and shall not preclude approval of the agreement.

IT IS SO ORDERED.

March 6, 1991 Cite as 43 Van Natta 467 (1991)

In the Matter of the Compensation of
ALAN G. HERRON, Claimant
WCB Case No. 90-13623
ORDER DENYING RECONSIDERATION
Malagon, et al., Claimant Attorneys
Nancy C. Marque (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our February 8, 1991 Order on Review which affirmed the Referee's order that directed SAIF to pay claimant's scheduled permanent disability award at the rate of $305 per degree.

The request for reconsideration is denied. We adhere to our February 8, 1991 order. The parties' rights of appeal shall continue to run from the date of our February 8, 1991 order.

IT IS SO ORDERED.

March 6, 1991 Cite as 43 Van Natta 467 (1991)

In the Matter of the Compensation of
JULIO G. MEJIA, Claimant
WCB Case No. 89-21482
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Speer and Howell.

The insurer requests review of that portion of Referee Shebley's order that set aside its denial of claimant's aggravation claim for a bilateral knee condition. Claimant cross-requests review of that portion of the order that found claimant's condition medically stationary as of June 29, 1989 and that his claim was not prematurely closed. On review, the issues are premature closure, medically stationary date and aggravation. We modify in part and affirm in part.

FINDINGS OF FACT

Claimant, thirty-nine years of age, was working as a mechanic for the insured when he fell and injured both knees in December 1984. He had several surgeries on the right knee and returned to work. Thereafter his left knee became more symptomatic and he underwent multiple arthroscopic surgeries on his left knee in 1988-89.

Even though claimant was permanently restricted from physically performing his old job, which required lifting 60 pounds, climbing, kneeling, and constant standing and walking, he persuaded his doctor to release him to his at-injury job. He returned to work in June 1989 and quit in September 1989 when his condition deteriorated.

Claimant completed a physical therapy program on September 6, 1989.

A Determination Order issued on October 12, 1989. It declared claimant medically stationary on September 14, 1989 (three days after he quit work) and rated his permanent partial disability. Claimant appealed this Determination Order contending that it prematurely closed his claim.

In November 1989, claimant was involved in a noncompensable motor vehicle accident which involved further trauma to his knees. Subsequently, in a January 15, 1990 letter, the insurer denied reopening of the claim on an aggravation theory. Claimant also appealed this denial.

ULTIMATE FINDINGS OF FACT

As of September 6, 1989, when claimant's physical therapy program was completed, no further material improvement in claimant's compensable condition would reasonably have been expected with either further medical treatment or the passage of time.

Following the November 8, 1989 motor vehicle accident, claimant experienced increased loss of use or function of his knees as compared to his condition on October 12, 1989. His compensable injury was a material contributing cause of his worsened bilateral knee condition after the November 1989 auto accident.

CONCLUSIONS OF LAW AND OPINION

The Referee refers to an excluded exhibit (Ex. 216A) twice in his order -- once in his "Findings of Fact" on page 3 and again in his "Opinion" on page 5. We review the record de novo, without the excluded exhibit.

Premature Closure

Workers' compensation claims shall not be closed if the worker's compensable condition has not become medically stationary. Former ORS 656.268(1). To establish that the October 12, 1989 Determination Order prematurely closed his claim, claimant must show he was not medically stationary on the date of closure. Scheuning v. J. R. Simplot & Company, 84 Or 622, 625, rev denied 303 Or 590 (1987); Aldrich v. SAIF, 71 Or App 168 (1984); Harmon v. SAIF, 54 Or App 121 (1981). "Medically stationary" means that no further material improvement would reasonably be expected from either medical treatment or the passage of time. ORS 656.005(17). Medical reports offered after closure may be considered where there has been no post-closure change in claimant's condition and the only question is whether the claimant was stationary at the time of closure. Scheuning, supra.

Here, the evidence is clear that claimant's bilateral knee condition deteriorated during his return to work in the summer of 1989. For example, Dr. Burroughs, internist, reported on September 11, 1989:

> "It was my impression that there was more irregularity with the patellar tracking on the left than on my prior examination. It also is noteworthy that his leg continues to show atrophy....
>
> "It seems that this degenerative process is proceeding at a fairly rapid rate." (Ex. 172).

Similarly, on January 24, 1990, Dr. Jansen, claimant's treating doctor since the industrial injury, reported claimant has:

> "...continuing atrophic response in the left quadricep group, what appears to be increased crepitis and abnormal tracking of the patellar femoral mechanism. Palpation reveals increased joint line tenderness in the left knee and intermittent edematous change." (Ex. 226).

However, the legal test for determining whether claimant was medically stationary at closure does not turn upon whether claimant's condition was, or was not, deteriorating. Rather, the test pursuant to ORS 656.005(17) is whether it is reasonable to expect further material improvement. Here, despite the evidence of continuing deterioration, there is no persuasive evidence that claimant's condition would reasonably be expected to improve with either further medical treatment or the passage of time.

While Dr. Burroughs requested "appropriate rehabilitation" in his September 11, 1989 report, it appears from the context of his report that he was referring to vocational rehabilitation rather than physical rehabilitation. We also note that claimant's physical therapy program was discontinued on September 6, 1989, on the grounds that he had completed that program. (Ex. 170). In addition, no other medical treatment was being proposed at that time to improve claimant's condition. Moreover, there is no other evidence in the record that, as of October 12, 1989, claimant was anticipated to improve with the passage of time. Instead, all of the medical evidence suggested further deterioration over time. Accordingly, claimant has failed to establish that, as of October 12, 1989, he was not "medically stationary" as defined by statute. Thus, his claim was not prematurely closed.

Medically Stationary Date

The October 12, 1989 Determination Order found claimant to be medically stationary as of September 14, 1989. The Referee modified that date to June 29, 1989, at which time the Orthopaedic Consultants reported that claimant was medically stationary. As discussed above, claimant contends that he was never medically stationary prior to issuance of the October 1989 Determination Order. We have concluded otherwise. We further conclude that claimant became medically stationary as of September 6, 1989, when his physical therapy program was completed. Until then, it could reasonably have been expected that claimant's condition would improve. Thereafter, the evidence fails to establish that further materially improvement could reasonably have been expected.

Aggravation

The Referee set aside the insurer's aggravation denial. We agree that claimant has established a compensable aggravation claim, however we do so based on the following analysis.

On January 15, 1990, the insurer denied claimant's aggravation claim following his November 8, 1989 nonindustrial motor vehicle accident. To establish a compensable aggravation, claimant must prove that: (1) his condition has worsened since the last arrangement of compensation, so that he is more disabled, either temporarily or permanently; and (2) his compensable injury was a materially contributing cause of the worsened condition. Former ORS 656.273(1); Grable v. Weyerhaeuser, 291 Or 387, 400-01 (1981). If the claim involves a scheduled body part, "more disabled" means increased loss of use or function of the scheduled body part. International Paper Co. v. Turner, 304 Or 354 (1987).

We first examine the causal relationship question. The medical evidence is uniform in stating that claimant's knee symptoms never resolved prior to the November 8, 1989 motor vehicle accident. The sole medical opinion on the issue of the role of claimant's compensable injury on his post-November 8, 1989 condition comes from Dr. Jansen, chiropractor, who treated claimant both before and after the November 8, 1989 nonindustrial accident. Following the accident, on January 24, 1990, Dr. Jansen opined that claimant had experienced an aggravation of his compensable injury. In addition, Dr. Jansen reported that the motor vehicle accident would not have resulted in any disability to claimant's knees had there not been a preexisting deterioration due to the compensable injury. There is no evidence to the contrary. Therefore, we conclude that claimant has sustained his burden of proving that his compensable injury was a materially contributing cause of his post-accident condition.

We next turn to the question whether claimant's condition worsened following the motor vehicle accident as compared to his condition at the time of the October 12, 1989 Determination Order. As noted above, worsened in this context means increased loss of use or function. In this regard, on December 18, 1989, Dr. Weintraub, orthopedist, noted that, while claimant had good range of motion, he also had swelling and tenderness along the joint line of his left knee. Similarly, Dr. Jansen noted increased crepitis, abnormal tracking of the patellar femoral mechanism and intermittent edematous change. He opined that claimant needed to refrain from any activity requiring repetitive or prolonged standing. Claimant testified to increased pain, swelling, and popping of his knees following the November accident. The Referee found claimant to be credible. We find no reason to reject this finding.

We conclude that claimant has established by a preponderance of the evidence that he experienced increased loss of use or function of his knees following the November 8, 1989 accident, and that his worsened condition was due, in material part, to his compensable injury. Therefore, he has established a compensable aggravation claim.

Rating Extent of Disability

The Referee was correct in deciding that claimant's condition was not medically stationary by the time of hearing. Consequently, he properly declined to rate claimant's disability.

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 aggravation issue is $600, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to this issue (as represented by claimant's respondent's brief), 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 regarding premature closure and shall receive an approved fee payable from the increased temporary disability compensation created by our modification of claimant's medically stationary date.

ORDER

The Referee's order dated March 28, 1990 is affirmed in part and modified in part. The October 12, 1989 Determination Order is modified to reflect a medically stationary date of September 6, 1989. The remainder of the Referee's order is affirmed. For services on Board review regarding the aggravation issue, claimant's attorney is awarded an assessed fee of $600, to be paid by the insurer. In addition, claimant's attorney is awarded an approved attorney fee equal to 25 percent of any increased temporary disability resulting from this order, in an amount not to exceed $1,050, payable directly to claimant's counsel by the insurer.

March 6, 1991 Cite as 43 Van Natta 471 (1991)

In the Matter of the Compensation of
BETTY L. ROBINSON, Claimant
WCB Case No. 89-14360
ORDER ON REVIEW
Charles Robinowitz, Claimant Attorney
Garrett, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Claimant requests review of those portions of Referee Seifert's order which: (1) found that claimant was not entitled to reimbursement for medical services; (2) declined to assess a penalty or related attorney fee for an allegedly unreasonable failure to pay for medical services; and (3) declined to award a penalty-related attorney fee for an allegedly untimely payment of temporary disability benefits. On review, the issues are reimbursement for medical services and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

In October 1984, claimant was involved in a motor vehicle accident in which she sustained injuries to her neck and back. Claimant's medical billings were processed through her private health carrier and her automobile insurance carrier. Under these policies there was a yearly deductible of $200 and payment up to 80 percent. Claimant paid the remaining 20 percent of the medical billings.

In 1986, claimant filed a workers' compensation claim for the 1984 motor vehicle accident. By letter of December 10, 1986, the insurer accepted the claim. Following acceptance of her claim, claimant requested reimbursement from the insurer for the portion of medical billings which she had paid. In this regard, on January 7, 1987, she submitted several billings from health care providers as well as vouchers from her private health carrier.

In a May 7, 1987 letter, the insurer advised claimant's counsel that the reimbursement request could not be processed as the vouchers from claimant's private health carrier did not include CPT codes or a description of the medical services rendered. The letter also noted that some recent billings for medical services, in particular an October 14, 1986 billing from the Davies Clinic, did not appear to be related to the accepted injury.

In August 1987, claimant requested a hearing on the issues of temporary disability benefits, medical services and penalties and attorney fees for failure to pay or deny medical bills. On November 10, 1987, the insurer's attorney

confirmed a prior telephone conference with claimant's counsel advising that the insurer was willing to pay medical billings which had been paid by the private health carrier and automobile insurance carrier. It was suggested that communication be directly between the insurance companies to fully satisy their liens.

On November 25, 1987, claimant's attorney and the insurer's attorney reached an agreement regarding certain compensation that claimant was to receive. By letter dated November 27, 1987, claimant's attorney advised the insurer's attorney that claimant had received medical bills through October 10, 1986 in the amount of $10,546.64. Of this amount claimant had paid $1,299.35. It was claimant's counsel's understanding that the insurer would send claimant a check for $900 immediately and a check for the balance after the billings had been audited to determine if any of the charges exceeded workers' compensation guidelines.

The insurer's counsel, in a November 30, 1987 letter, advised that approximately $1,300 in medical bills paid by claimant would be reimbursed to the extent that they were related to the accepted injury and reasonable. The letter further advised that the insurer would check the medical fee guidelines, but that it would forward claimant a check for $900 at the present time. On December 16, 1987, claimant's August 1987 hearing request was dismissed pursuant to the parties' representation that their dispute had been settled.

On May 26, 1988, the insurer wrote claimant's attorney indicating its approval of a third party claim settlement stemming from the accepted claim. The letter noted that there appeared to be issues raised in a prior letter from claimant's attorney regarding outstanding medical benefits and temporary disability benefits. The letter advised that if these benefits were owed, they should become part of the settlement lien.

On October 17, 1988, claimant's attorney wrote the insurer advising that he was retaining the insurer's portion of the third party settlement until it honored its agreement of November 25, 1987. He indicated that the agreement had been violated as claimant had not received the additional $399.35 reimbursement for medical bills and noted that the insurer had not audited the remaining billings.

The insurer neither audited the billings nor paid claimant any sum beyond the $900 paid in 1987.

On July 25, 1989 claimant requested a hearing. On the request for hearing, an "x" is marked beside temporary total disability and penalties and attorney fees. Claimant specified that penalties and attorney fees were sought for "unreasonable delay and failure to pay claimant's medical bills and time loss." Nevertheless, the issue of a penalty or related attorney fee for unreasonable delay in payment of temporary total disability was not raised by claimant's counsel when the issues were stated at the outset of the hearing.

CONCLUSIONS OF LAW AND OPINION

Reimbursement of Medical Services

The Referee concluded that the parties did not have an agreement regarding the payment of the disputed medical billings and therefore dismissed claimant's request for hearing. We disagree.

The insurer accepted claimant's claim in December 1986. Thereafter, claimant requested reimbursement for medical services that she had previously paid in the amount of $1,299.35. In August 1987, claimant requested a hearing concerning the failure to reimburse her for the aforementioned medical services.

In November, the parties reached an oral agreement regarding the reimbursement of medical services paid by claimant. In a November 27, 1987 letter, claimant's counsel memorialized the agreement to the effect claimant would receive $900 and thereafter receive the balance following an audit of the medical billings. By a November 30, 1987 letter, the insurer's counsel further memorialized the agreement to the effect that claimant would receive $900 and that the balance would be paid to the extent that the billings were related to the injury and consistent with the medical guidelines. Thereafter, claimant's August 1987 request for hearing was dismissed by motion of the parties.

The letters of counsel and the dismissal of the request for hearing persuade us that the parties did enter an agreement. The question is what each agreed to do.

The only evidence beyond the letters of counsel, regarding the parties' November 1987 agreement, came from claimant. She testified that it was her understanding that following the agreement she was not required to do anything in order to receive the $399.35 balance remaining on the medical billings which she had previously paid.

We find that the parties entered into an agreement in which claimant was to be reimbursed for medical billings of approximately $1,300 which she had paid prior to claim acceptance. We further find that the only limitation on the duty to reimburse was that services would be reimbursed up to the fee limit specified by the administrative rules. Pursuant to the agreement, claimant had no obligation to do anything as a condition precedent of reimbursement of the $399.35 balance.

We reject the insurer's contention that the agreement required claimant to submit itemized medical bills, a description of the medical services provided, CPT codes or an analysis of the bills as relates to the fee schedules. Assuming, arguendo, that the workers' compensation law requires a worker to submit such information to obtain reimbursement, we find that any such conditions were waived by the insurer when it undertook to determine the amount to be paid without submission of further information by claimant.

The insurer has not done what was required of it by the agreement. It has not paid the $399.35. Moreover, there is no evidence that the insurer audited the bills to determine the extent to which the bills exceeded the maximum provided for by the administrative rules. Under these circumstances, the insurer has only partially satisfied its obligation by paying $900 of the medical billings in question. Therefore, we conclude that pursuant to the parties' agreement, the insurer is required to reimburse claimant for the remaining balance of $399.35.

Penalties and Attorney Fees

The Referee declined to assess a penalty or related attorney fee for the insurer's allegedly unreasonable failure to reimburse claimant the $399.35 balance of remaining medical billings. We agree.

Penalties and attorney fees may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10); 656.382(1). The reasonableness of a carrier's action must be gauged based upon the information available to the carrier at the time of its action. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123 (1985).

Although we have herein found that the insurer was obligated to reimburse claimant the remaining balance, we do not find its failure to do so unreasonable. The agreement was oral; and the parties' memorializations of it vary with

regards to the method and criteria for the audit of the remaining balance. Therefore, the insurer had legitimate doubts as to the extent of its obligation to reimburse claimant for the balance of medical billings she had previously paid. Accordingly, neither a penalty nor attorney fee is warranted.

Attorney Fee

Claimant contends that she is entitled to a penalty-related attorney fee for the insurer's allegedly unreasonable delay in paying temporary disability compensation. The Referee did not address this issue.

Although claimant's hearing request contains an "x" beside the issue lines of "Temporary Total Disability" and "Penalties & Attorney Fees," that issue was not raised as an issue by claimant's counsel at the hearing, nor was there any evidence presented with regard to this issue. The only discussion between the parties at hearing concerned the reimbursement of medical services and penalties and attorney fee for an allegedly unreasonable failure to reimburse. In a post-hearing letter to the Referee, claimant's counsel indicated that an agreement had been reached regarding the payment of temporary total disability and a penalty. At that time, claimant's attorney sought an attorney fee connected with the delay in payment of temporary disability compensation.

Under these circumstances, we conclude that it would be fundamentally unfair to now address the issue of a penalty-related attorney fee for an allegedly unreasonable delay in paying temporary disability benefits and therefore decline to do so. Mavis v. SAIF, 45 Or App 1059, 1062-63 (1980); Linda R. Scott, 42 Van Natta 910, 912 (1990); Richard C. Centeno, 41 Van Natta 619, 620 (1989).

Finally, were we to address the question of a fee for delay in the payment of temporary disability compensation, we would find that there is no evidence in the record to establish that the insurer unreasonably resisted the payment of temporary disability compensation. For this reason also, no attorney fee will be assessed.

ORDER

The Referee's order dated June 4, 1990, as corrected June 13, 1990, is reversed in part and affirmed in part. That portion which declined to grant claimant reimbursement for medical billings in the amount of $399.35 is reversed. The insurer is directed to pay claimant $399.35 for reimbursement of medical services. The remainder of the order is affirmed.

March 6, 1991 Cite as 43 Van Natta 474 (1991)

In the Matter of the Compensation of
JESSE D. STARR, Claimant
WCB Case No. 89-14581
ORDER ON REVIEW
Kirkpatrick & Zeitz, Claimant Attorney
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Hoguet's order that: (1) increased claimant's unscheduled permanent disability award for a low back injury from 27 percent (86.4 degrees), as awarded by a Determination Order, to 34 percent (108.8 degrees); and (2) declined to grant permanent total disability. On review, the issue is extent of unscheduled permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT

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

Claimant has both on and off-the-job training in the vocation of barber/hair stylist.

Claimant is capable of lifting between 25 and 49 pounds occasionally. He is restricted from sitting for more than four hours at a time and from standing and walking more than six hours at a time. Claimant is restricted to only intermittent bending, crawling and squatting.

As a result of his compensable injury, claimant has loss of flexion in the thoracolumbar region (from 90 degrees to 45 degrees). Claimant also has loss of extension in the thoracolumbar region (from 30 degrees to 15 degrees).

As a result of his injury, claimant has undergone laminectomies with discectomies at two different levels (L4-L5 and the L5-S1). Claimant has also undergone two spinal fusions, one at the L5-S1 level and the second at the L4-L5 level.

As a result of the injury, claimant has limited ability to repetitively bend, sit, stand, crawl and squat.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

The Board adopts the Referee's "Conclusions and Opinion" on the issue of permanent total disability.

Extent of Unscheduled Permanent 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). 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(1).

Because claimant's condition became medically stationary on January 1, 1989, and his claim was closed by Determination Order on July 17, 1989, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent partial 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.

In the present case, claimant does not dispute the values assigned by the Referee for claimant's age, formal education and skills. We adopt the values and reasoning related to those values assigned by the Referee and discuss only the issues of training, adaptability and impairment.

Training

The Referee concluded that, for his barber school training, claimant should be assigned a value of zero. We agree. Whether claimant is entitled to a value for training under former OAR 436-35-300(5) is dependent upon whether or not claimant has demonstrated competence in some specific vocational pursuit. Competence in a "specific vocational pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off-the-job to perform other than an entry-level position. Larry L. McDougal, 42 Van Natta 1544 (1990).

Here, claimant has acquired sufficient on and off-the-job training to perform other than an entry-level position. We conclude that claimant has demonstrated competence in the vocation of barber/hair stylist. Therefore, the appropriate training value is 0. Former OAR 436-35-300(5).

Adaptability

The Referee assigned a value of 2.5 for adaptability. Claimant contends that, under former OAR 436-35-320(1), the Referee was required to take claimant's pain into account in arriving at a value for adaptability.

Claimant further argues that the proper adaptability value should be 10, as former OAR 436-35-310(4)(d) provides that the adaptability factor is a maximum of 10 when the worker is unable to perform "the full range of sedentary activities because of restricted abilities to sit, stand, walk, carry, stoop, crouch, kneel or twist." Claimant contends that he is unable to do anything for ten to twelve days per month and the remainder of the time, he is only capable of working up to three hours without resting. Therefore, claimant argues, he is entitled to the maximum value in adaptability. We disagree.

Dr. Misko, claimant's last treating physician, stated that claimant could lift 25 to 49 pounds occasionally. Dr. Misko also restricted claimant from sitting for more than four hours at a time and standing and walking more than six hours at a time. Finally, Dr. Misko restricted claimant to only intermittent bending, crawling and squatting.

We conclude that the Referee was not required to factor in a value for pain in arriving at the assigned adaptability value. The Referee relied upon Dr. Misko's report, which, in its restrictions of claimant's activity, obviously took claimant's pain into consideration. In addition, the Referee properly applied former OAR 436-35-310(4), as claimant is not working as a result of the injury and there is no evidence that employment has been offered.

We conclude that claimant is capable of performing work in the medium category (value of 1) based upon his ability to lift. See former OAR 436-35-310(4)(6). However, because claimant has limited abilities to sit, stand, walk, bend, crawl and squat, the adaptability value is the average of 1, (for the medium category for which he qualifies) and 4 (the value for the next lower category). See former OAR 435-35-310(4). Accordingly, we conclude that the Referee correctly assigned claimant an adaptability value of 2.5.

Impairment

The Referee found that claimant was entitled to an impairment value of 26 percent. Claimant argues that the Referee incorrectly combined, rather than added, claimant's general spinal findings, loss of motion in the spine and loss of repetitive use of the low back. We disagree. To arrive at a total impairment finding, the Referee correctly combined the total impairment value for lost range of motion, with the values for surgeries and loss of repetitive use. Former OAR 436-35-005(4) and 436-35-360(11). See Buford M. Spencer, 43 Van Natta 173 (1991).

Claimant is entitled to an impairment value for his lost range of motion in his lumbar spine. For loss of flexion in the thoracolumbar region (from 90 degrees to 45 degrees), claimant is entitled to a value of 4.5 percent. Former OAR 436-35-360(6). For loss of extension in the thoracolumbar region (from 30 degrees to 15 degrees), claimant is entitled to a value of 1.5 percent. Former OAR 436-35-320(7). For a total rating of the thoracolumbar area, the values for loss of motion are added for a total of 6 percent. Former OAR 436-35-360(10).

In addition, claimant is entitled to a value for his surgery and the resulting impairment. For each laminectomy with single discectomy, claimant is entitled to a value of 5 percent. Former OAR 436-35-350(2). Claimant has undergone laminectomies (with discectomies) at the L4-L5 level and the L5-S1 level. He is therefore entitled to a value of 9.75 percent. [Unlike the prior "standards," the "standards" applicable to this case require combining unless it is specifically required that they be added. Former OAR 436-35-005(4). Compare Michael E. Crist, 42 Van Natta 1093 (1990).]

Claimant is also entitled to a value for his spinal fusions. Former OAR 436-35-350(3). For his fusion at L5-S1, claimant is entitled to a value of 5 percent. For his fusion at L4-L5, claimant is entitled to a value of 3 percent. For his spinal fusions, claimant is entitled to a total value of 7.85 percent.

Finally, because claimant has limited ability to use his low back to repetitively bend, sit, stand, crawl and squat, he is entitled to a 5 percent impairment. Former OAR 436-35-320(4).

For a total rating of claimant's multiple residuals, the ratings are combined to reach a final impairment value of 25.7. Former OAR 436-35-005(4) and 436-35-360(11).

Computation of Unscheduled Permanent Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 1, is added to his education value, 2, the sum is 3. When that value is multiplied by claimant's adaptability value, 2.5, the product is 7.5. When that value is added to claimant's impairment value, 25.7, the result is 33.2 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, 34 percent.

ORDER

The Referee's order dated December 12, 1989 is affirmed.

March 7, 1991 Cite as 43 Van Natta 477 (1991)

In the Matter of the Compensation of
JOAN M. ALVARADO, Claimant
WCB Case No. 89-14600
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of that portion of Referee Seifert's order that declined to assess penalties and attorney fees for an allegedly unreasonable

denial of claimant's aggravation claim for a low back condition. On review, the issues are penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee did not find the denial by the SAIF Corporation to be unreasonable and did not assess penalties or associated attorney fees. We affirm, but for different reasons.

Claimant argues on review that the Referee relied on a medical report that was produced after the denial issued and should not be used in determining if the denial was reasonable when issued. We agree.

SAIF argues however, that at the time the denial was issued, a legitimate doubt existed as to compensability and therefore the denial was not unreasonable. We have previously held that when an employer has no information with which to determine whether a condition was, or was not, work-related, a legitimate doubt exists as to its liability. Joseph I. Vernaza, 42 Van Natta 1284 (1990).

After examining the evidence available at the time the denial was issued, we conclude that SAIF had a legitimate doubt regarding a worsening of the compensable condition, as well as doubt as to the cause of the alleged worsening.

ORDER

The Referee's order dated February 5, 1990, as reconsidered on May 18, 1990, is affirmed.

March 7, 1991 Cite as 43 Van Natta 478 (1991)

In the Matter of the Compensation of
ROBERT A. ELLER, Claimant
And, In the Matter of the Complying Status of
L & S Construction dba L & S Construction Co., Noncomplying Employer
WCB Case Nos. 89-22414, 89-17927, 89-21528 & 89-12828
ORDER ON REVIEW
Douglas D. Hagen, Claimant Attorney
Stoel, Rives, et al., Defense Attorneys
Cummins, et al., Defense Attorneys,
Williams, et al., Defense Attorneys
Barbara Brainard (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation, on behalf of J.W. Brayson, Builders (Brayson), requests review of those portions of Referee Mill's order which: (1) set aside its denial of claimant's occupational disease claim for a right shoulder condition; (2) upheld SAIF's denial, on behalf of Slater Construction (Slater), of claimant's claim for the same condition; and (3) upheld SAIF's denial, on behalf of L & S Construction (L & S), a noncomplying employer, of claimant's claim for the same condition. In its brief, on review, SAIF, on behalf of L & S, asserts that claimant sustained a discrete right shoulder injury with Slater, and that claimant has not proven that his injury is compensable as to L & S. On review,

the issues are compensability and responsibility. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "facts" as contained in the "Issues" and "Findings of Fact" sections.

FINDINGS OF ULTIMATE FACT

Claimant's repetitive work activities for Slater, Brayson and L & S were the major contributing cause of claimant's right shoulder condition and need for treatment.

Claimant's right shoulder condition first became disabling after he ceased working for L & S in March 1988. Claimant's work activities while SAIF/L & S was on the risk exposed claimant to potentially causal conditions which could have contributed to his right shoulder condition.

CONCLUSIONS OF LAW AND OPINION

Compensability

We affirm and adopt the Referee's reasoning and conclusion that claimant's condition is chronic and developed over time and that his claim is one for occupational disease as opposed to injury. We further affirm and adopt the Referee's reasoning and conclusion that claimant's condition is compensable.

Responsibility

Finding that employment with the last employer, L & S, did not independently contribute or affect in any way the causation of claimant's right shoulder condition, the Referee assigned responsibility to a prior employer, Brayson. On review, Brayson contends that L & S did not carry its burden of proof under the last injurious exposure rule such that responsibility shifts to a prior employer. We agree and reverse.

The last injurious exposure rule provides that, if a worker proves that an occupational disease was caused by work conditions that existed during a period when more than one carrier was on the risk, the last employment providing potentially causal conditions initially is deemed responsible for the disease. Boise Cascade Corporation 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 on which the claimant first becomes disabled as a result of the compensable condition or, if claimant does not become disabled, the date he first seeks medical treatment for the condition. Progress Quarries v. Vaandering, 80 Or App 160 (1986); SAIF v. Carey, 63 Or App 68 (1983). The initially responsible employer can then shift responsibility to an earlier employer only by proving that work activities for the earlier employer were the sole cause of claimant's disability or that it was impossible for work exposure for the initially responsible employer to have caused the condition. Starbuck, supra, at 244 n.3; FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified 73 Or App 223 (1985).

Claimant worked for Slater as a carpenter from April 1985 to April 1986, performing work activity which required repetitive use, including repetitive overhead use of the right shoulder. From September 1986 to February 1987, claimant worked for Brayson, performing essentially the same kinds of tasks. Although claimant experienced occasional right shoulder discomfort while doing

heavy repetitive overhead work for both Slater and Brayson, he missed no time from work and asserted no claim while employed by either Slater or Brayson. Later, from December 1987 through January 1988, claimant worked for L & S, also as a carpenter, again performing essentially the same kind of tasks, although he did considerably less repetitive and overhead work for L & S than he had for the prior employers. Claimant experienced the same occasional right shoulder discomfort while working for L & S. Claimant first sought medical treatment for his right shoulder condition from Dr. Dresher on March 2, 1988. Under such circumstances, we conclude that the onset of disability for claimant's occupational disease claim was March 1988. Consequently, responsibility for claimant's right shoulder condition rests, in the first instance, with SAIF/L & S, the carrier/employer immediately prior to the March 2, 1988 onset of disability. Starbuck, supra; Meyer v. SAIF, supra.

SAIF/L & S can establish that responsibility should be assigned to a prior employer by showing that a prior employment exposure with Brayson or Slater was the sole cause of claimant's disability or that it was impossible for claimant's employment exposure while SAIF/L & S was on the risk to have caused claimant's disability. FMC Corp. v. Liberty Mutual Ins. Co., supra.

Dr. Graham, claimant's treating physician for his right shoulder condition, stated that no specific injury caused claimant's rotator cuff tear; rather, he explained, the tear represents cumulative trauma secondary to chronic work exposure to repetitive overhead heavy use of the arm. He concluded that claimant's ongoing work activities as a carpenter for all employers contributed to the development of this condition. The Western Medical Consultants examined claimant and agreed that overheard work activities were a contributing factor to the rotator cuff tear; in addition, they opined that two months work for L & S had "no significant" impact on the pathology of the tear. Dr. Farris, the author of the Consultants' report, later reiterated that claimant's condition was primarily the result of many years work as a carpenter. Because claimant only worked for L & S for two months, Dr. Farris opined that claimant's work activities for this employer probably had a "negligible" impact on the development of claimant's right rotator cuff tear.

"Negligible" impact and "no significant" impact are not the legal test for determining responsibility for claimant's occupational disease. There is no medical opinion that work exposure at L & S did not and could not have contributed to the development of claimant's right shoulder condition. Although none of these physicians stated that claimant's actual work activities during his brief employment with L & S contributed significantly to his shoulder condition, nevertheless, they all agree that work exposure at L & S contributed slightly to that condition.

Accordingly, we conclude that work activity with L & S could have caused claimant's right shoulder condition. We further conclude that L & S has failed to establish either that claimant's prior employment activities with Slater or Brayson were the sole cause of claimant's right shoulder condition, or that it was not possible for claimant's work activities with L & S to have contributed to his disability. Consequently, SAIF/L & S is the responsible insurer/employer for claimant's compensable right shoulder condition. Id.

Inasmuch as claimant did not submit a brief on review, no attorney fee is awarded. Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated April 20, 1990 is affirmed in part and reversed in part. The SAIF Corporation's denial, on behalf of L & S Construction, of

claimant's right shoulder occupational disease claim is set aside. The claim is remanded to SAIF for further processing according to law. SAIF's denial, on behalf of J. W. Brayson, Builders, is reinstated and upheld. The Referee's assessed attorney fee award of $3,000 for prevailing on the denial of claimant's occupational disease claim shall be paid by SAIF on behalf of L & S, rather than by SAIF on behalf of Brayson. The remainder of the order is affirmed.

March 7, 1991 Cite as 43 Van Natta 481 (1991)

In the Matter of the Compensation of
ALAN G. HERRON, Claimant
WCB Case No. 90-13623
ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
Nancy C. Marque (Saif), Defense Attorney

The Board has now received a memorandum in support of the SAIF Corporation's motion to abate and reconsider our February 8, 1991 Order on Review which affirmed a Referee's order that directed SAIF to pay claimant's scheduled permanent disability award at the rate of $305 per degree. In order to permit us adequate time to consider SAIF's argument and to solicit claimant's response, we withdraw our February 8, 1991 Order on Review and our March 6, 1991 Order Denying Reconsideration.

Claimant is requested to submit his response to SAIF's memorandum within 10 days from the date of this order. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

March 7, 1991 Cite as 43 Van Natta 481 (1991)

In the Matter of the Compensation of
ZINNIA L. PALMER, Claimant
WCB Case No. 89-12772
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Nichols, Brittingham and Crider.

Claimant requests review of Referee Black's order which: (1) declined to grant permanent total disability; and (2) increased claimant's unscheduled permanent disability award for a low back injury from 26.25 percent (84 degrees), as awarded by a Determination Order and Stipulated Order, to 77 percent (246.4 degrees). The self-insured employer cross-requests review of that portion of the order which increased claimant's unscheduled permanent disability award. On review, the issue is extent of disability, including permanent total disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and supplement with the following additional facts.

Claimant retains thoracolumbar spine ranges of motion as follows: forward flexion - 45 degrees; extension - 15 degrees; right and left lateral flexion - 25 degrees; and right and left rotation - 40 degrees.

Claimant became medically stationary May 10, 1989.

A Determination Order issued June 28, 1989.

FINDINGS OF ULTIMATE FACT

Claimant is not permanently and totally disabled based on medical reasons alone. Nor is she permanently and totally disabled as a result of a combination of medical and nonmedical factors. Although work search efforts might be futile for claimant, she has not established that, but for her compensable condition, she is willing to work. Claimant has made no effort to find work.

Claimant has sustained a 77 percent loss of earning capacity as a result of her compensable low back injury.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

Extent of Impairment

We affirm and adopt the Referee's conclusion that claimant is not permanently and totally disabled based solely on her physical condition with the following supplementation.

In January 1989, Dr. MacRitchie, an industrial medicine specialist and claimant's longtime treating physician, indicated that claimant should be able to return to the modified job she had performed in the past. The doctor previously had indicated that claimant could work 4 hours per day performing work activity requiring her to lift up to 10 pounds, with limited bending and stooping and no work above waist level.

On March 1, 1989, claimant was evaluated by the Northwest Medical Consultants. The Consultants reported that claimant had degenerative low back disease with instability, limitation of low back motion, and chronic lumbar sprain. They recommended no job retraining as claimant was retired, and rated claimant's impairment at 11 percent under the AMA Guidelines.

Likewise, Mr. Smith, claimant's longtime vocational counselor, concurred that claimant was physically capable of performing sedentary work as a parts clerk.

Thus, the opinions of both Dr. MacRitchie and the Consultants, as well as claimant's vocational counselor, support a finding that claimant is not permanently and totally disabled on the basis of her physical incapacity alone. We must, therefore, address claimant's assertion that she is permanently and totally disabled under the "odd-lot" doctrine.

Odd-Lot Doctrine

We also affirm and adopt the Referee's conclusion that claimant is not totally disabled based on a combination of medical and nonmedical factors; however, we do so for the following reason.

In contrast to the Referee, we do not find it dispositive that claimant's at-injury employer offered her modified work. Dr. MacRitchie only released claimant to return to part-time restricted sedentary work on a one-week trial basis. In our view, such a release does not establish that claimant is employable at the modified job offered or that she has the ability to sell her

services in the competitive labor market. Harris v. SAIF, 292 Or 683 (1982); Norton v. SAIF, 86 Or App 447, 453 (1987).

Instead, we affirm the Referee's conclusion based on claimant's failure to prove that she is willing to work. Where, as here, claimant was not employed or seeking work at the time of the hearing, claimant has the burden of establishing that, but for the compensable injury, she would have been willing to seek regular gainful employment. SAIF v. Stephen, 308 Or 41 (1989); SAIF v. Beswick, 104 Or App 494 (1990).

Claimant is now 63 years old, has no transferable skills, and is severely limited in her physical capabilities. Moreover, she has taken early retirement after working for the at-injury employer for 17 years. Nevertheless, while a return to work or a job search might be or have been futile for this claimant, in light of the Court's holding in Stephen as followed in Beswick, it is claimant's burden to prove that, but for the compensable condition, she is or was willing to seek regular gainful employment or would have made reasonable efforts to obtain such work. The record simply does not support such a finding.

As early as June 1987, claimant indicated that she planned to retire at age 62. In fact, she specifically terminated her involvement in a return-to-work program and rejected the employer's offer of a modified job for this very reason. Moreover, claimant has made no attempt to seek employment anywhere since she ceased work for the employer.

In sum, claimant retains the ability to perform part-time sedentary level work. Furthermore, on this record, claimant has not demonstrated that she is willing to seek regular gainful employment. Consequently, claimant is not entitled to an award of permanent total disability on an "odd-lot" basis.

Permanent Partial Disability

Although we assign a lower value to claimant's range of motion losses than the Referee, we affirm his award of 77 percent permanent disability.

To establish the extent of claimant's injury-related 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, because claimant's condition became medically stationary on May 10, 1989, and her claim was closed by Determination Order on June 28, 1989, we apply former OAR 436-35-270 through 436-35-440 which became effective January 1, 1989, to the rating of claimant's unscheduled permanent disability. OAR 438-10-010.

On review, the parties do not dispute the values assigned by the Referee to the social/vocational factors which include a value of 1 for age; a value of 0 for education; a value of 1 for training; and a value of 4 for SVP. However, claimant contends that the Referee incorrectly combined the values of her spinal impairment, and the employer argues that the Referee erred in rating claimant's adaptability under subsection (4) of former OAR 436-35-310 rather than applying subsection (3) of the rule. Therefore, we address only the adaptability and impairment values.

Adaptability

It is undisputed that claimant left work because of her compensable injury. The parties dispute, however, whether an "offer" of employment was made. Claimant's adaptability value is dependent upon whether an "offer" was made.

The adaptability value for a claimant who has either returned to modified work or received a work offer [see former OAR 436-35-270(3)(d)] is determined from a matrix of values at former OAR 436-35-310(3). On the other hand, the adaptability value for a claimant who is not working as a result of his or her compensable injury/condition and who has not received an offer of employment is based on the worker's residual physical capacity without regard to that claimant's physical capacity prior to the injury. Former OAR 436-35-310(4).

The employer challenges the Referee's award of an adaptability value of 10 under former OAR 436-35-310(4)(d), contending that the Referee improperly disregarded the employer's oral offer of modified employment. Claimant's verbal statement of intent to refuse the job offer in favor of retirement, asserts the employer, rendered "futile" and "vain" any redundant written offer meeting the technical requirements of subsection (3) of former OAR 436-35-310.

Even if we were to find that claimant intended to refuse the employer's latest offer of modified work, that still would not obviate the requirement that the employer's offer be in writing. Former OAR 436-35-270(3)(d) specifically defines "work offer" as used in former OAR 436-35-310(3) as the "delivery in person or by certified mail . . . of a written offer of work by the employer to which there is a physician's release." [emphasis supplied]. Neither the Referee nor this Board has the authority to substitute substantial compliance for strict compliance with a precisely defined rule. Consequently, we find that no employment has been offered under former OAR 436-35-310(3). Thus, claimant's adaptability value is derived from former OAR 436-35-310(4). See, analogously, Eastman v. Georgia Pacific Corp., 79 Or App 610 (1986).

Claimant has restrictions in performing work activities that require prolonged sitting, bending, stooping, walking, standing or lifting over 10 pounds. She is also limited to performing activities only at or below waist level, and must be afforded the opportunity to lay down periodically to reduce her symptoms and discomfort. Given claimant's restricted residual physical capacity, the Referee properly assigned an adaptability value of 10. Former OAR 436-35-310(4)(d).

Impairment

Claimant contends that the Referee incorrectly combined her multiple spinal impairment values. The calculation of claimant's total spinal impairment does contain a mathematical error. However, on de novo review, we find that claimant's range of motion value is slightly less than that assigned by the Referee. Nevertheless, after recalculation with the corrected value, we concur with the Referee's impairment rating.

The Referee awarded claimant 11 percent for her lost range of thoracolumbar motion. However, he did not specify how he arrived at this value. The range of motion testing performed closest in time to the hearing was performed by the Northwest Medical Consultants. Therefore, we rely on those measurements in determining claimant's impairment rating.

We find that claimant is entitled to the following values for lost thoracolumbar ranges of motion: For 45 degrees of flexion, claimant is assigned an impairment value of 4.5 percent. Former OAR 436-35-360(6). For 15 degrees of extension, claimant is assigned an impairment value of 1.5 percent. Former OAR 436-35-360(7). For 25 degrees of right flexion, claimant is assigned an impairment value of 1. Former OAR 436-35-360(8). For 25 degrees of left flexion, claimant is assigned an impairment value of 1. Former OAR 436-35-360(8).

When these values are added (not combined), we find that claimant is entitled to 8 percent for loss of thoracolumbar spine range of motion. Former OAR 436-35-360(10).

The Referee awarded claimant 4 percent for an unoperated disc bulge. We agree. Former OAR 436-35-350(2). The Referee awarded claimant 5 percent for her severe chronic condition limiting repetitive use of the back. We agree with this award as well. Former OAR 436-35-320(4).

The values for multiple residuals in the thoracolumbar spine are combined (not added) to find the total impairment of the spine. Former OAR 436-35-360(11). When claimant's lost range of motion value of 8 percent, unoperated disc bulge value of 4 percent, and loss of repetitive use value of 5 percent are combined, claimant's impairment value totals 16.1 percent.

Recomputation of Unscheduled Permanent 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 5, the sum is 6. When that value is multiplied by claimant's adaptability value 10, the product is 60. When that value is added to claimant's impairment value 16.1, the result is 76.1 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, 77 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". Former 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 asserts that, based on clear and convincing evidence of greater impairment, she is entitled to a permanent disability award of 90 percent. Claimant argues that because she suffers from a condition that is "worsening," it is highly probable that her condition at the time of hearing in October 1989 was worse than it was when she was examined seven months earlier by the Consultants in March 1989 when the measurements upon which her impairment rating was based were performed. Therefore, claimant contends, she has shown by clear and convincing evidence that her condition has not been adequately rated under the standards.

However, the limitations to which claimant testified at hearing were consistent with the residual physical capacity assessed by her attending physician in September 1988. This record does not support claimant's contention that her condition has progressively worsened since her injury. On this record, then, we find that claimant has not proven that her permanent impairment is greater than 77 percent as awarded under the standards.

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 employer's cross-request for reduction of claimant's unscheduled permanent disability award is $650 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 reply brief), the complexity of the issue, and the value of the interest involved.

Clarification of Referee's Order

As discussed above, the Referee concluded that claimant was entitled to 77 percent unscheduled permanent disability. However, the order clause of the Referee's Opinion and Order stated: "Claimant's award of permanent partial disability is increased to 77 percent representing a 31.75 percent increase equal to 98.6 degrees." We note that the Referee intended to allow a total award of 77 percent unscheduled permanent disability. The order clause should have read: In addition to the 20 percent (64 degrees) unscheduled permanent disability awarded by Determination Order, and in addition to the 6.25 percent (20 degrees) unscheduled permanent disability awarded by Stipulated Order, claimant is further awarded 50.75 percent (162.4 degrees) unscheduled permanent disability, giving her a total award to date of 77 percent (246.4 degrees) unscheduled permanent disability for a low back injury.

ORDER

The Referee's order dated November 17, 1989, as clarified by this order, is affirmed. Claimant's attorney is awarded an assessed fee of $650, payable by the self-insured employer.

Board Member Crider, dissenting.

Claimant was compensably injured in November 1986. She worked until, after exceeding her doctor's restrictions, she was forced off work for eight months. Since the injury, claimant has repeatedly returned to work, repeatedly experienced flare ups of her condition when her doctor's restrictions were exceeded at the employer's direction, and repeatedly left work due to the disability. Despite her admirable efforts to continue to work, the majority finds claimant was unwilling to work and on that ground, denies her an award of permanent total disability. Claimant is entitled to that award. Therefore, I dissent.

My challenge to the majority's decision is twofold. First, I do not believe that claimant, who was working at the time she became disabled, is required to prove that she is willing to work to establish entitlement to PTD. If, however, she is required to prove willingness to work, the evidence of that willingness is overwhelming.

I.

In SAIF v. Stephen, 308 Or 41 (1989), the Supreme Court held that a worker who voluntarily leaves work and thereafter becomes totally disabled must prove, as a condition of entitlement to permanent total disability compensation, that she is willing to work. The purpose of the rule is to ensure that PTD awards serve a wage-replacement function.

Ordinarily, we determine whether or not a claimant is a worker, entitled to disability compensation, as of the date of disability. See Weyerhaeuser v. Kepford, 100 Or App 410 (1990). Where, as here, a worker is forced to leave work due to the injury, the worker is entitled to disability compensation. The worker is not required to establish continued willingness to work.

SAIF v. Stephen, supra, protects workers who leave work for reasons unrelated to a compensable injury before they become disabled by allowing them to demonstrate that they would have returned to the work force but for the injury--thus, that a PTD award would serve as wage replacement. The majority turns the decision on its head by requiring a worker who never voluntarily left the work force to establish her willingness to work.

I am aware that the Court of Appeals has recently ordered the Board to determine whether a worker was willing to work in a situation analogous to this one. See SAIF v. Beswick, 104 Or App 494 (1990). In that case, however, the court did not discuss the facts of the case or its understanding of Stephen. Therefore, I respectfully suggest that the issue merits further consideration.

II.

Assuming that each and every claimant seeking a PTD award must prove willingness to work, regardless of the reason that worker left work, claimant has clearly established that, but for the compensable injury, she would be willing to seek work. Most importantly, she worked until she could do so no longer. In addition, she testified at hearing that she would be willing to work if she could. In the face of this evidence, the panel finds that claimant was not willing to work because she planned to retire when she reached 62 years of age. While claimant told several medical and vocational service providers that she did not plan to return to work after age 62, she did not do so until she was forced to leave work in December 1988 before she reached 62 years. (Ex 90-2, Ex 98-1). Under these circumstances, her plan to retire does not establish that she was not willing to work.

Claimant worked until she could do so no longer. She should not be penalized because she, unlike less fortunate workers, had a retirement program to fall back on. I would award her permanent total disability benefits.

March 8, 1991 Cite as 43 Van Natta 487 (1991)

In the Matter of the Compensation of
KENNETH CAGE, Claimant
WCB Case Nos. 88-04373, 88-06497, 86-14231 & 88-06498
INTERIM ORDER (REMANDING)
Royce, et al., Claimant Attorneys
Acker, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

Liberty Northwest Insurance Corporation (Market Transport) requests review of that portion of Arbitrator Neal's order that: (1) set aside its denial of claimant's occupational disease claim for his current carpal tunnel syndrome condition; (2) upheld Liberty Northwest's (Norpac Services) denial of the same condition; and (3) awarded attorney fees to claimant's counsel for services provided before hearing. Claimant cross-requests review of that portion of the Arbitrator's order that declined to award attorney fees for services at hearing. In its brief, Liberty Northwest contends that if claimant's counsel is entitled to an attorney fee, the Arbitrator's award was excessive. On review, the issues are responsibility and attorney fees. We remand on the attorney fee issue.

We note preliminarily that claimant's requests for hearing from Market Transport's denial and from Norpac's denial were assigned WCB Case Nos. 86-14231 and 88-04373 respectively. A hearing was scheduled to address those requests before Referee Neal. Subsequently, upon receipt of an ORS 656.307 order from the Department, two new WCB Case Nos. were assigned to this matter: 88-06497 and 88-06498. Initially, Arbitrator Galton was appointed to conduct the arbitration proceeding under ORS 656.307(2). However, on May 11, 1988, the arbitration proceeding was consolidated with the previously scheduled hearing and Arbitrator Neal was appointed. The parties were advised of the consolidation and appointment by Notice of Hearing mailed May 17, 1988.

Inasmuch as the additional case numbers, assigned to the arbitration proceeding, dealt with the same responsibility issue raised in the pending hearing requests, they were properly consolidated for hearing. Moreover, because the ".307" order in this matter was received after January 1, 1988, the hearing was an arbitration, notwithstanding the Arbitrator's use of the terms "Referee" and "Opinion and Order." See Timothy R. Schroeder, supra.

Following the proceeding, Arbitrator Neal, rather than disposing of all consolidated case numbers by a single order, issued two separate orders. One order addressed the responsibility issue on the merits. The other dismissed WCB Case Nos. 88-06498 and 88-06497. Because all WCB Case Nos. related to the identical issue, and because Liberty Northwest has requested review of both of the Arbitrator's orders by the Board, we consolidated them for purposes of Board review. Further, we treat Arbitrator Neal's disposition of the case as the "determination of the arbitrator" for purposes of our review pursuant to ORS 656.307(2).

The Arbitrator awarded a fee to claimant's counsel for services rendered before the hearing. She declined to award a fee for services rendered at hearing. We remand.

The current version of ORS 656.307 authorizes an insurer-paid attorney fee if claimant participated in the responsibility proceeding. Specifically, subsection (5) provides that, if claimant appears in any arbitration proceeding and "actively and meaningfully participates" in the proceeding through an attorney, the arbitrator may require that a reasonable attorney fee be paid by the insurer determined by the arbitrator to be the party responsible for paying compensation. This statutory language is essentially duplicated in OAR 438-15-090, effective January 1, 1988. Jean Novotny, 42 Van Natta 1060, 1061 (1990).

Pursuant to ORS 656.307(5), claimant may be awarded an assessed fee if he "actively and meaningfully" participates through an attorney in a ".307" proceeding. Claimant's attorney here provided services prior to issuance of the ".307" order and actively prosecuted the case after the Board received the ".307" order and through the hearing. Claimant's attorney spoke with his client and with counsel for the insurer. Claimant's attorney was present at the hearing to examine and cross-examine witnesses. Claimant took the position at hearing that the employment at Market Transport caused the carpal tunnel condition and that, between the two employers, Market was responsible. Under the circumstances, we conclude that claimant's attorney actively and meaningfully participated in the ultimate determination of the responsible insurer.

Neither ORS 656.307(5), nor OAR 438-15-090, requires an arbitrator to award a fee in any particular case. However, we have concluded that, when a claimant actively and meaningfully participates in an arbitration proceeding, an insurer-paid fee should be awarded absent unusual circumstances. Daniel J. Bergmann, 42 Van Natta 949 (1990). Because an award under the statute is within the discretion of the arbitrator, we conclude that remand is appropriate. Id.

Accordingly, this matter is remanded to the Arbitrator. Within 14 days of the date of this order, the Arbitrator shall provide an interim order on remand determining whether claimant should be awarded a fee in this case under ORS 656.307(5) and, if so, the amount of a reasonable fee. We retain jurisdiction over this matter. Upon receipt of the Arbitrator's order, we shall proceed with our review.

IT IS SO ORDERED.

In the Matter of the Compensation of
J. C. DANIELS, JR., Claimant
WCB Case No. 89-25265
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Darryl Nelson, Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Brown's order that: (1) upheld the insurer's denial of his low back injury claim; (2) declined to assess a penalty and related attorney fee for an allegedly unreasonable denial; and (3) declined to assess a penalty and related attorney fee for the insurer's failure to pay interim compensation. In his brief, claimant requests that the Board order payment of interim compensation. On review, the issues are compensability, interim compensation and penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings," as supplemented by the following "Ultimate Findings."

Claimant's October 22, 1989 industrial injury was a material contributing cause of his current low back condition.

The employer had knowledge of claimant's industrial injury and immediate disability on October 22, 1989, the date of injury.

CONCLUSIONS OF LAW AND OPINION

Compensability

It is undisputed that the incident with the refrigerator occurred and that claimant suffered immediate disabling pain thereafter. Claimant's immediate disability was observed by others, including the employer. Claimant reported having suffered immediate pain at his first doctor's visit. (Ex. 2). In this regard, we also note that the medical evidence relating claimant's current low back problems to his industrial injury is uncontroverted.

The Referee found claimant to be an unreliable witness. When, as here, that determination is based on arguable objective inconsistencies in the record, we are in as good a position as the Referee to evaluate claimant's truthfulness and reliability. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). In this case, after reviewing the record, we disagree with the Referee's conclusion regarding claimant's reliability.

The employer contends that claimant variously reported that his back pain was immediate and, on another occasion, that it started 15 to 30 days after the accident. Claimant explained that his left leg pain was immediate and that his whole body also felt "stretched." (Tr. 6). Moreover, having suffered a previous painful gun shot wound in both legs, claimant's report of symptoms takes on added reliability. In this regard, he stated that, after the work injury, leg pain was immediately acute, and back pain worsened, becoming unbearable over the ensuing weeks. (Tr. 18-20). Under the circumstances, including claimant's preexisting leg problems, we find his reporting of symptoms and his explanation of

them to be reasonable. In our view, claimant's reporting does not support a finding that he is unreliable as a witness.

Moreover, claimant's descriptions of the refrigerator incident and its sequelae are materially consistent and corroborated by the employer's observations. We find no record evidence which calls claimant's reliability as a witness into question.

Under these circumstances, and in the absence of a negative demeanor-based credibility finding, we are unwilling to disbelieve claimant's account of the injury. And, inasmuch as the medical evidence supports claimant's claim, we conclude that claimant has carried his burden of establishing that his current disability and need for treatment resulted from his October 22, 1989 industrial injury.

Interim Compensation

Former ORS 656.262(4) requires the payment of interim compensation within 14 days of the employer's notice or knowledge of a claim. ORS 656.005(6) provides: "'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." (Emphasis added.) A claimant must "leave work" within the meaning of ORS 656.210 in order to be entitled to interim compensation. Bono v. SAIF, 298 Or 405, 408-10 (1984).

In this case, it is undisputed that claimant left work immediately following his on-the-job injury and that the employer was present and aware of claimant's disability. Therefore, claimant was entitled to temporary disability compensation, in the form of interim compensation, beginning October 22, 1989 and pending acceptance or denial of his claim.

Penalties and Attorney Fees

Unreasonable Denial

The standard for determining an unreasonable denial is whether the employer/insurer had a legitimate doubt as to its liability. "Legitimate doubt" is to be considered in light of all the evidence available to the employer/insurer at the time. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988); Norgard v. Rawlinsons, 30 Or App 999, 1003 (1977).

At the time of the November 30, 1989 denial, all of the existing medical evidence related claimant's disability and need for treatment to the undisputed refrigerator incident. Moreover, it is undisputed that claimant left work following his injury and that the employer knew that claimant was unable to finish the job, due to his injury. That knowledge will be imputed to the insurer. Nix v. SAIF, 80 Or App 656, 660 (1986). Therefore, regardless of any statements regarding fault which claimant may have made, we conclude that "legitimate doubt" did not exist concerning the compensability of claimant's injury and that the denial was unreasonable.

Failure to Pay Interim Compensation

The employer testified that the first time he saw claimant subsequent to the incident was around November 15, 1989, after claimant had been to the doctor. However, inasmuch as the employer knew that claimant had been disabled by his injury, we conclude that the insurer's failure to pay interim compensation was unreasonable.

Therefore, the insurer both unreasonably denied the claim and unreasonably failed to pay interim compensation. Claimant is entitled to a penalty for the insurer's unreasonable conduct. ORS 656.262(10). In addition, the insurer's conduct constitutes an unreasonable resistance to the payment of compensation warranting the assessment of a penalty-related attorney fee. ORS 656.382(1). Under the circumstances of this case, we award a penalty-related fee of $350. In arriving at the amount of the fee, we have considered the factors set forth in OAR 438-15-010(4). In particular, we have considered the time devoted to this issue, as well as the value of the benefit secured for claimant.

In addition, claimant is entitled to a reasonable assessed fee for prevailing on a denied claim. ORS 656.386(1). 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 $2,200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the length of the hearing, the time devoted to the case on review, the moderate complexity of the issue, the risk that counsel's services might go uncompensated, and the benefit secured for claimant.

ORDER

The Referee's order dated May 24, 1990 is reversed. The insurer's denial is set aside and the claim is remanded to it for further processing according to law. Claimant is awarded interim compensation from October 22, 1989 to November 30, 1989, payable by the insurer. Claimant's counsel is awarded 25 percent of this interim compensation created by this order, not to exceed $3,800. Claimant is further awarded a penalty equal to 25 percent of the interim compensation due by virtue of this order, payable by the insurer. Claimant's counsel is awarded a reasonable assessed fee of $350 for the insurer's unreasonable resistance to the payment of compensation. In addition, claimant's counsel is awarded a reasonable assessed fee of $2,200, for his services at hearing and on review regarding the compensability issue, to be paid by the insurer.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARVIN W. GARNER, Claimant
WCB Case Nos. C1-00282 & C1-00281
ORDER DENYING RECONSIDERATION
Sara L. Gabin, Claimant Attorney
Noreen K. Saltveit, Defense Attorney

Claimant and the insurer jointly request reconsideration of our February 11, 1991 Order Disapproving Claim Disposition Agreement. Specifically, the parties contend that the CDA did not lack the required "order" clause as indicated in our disapproval order. Further, the parties argue that inasmuch as the CDA was for a nondisabling claim, there was no date of first claim closure to report.

We agree with the parties. Page 5 of the CDA contained the required "order" clause, and further, a nondisabling claim does require claim closure. Thus, the parties did not fail to provide required information.

However, in our review of the CDA, we also noted a modification of the agreement on page 2, line 25, by claimant and his counsel deleting the word

"claims" and inserting the phrase "related matters." Our concern with such a modification is twofold.

First, it is unclear what "related matters" refers to. It could be interpreted that the proposed agreement purports to release claimant's rights and obligations, with the exception of medical services, not only under his accepted claim, but also attempts to resolve "related matters" which fall outside of ORS Chapter 656. In that regard, we note that page 3, lines 20-21, of the agreement also purports to release without limitation "all other rights and benefits allowed to be released by law."

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 medical services, in an accepted claim." OAR 436-60-005(9). See also OAR 438-09-001. The underscored portion of the rule makes it clear that only rights and/or obligations under ORS Chapter 656 may be released by a claim disposition agreement. See Karen A. Vearrier, 42 Van Natta 2071 (1990).

Because the terms of the agreement raises doubts as to the intentions of the parties with regard to the release of related matters outside of the ORS Chapter 656, we decline to approve the CDA.

Second, inasmuch as the modification could be construed as changing the nature of the agreement, we note there is no evidence that the insurer was aware of or consented to the alteration of the agreement made by claimant. We further note that the insurer's counsel signed the CDA prior to the modification being made.

In light of the above, the motion to reconsider the disapproval order is denied. However, the Board would be willing to consider a revised CDA which resolves these additional issues. Upon receipt of such an agreement, we will follow our standard acknowledgment procedures.

IT IS SO ORDERED.

March 8, 1991 Cite as 43 Van Natta 492 (1991)

In the Matter of the Compensation of
CLAUDE E. HARRIS, Claimant
WCB Case No. 89-20661
ORDER ON REVIEW
Ginsburg, et al., Claimant Attorneys
Roberts, Reinisch & Klor, Defense Attorneys

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Leahy's order which: (1) declined to award temporary disability compensation beyond May 5, 1989; (2) declined to assess a penalty and attorney fee for the insurer's allegedly unreasonable failure to pay temporary disability compensation on claimant's aggravation claim; and (3) dismissed claimant's request for hearing. On review, the issues are the propriety of the Referee's dismissal, temporary disability compensation, penalties and attorney fees. We reverse.

FINDINGS OF FACT

Claimant compensably injured his back in 1985. In June 1988, claimant began working as a surgical aide at a hospital. He was working at that job on December 19, 1988, when he sustained an injury which caused an aggravation of his back condition. Claimant continued to work on restricted duty until March 13, 1989 when the hospital determined that he was unable to meet the physical demands of the job.

In a May 30, 1989 report, Dr. Mirka, claimant's treating physician, released him for "regular" work and declared him medically stationary retroactive to May 5, 1989. Claimant did not return to work as a surgical aide but, instead, began working as an on-call data entry technician at the hospital on May 9, 1989.

In an Opinion and Order dated August 14, 1989, Referee Schultz found the insurer to be responsible for claimant's December 1988 aggravation claim and directed it to accept and process the claim in accordance with the law. This order was not appealed and became final by operation of law.

Due to flare-ups in his condition, claimant's treating physician restricted him to part-time work, four hours per day, beginning September 6, 1989. The insurer's attorney wrote Dr. Mirka on October 25, 1989, requesting additional information about claimant's symptomatic flare-up the previous month. In his October 26, 1989 response, Dr. Mirka stated that claimant was not presently released to full-time regular work, and had been restricted to part-time work, four hours per day, since September 6, 1989. Dr. Mirka did not thereafter release claimant to regular work. In a letter dated November 10, 1989, Dr. Mirka stated that in May 1989 he intended to release claimant to a data entry job, not his at-injury job as a surgical aide.

On November 11, 1989, a hearing was held before Referee Leahy regarding the insurer's failure to pay temporary disability benefits. As of that date, the insurer still had not paid claimant any temporary disability compensation on this claim. On December 4, 1989, after the November hearing but before Referee Leahy issued his Opinion and Order, a Determination Order issued, awarding claimant temporary partial disability from December 19, 1988 through May 5, 1989.

FINDINGS OF ULTIMATE FACT

Claimant was unable to perform his regular work, due to his compensable aggravation, commencing December 19, 1988. Claimant became medically stationary and was released to modified work on May 5, 1989. Claimant's treating physician did not release him to regular work prior to claim closure on December 4, 1989.

The insurer unreasonably resisted the payment of compensation by not paying temporary disability compensation from December 19, 1988 through May 5, 1989, and from September 6, 1989 through December 4, 1989.

CONCLUSIONS OF LAW AND OPINION

Propriety of Dismissal

The Referee found that claimant was not entitled to temporary disability compensation beyond May 5, 1989, and he 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.

Temporary Disability Compensation

At the outset, we note that the December 4, 1989 Determination Order was not part of the hearing record, having issued after the hearing. However, the Board may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." ORS 40.065(2); ORE 201(b); Groshong v. Montgomery Ward, 73 Or App 403 (1985). A Determination Order may be so noticed. See Leslie G. Mullenix, 41 Van Natta 2068 (1989); Susan Teeters, 40 Van Natta 115 (1988).

Accordingly, we take administrative notice of the December 4, 1989 Determination Order. However, in all other respects, we rely exclusively on the record as developed in the hearing below. See ORS 656.295(5). Moreover, we do not address claimant's substantive entitlement to temporary disability benefits under the December 4, 1989 Determination Order, which is not before us on review. We limit our review to claimant's procedural entitlement to temporary disability.

Procedurally, an injured worker is entitled to receive payment of temporary disability compensation until he is both medically stationary and released by the attending physician to return to regular work, or is both medically stationary and the claim is closed. Former ORS 656.268(1) and (2); Fazzolari v. United Beer Distributors, 91 Or App 592, 595, on recon 93 Or App 103, rev den 309 Or 236 (1988). We find that claimant was never released to his regular work. Accordingly, he is procedurally entitled to temporary disability benefits until his claim was closed by the December 4, 1989 Determination Order.

On December 19, 1988, Dr. Mirka documented that claimant had sustained an on-the-job injury and restricted claimant to modified work. In a subsequent report dated May 30, 1989, Dr. Mirka indicated that claimant had become medically stationary and was retroactively released to return to his "regular" job as of May 5, 1989. Claimant asserts that in fact Dr. Mirka did not intend to release him to return to his at-injury job, but rather to the modified job of data entry technician that claimant had begun May 9, 1989.

We are convinced that Dr. Mirka only intended to release claimant to return to the modified job he had begun performing three weeks earlier, notwithstanding the doctor's inartful usage of legal terminology. Dr. Mirka was involved in deciding that claimant should not return to his regular job as a surgical aide. On May 9, 1989, immediately after Dr. Mirka's May 5, 1989 release, claimant was offered and accepted the data entry job. The juxtaposition of these events convinces us that the release was in fact for the data entry job. Moreover, Dr. Mirka clarified that he had intended to release claimant to the data entry job in a subsequent letter dated November 10, 1989. We find Dr. Mirka's explanation of the events surrounding his release of claimant to return to work to be persuasive.

Therefore, because he was never released by his attending physician to return to regular work, as a procedural matter claimant was entitled to payment of temporary disability compensation until his claim was closed by the December 4, 1989 Determination Order. Former ORS 656.268(1) and (2); Fazzolari, supra.

Penalties and Attorney Fees

The Referee did not address claimant's request for a penalty and attorney fee for unreasonable failure to pay temporary disability benefits pursuant to Referee Schultz' order, dated August 14, 1989, which set aside the insurer's denial of claimant's aggravation claim and directed the insurer to process the claim. An insurer must pay temporary disability compensation within 14 days of

the date a Referee issues an order finding a claimant to be disabled. Former OAR 430-60-150(3)(e). If a carrier unreasonably delays or unreasonably refuses to pay compensation, it is liable for an additional amount, up to 25 percent of the benefits then due, plus a reasonable attorney fee. See ORS 656.262(10) and 656.382(1).

Referee Schultz found claimant to be partially disabled as of December 19, 1988. No one contests that finding of fact in this case. Nevertheless, the insurer took no action regarding the payment of temporary disability benefits and, at hearing, indicated that it had refused to pay temporary disability compensation solely on the ground claimant was terminated from his job in October 1989 for reasons unrelated to the compensable injury.

We do not find termination from a different job ten months after the original injury to be a persuasive explanation for the insurer's failure to comply with the rule. The insurer's failure to pay temporary disability benefits within 14 days of Referee Schultz' August 1989 order was an unreasonable resistance to the payment of compensation. Therefore, claimant is entitled to a penalty and related attorney fees. See ORS 656.262(10) and 656.382(1); former OAR 436-60-150(3)(e).

Nevertheless, we conclude that the penalty and related attorney fee should only be assessed against a portion of the unpaid temporary disability compensation. On its face, Dr. Mirka's report to the insurer purported to both declare claimant medically stationary and release him to return to regular work on May 5, 1989. Therefore, it was not unreasonable for the insurer to conclude from Dr. Mirka's words that claimant was released to regular work as of that date.

However, claimant's condition worsened in September 1989, and the insurer acted unreasonably when it failed to recommence payment of temporary disability benefits at that time. On October 25, 1989, the insurer's attorney wrote Dr. Mirka requesting additional information about claimant's symptomatic flare-up the previous month. In his October 26, 1989 response, Dr. Mirka stated that claimant was not presently released to full-time regular work, and had been restricted to part-time work, four hours per day, since September 6, 1989. As discussed above, Dr. Mirka did not thereafter release claimant to regular work. Therefore, the insurer acted unreasonably when it failed to recommence temporary disability benefits as of September 6, 1989, and continue paying those benefits through claim closure.

In summary, we find that the insurer acted unreasonably in failing to pay temporary disability benefits through May 5, 1989, and from September 6, 1989 through claim closure. Accordingly, we assess a penalty of 25 percent of the unpaid temporary disability benefits due for those periods.

In addition, 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 concerning the insurer's unreasonable conduct is $1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue, the complexity of the issue, and the value of the interest involved.

ORDER

Claimant's hearing request is reinstated. The Referee's order dated December 8, 1989 is reversed. Claimant is awarded temporary disability compensation from December 19, 1988 to December 4, 1989. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, payable

directly to claimant's attorney, not to exceed $3.800. The insurer shall pay to claimant a penalty of 25 percent of the temporary disability compensation due from December 19, 1988 through May 5, 1989, and from September 6, 1989 through December 4, 1989. Claimant's attorney is awarded a penalty-related attorney fee of $1,000, to be paid by the insurer.

March 8, 1991 Cite as 43 Van Natta 496 (1991)

In the Matter of the Compensation of
JOHN W. KUYKENDALL, Claimant
WCB Case No. TP-90056
THIRD PARTY DISTRIBUTION ORDER
Smith & Smith, Claimant Attorneys
J. David Thurber (Saif), Defense Attorney

Claimant has petitioned the Board for resolution of a conflict concerning the "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, the dispute pertains to the SAIF Corporation's contention, as a paying agency, that all of its claim costs accruing after the incident that resulted in the third party action are reimbursable from the settlement. We conclude that SAIF is entitled to a portion of its asserted lien.

FINDINGS OF FACT

In July 1985 claimant sustained a compensable right wrist injury while working as a veneer off-bearer. SAIF eventually accepted the claim and provided compensation.

Claimant continued to work, with some modifications in his job duties. Treatment was initially conservative, primarily consisting of prescribed medication and aspirin. Claimant's aspirin consumption prompted gastric complaints, which caused Dr. Maurer, his treating orthopedist, to prescribe Tagamet for the stomach symptoms.

When claimant's right wrist complaints became unbearable, a lunate replacement surgery was performed by Dr. Maurer in August 1986. This surgery involved the removal of the lunate bone and the insertion of a silicone prosthesis.

Post-operatively, claimant's condition began to improve. In September 1986 a physical therapy program was implemented. The goal of the program was to increase claimant's range of motion and strength in his right wrist to "its maximum potential." The estimated length of the thrice weekly treatments was three weeks, which would be followed by the establishment of a home exercise program.

In October 1986, while engaging in his physical therapy program, claimant felt a "pop" in his right wrist. X-rays confirmed that the prosthesis had become dislocated. A variety of surgical procedures, including reimplementation of the implant or fusion, were considered.

In April 1987 Dr. Maurer performed a second surgery. The prosthesis was removed and replaced with a fascia (soft tissue) implant.

A physical therapy program was reimplemented in June 1987. Following a treatment schedule of twice weekly sessions for three weeks, claimant was

instructed in a home exercise program and advised to seek treatment from Dr. Maurer whenever necessary.

In August 1987 claimant was released to full-time work activities by Dr. Maurer. Claimant was restricted to light to medium employment, which avoided repetitive duties involving the right wrist.

Vocational rehabilitation efforts began in October 1987. Based on the extent and variety of claimant's prior work history, experiences, and interests, vocational goals in warehousing, dispatching and wholesaling were identified. These goals were determined to be within claimant's transferable skills and physical limitations. Costs for these vocational services were projected to not exceed $3,620.

A Determination Order issued in November 1987. Claimant was awarded temporary total disability between July 1986 and July 1987, as well as temporary partial disability between July 1987 and September 1987. He was also awarded 35 percent scheduled permanent disability for loss of use or function of the right forearm (wrist).

At the time of this claim closure, Dr. Maurer was continuing to prescribe Tagamet for claimant's intermittent stomach complaints. In the event that these complaints continued, Maurer recommended a consultation from a gastroenterologist. This consultation eventually was performed. SAIF has paid the $395 bill for these consultative services, as well as $2,519.86 in pharmacy bills for all prescription medication (including Tagamet).

As a result of the prosthesis dislocation, claimant experienced right wrist pain with any activity requiring resistive forces across the wrist in excess of 2 to 3 pounds. Had the prosthesis not failed, claimant's right wrist was capable of resisting forces in excess of 20 pounds without pain. In any event, such limitations would have prevented claimant from performing the repetitive and forceful wrist activities required at the mill. In addition, long term repetitive and resistive use against forces in excess of 20 pounds would have eventually led to the failure of the silicone prosthesis within 15 years.

Claimant engaged legal counsel to explore the possibility of bringing suit against the hospital that conducted the physical therapy program. Thereafter, a third party action for negligence was initiated.

With SAIF's approval, the third party action was settled for $90,131.97. Following deductions for claimant's attorney fee, litigation expenses, and statutory 1/3 share, a balance of $37,248.53 remains.

Asserting a lien of $38,365.11, SAIF seeks the entire balance as reimbursement for its actual and future claim costs. Contending that SAIF is apparently attributing all of its claim costs incurred after the October 1986 physical therapy incident to the third party action, claimant objects to SAIF recovering the entire remaining balance. After accomodating for claimant's condition prior to the October 1986 incident, claimant proposes that SAIF receive $33,167.50 of the remaining balance.

A distribution of third party settlement proceeds in which SAIF receives $33,167.50 would be "just and proper."

CONCLUSIONS OF LAW

A paying agency is entitled to the recovery of its claim costs from a third party settlement for malpractice to the extent that the agency is

receiving reimbursement for additional expenses incurred as a result of the malpractice. Ray F. Littlefield, 41 Van Natta 1781 (1989); John Galanopoulos, 34 Van Natta 615, 616 (1982). The burden of proof is upon the paying agency to establish the extent of expenditures attributable to the malpractice. Id.

Here, SAIF asserts a $38,365.11 lien against the third party settlement stemming from the October 1986 physical therapy "malpractice." This lien is composed of several components consisting of temporary disability, permanent disability, vocational rehabilitation, medical bills, and future medical expenses. We shall address each component separately.

To begin, SAIF does not contest claimant's assertion that its lien against the $9,000 permanent disability award should be reduced to $6,000. Inasmuch as there is no dispute over this component, we find that $6,000 of SAIF's permanent disability claim costs are attributable to the October 1986 incident and reimbursable from the settlement proceeds.

Turning to the issue of reimburement for temporary disability benefits, SAIF seeks the recovery of all such benefits provided after October 15, 1986. ($11,290.25). It bases this contention on a purported allegation in claimant's third party complaint that he expected to return to work on October 15, 1986. In addition, SAIF relies upon a September 29, 1986 physical therapy report, which provided a goal that the range of motion and strength in claimant's right wrist would achieve maximum potential in three weeks.

The record before us does not support SAIF's assertion that all of its lien for temporary disability benefits is attributable to expenditures arising from the October 1986 incident. The September 29, 1986 physical therapy goals did anticipate a three week "physical therapist" program designed to achieve range of motion and strength findings in claimant's right wrist "within its maximum potential." Yet, this report did not state that claimant's right wrist condition would be medically stationary at the conclusion of the program. Moreover, the report anticipated the establishment of a home exercise program once the physical therapist had completed the 3-week program.

Thus, SAIF's contention that claimant's condition would have become medically stationary by October 15, 1986 (had the October 8, 1986 physical therapy incident not occurred), is highly speculative and unpersuasive. We draw further support for this conclusion from the fact that, following a July 1987 physical therapy program, claimant continued in a home exercise program and did not become medically stationary until September 1987, some three months later. Finally, the complaint submitted for our review does not contain an allegation, as SAIF asserts, that claimant represented that he was expecting to return to work on October 15, 1986. However, even if it did, we would consider such an allegation to be likewise speculative and unpersuasive, as well as not supported by the remaining portions of the record.

In response to SAIF's asserted lien for $11,290.25 in reimbursed temporary disability benefits, claimant proposes that SAIF recover $10,015. Considering this concession, we find that SAIF is entitled to $10,015 of the third party settlement as reimbursement for temporary disability benefits attributable to the October 1986 physical therapy incident.

SAIF claims $12,218.36 in actual medical expenditures related to the October 1986 incident. Included within these claim costs are $2,519.86 in prescription medication and $395 for a gastroenterology consultant's fee. SAIF repeats that, but for the October 1986 incident, claimant would have returned to work by October 15, 1986. Based upon this assumption, SAIF contends that, had the October 1986 physical therapy incident not occurred, claimant would not have

required further prescription medication and "in all likelihood" would not have needed the gastroenterologist's consultation. Since these expenses arose subsequent to the October 1986 incident, SAIF argues that it is entitled to full reimbursement from the third party settlement.

Once again the record does not support SAIF's contention. Based on the reasoning previously expressed, we do not share SAIF's speculative assumption that claimant would have returned to work on October 15, 1986, but for the October 8, 1986 physical therapy incident. We also consider SAIF's argument that future prescribed medication and consulting costs were brought on by the October 1986 incident to be similarly speculative and unpersuasive.

From the outset of claimant's July 1985 compensable injury, Dr. Maurer has prescribed medication for wrist pain. Maurer also initially recommended aspirin. Because of claimant's aspirin use, stomach complaints were identified beginning in February 1986, some eight months before the October 1986 incident. Following the February 1986 examination, Maurer recommended that claimant avoid aspirin and prescribed Tagamet for the digestive problem. Finally, Dr. Maurer has concluded that: (1) claimant's need for Tagamet has been ongoing during his treatment of the wrist; and (2) in the event that claimant's stomach symptoms did not resolve, a gastroenterology consultation would be appropriate.

Dr. Maurer's chart notes and opinion persuade us that claimant required prescription medication and was experiencing stomach ailments well in advance of the October 1986 physical therapy incident. What is more, the record does not establish that, but for the October 1986 incident, the need for such medication to treat his pain and stomach complaints or to further investigate his gastroenterological problems would have ended. Under such circumstances, we are not persuaded that all of SAIF's claim costs for presription medication and gastroenterology consultation fees after the October 1986 physical therapy incident are attributable to that incident.

In response to SAIF's asserted lien for $12,218.36 in reimbursed actual medical expenses, claimant proposes that SAIF recover $11,246.74. This proposal is based on an admittedly arbitrary 1/3 reduction in SAIF's lien for the $2,519.86 in prescription medication and $395 in gastroenterology consultant fees. In light of our discussion concerning SAIF's contentions and considering claimant's concession, we conclude that SAIF is entitled to $11,246.74 of the third party settlement as reimbursement for actual medical expenses attributable to the October 1986 incident.

SAIF also seeks reimbursement of reasonably anticipated future medical expenses of $4,280. These costs are based on future prescription medication for claimant's pain and stomach problems ($3,930), as well as doctor visits ($350). SAIF's claims examiner states that these costs are based on a "conservative" estimate of only 5 years of medication since the treating physician "has stated that the claimant will probably have to take Tagamet for the rest of his life."

To support its lien for anticipated future expenditures, the paying agency must establish that it is reasonably certain to incur such expenditures. Donald P. Bond, 40 Van Natta 361, 480 (1988); Leonard Henderson, 40 Van Natta 31 (1988). Based on the reasoning previously expressed, we are not persuaded that all of SAIF's asserted lien for future medical expenditures is reasonably certain to occur as a result of the October 1986 physical therapy incident. However, in response to SAIF's assertion, claimant has again arbitrarily proposed to reduce SAIF's lien by 1/3. Consistent with our reasoning concerning SAIF's claim for actual medical claim costs, we conclude that SAIF is entitled to $2,854.76 of the third party settlement as reimbursement for reasonably anticipated medical expenses attributable to the October 1986 incident.

Finally, SAIF contends that it is entitled to recover all of its vocational rehabilitation costs ($4,576.50) from the third party settlement. It relies upon the assumption that claimant would have returned to his regular work following the successful completion of the physical therapy program. Yet, Dr. Maurer concluded that, even if the initial surgery had been successful, claimant would have been unable to return to the repetitive and forceful wrist activities present in his prior millwork. Such an opinion persuasively outweighs SAIF's speculative assumption that, but for the October 1986 incident, vocational rehabilitation expenses would not have been incurred. Under such circumstances, we are not persuaded that all of SAIF's vocational rehabilitation claim costs are attributable to the October 1986 physical therapy incident.

Once again proposing an arbitrary 1/3 reduction, claimant suggests that SAIF's asserted lien of $4,576.50 be reduced to $3,051. Consistent with our prior reasoning concerning SAIF's contentions and claimant's concessions, we conclude that SAIF is entitled to $3,051 of the third party settlement as reimbursement for vocational rehabilitation claim costs attributable to the October 1986 incident.

Accordingly, from the remaining balance of third party settlement proceeds, claimant's attorney is directed to immediately forward to SAIF the sum of $33,167.50. Claimant's attorney shall distribute the remaining portion of the settlement to claimant in accordance with 656.593(1)(d). Based on the reasoning expressed above, we hold that such a distribution is "just and proper." See ORS 656.593(3).

IT IS SO ORDERED.

In the Matter of the Compensation of
ROY L. PLUMLEE, Claimant
WCB Case No. CO-00515
ORDER DENYING RECONSIDERATION
Bischoff & Strooband, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

The Aetna Commerical Insurance Company requests reconsideration of our February 8, 1991 Order Disapproving Claim Disposition Agreement. Specifically, the employer seeks approval of the claim disposition agreement (CDA) on the ground that it had provided separate notice regarding the claim disposition pursuant to OAR 436-60-145(4)(g). In sum, a letter was sent to claimant which incorporated the language required by the administrative rule.

The claim disposition agreement was acknowledged on February 15, 1991 in accordance with our standard procedures under former OAR 438-09-025(2) & (3).

On February 8, 1991, we issued an order disapproving the CDA. We disapproved the CDA because the notice required pursuant to OAR 436-60-145(4)(g) is neither in the agreement nor incorporated by reference into the agreement. A proposed disposition that does not contain the required notice will not be approved by the Board. See OAR 436-60-145(5); 438-09-020(1). The required notice was neither in the agreement nor had it been incorporated by reference. Consequently, we set aside the CDA.

On February 13, 1991, the employer moved for reconsideration of the disapproval order, alleging that the claim disposition agreement provided that notice

had been given to claimant and that a separate letter had been sent to claimant which incorporated the language required by the administrative rule.

Here, our sole objection to the claim disposition agreement has not been resolved. Pursuant to former OAR 436-60-145(6)(d), it was sufficient for a CDA to recite that the required notice had been sent. Nevertheless, pursuant to OAR 436-60-145(4)(g), which applies to this agreement, the notice language must actually appear in the actual agreement or be incorporated by reference in the agreement. The notice enclosed with the Motion for Reconsideration is not contained in the disposition agreement nor incorporated by reference.

Accordingly, the request for reconsideration is denied. We adhere to our February 8, 1991 order. Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

March 8, 1991 Cite as 43 Van Natta 501 (1991)

In the Matter of the Compensation of
DEBORAH A. STEHR, Claimant
WCB Case No. 89-25623
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Mitchell, et al., Defense Attorneys

Reviewed by Board Members Myers and Westerband.

Claimant requests review of those portions of Referee Menashe's order which upheld the self-insured employer's denial of medical services. On review, the sole issue is medical services. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. The treatments in issue were reasonable and necessary treatments for the compensable injury.

CONCLUSIONS OF LAW AND OPINION

The employer originally denied the medical treatments because the treating chiropractor had failed to provide requested information which would have established compensability of the treatments. When the treating doctor finally provided the information, the employer paid the disputed bills; it did not, however, rescind its denial.

At hearing, claimant proved, and the Referee concluded, that the medical treatments were compensable. The Referee reasoned that the denial was moot because the medical bills had already been paid and, therefore, that the employer had no need to rescind the denial and the Referee had no need to set it aside. We disagree.

ORS 656.262(9) provides that:

> "Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability...."

Therefore, even though the employer paid the medical billings in question, that payment did not mean that the employer accepted the compensability of them. By upholding the denial, the Referee made it the law of the case that those treatments were not compensable. Although his decision may have no practical effect on the particular compensation in issue, it may have far reaching effects under the doctrine of res judicata on future claims made for this compensable injury.

Accordingly, we set aside the denial because claimant has proven that the treatments in issue are compensable. Claimant's attorney is, likewise, entitled to an assessed fee for his effort at hearing and on Board review for prevailing over this denial.

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 is $1,500, to be paid by the employer. 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 May 21, 1990 is affirmed in part and reversed in part. Those portions of the Referee's order which upheld the employer's denial are reversed. The balance of the Referee's order is affirmed. Claimant's attorney is awarded an assessed fee of $1,500 for services at hearing and on Board review, to be paid by the employer.

In the Matter of the Compensation of
JULIAN H. COMBS, Claimant
WCB Case No. C1-00124
AMENDED ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Michael B. Dye, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

On February 19, 1991, we approved the parties' claim disposition agreement (CDA). In so doing, we parenthetically noted that a provision, which stated that, in the event the agreement was disapproved, the SAIF Corporation could offset money advanced to claimant while the agreement was pending Board consideration against future compensation, was invalid. We retract that statement.

If a proposed agreement provided that proceeds from an approved CDA could be offset against future compensation, such a provision would be contrary to law in that the parties would be attempting to offset "noncompensation" from the CDA against future compensation. See Robert D. Surina, 40 Van Natta 1855, 1857 (1988). On the other hand, if the CDA was disapproved, the proceeds would no longer be "noncompensation" and could be considered as a prepayment of future compensation if the CDA so provided. To reach any other conclusion would not only be inconsistent with the reasoning expressed in Surina, but could be interpreted as discouraging carriers from providing compensation other than medical services pending the Board's consideration of the proposed CDA. Such an interpretation would be contrary to the language of ORS 656.236(3), which permits parties to agree to make payments to claimant prior to Board approval of the CDA.

Accordingly, as amended herein, we adhere to our February 19, 1991 order.

IT IS SO ORDERED.

March 8, 1991 Cite as 43 Van Natta 503 (1991)

In the Matter of the Compensation of
CHRISTOPHER P. MURCHIE, Claimant
WCB Case No. 90-11882
ORDER OF ABATEMENT
Ronald M. Somers, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

On February 28, 1991, the Board issued its Order on Review. Our order affirmed the Referee's order which directed the insurer to pay claimant's award of scheduled permanent disability at a rate of $305. In reaching our conclusion, we relied on our decision in Alan G. Herron, 43 Van Natta 267 (1991). Recently, we have abated our order in Alan G. Herron, supra, in order to reconsider the decision. Therefore we find it appropriate to abate our order in the instant case.

Accordingly, our February 28, 1991 order is abated and withdrawn. Following our reconsideration of Alan G. Herron, supra, we will issue a corresponding order in the instant case.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRENDA J. RUSSELL, Claimant
WCB Case No. 89-23753
ORDER ON REVIEW
Dobbins & McCurdy, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Thye's order which found that the issue of extent of permanent disability was barred by claim preclusion. On review, the issue is claim preclusion. We affirm.

FINDINGS OF FACT

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

Claimant was injured on July 26, 1988. The claim was closed by Determination Order on July 3, 1989, which found claimant medically stationary on May 11, 1989, awarded various periods of temporary partial and temporary total disability and awarded no permanent disability. Claimant requested a hearing from that Determination Order, contending that the claim was prematurely closed. A hearing was held on October 12, 1989. An Opinion and Order issued December 15, 1989, affirming the Determination Order.

The December 15, 1989 Opinion and Order affirming the Determination Order, was appealed to the Board. The Board affirmed that Opinion and Order on January 16, 1991 and no request for review was filed with respect to that order.

Claimant requested a second hearing, on November 24, 1989, regarding the July 3, 1989 Determination Order, this time specifying extent of permanent disability as the issue.

ULTIMATE FINDINGS OF FACT

1. The Board's January 16, 1991 order arose from litigation between claimant and the employer regarding the propriety of the claim closure made by the July 3, 1989 Determination Order.

2. The Board's January 16, 1991 order is a final judgment between claimant and the employer.

3. The "claim" asserted by claimant against the employer at the March 29, 1990 hearing is a "claim" involving the same parties as were party to the Board's January 16, 1991 order. The "claim" asserted at the March 29, 1990 hearing was the same "claim" for claim preclusion purposes as was asserted at the October 12, 1989 hearing and which gave rise to the Board's January 16, 1991 order. That "claim" could have been litigated at the earlier hearing and on Board review.

CONCLUSIONS OF LAW AND OPINION

Res judicata, or preclusion by prior adjudication, incorporates two branches, "claim preclusion" and "issue preclusion." The Referee held that

claimant was barred by "claim preclusion" from asserting entitlement to permanent disability compensation at the March 29, 1990 hearing. We agree.

Claim preclusion has been described by the Supreme Court:

> "[A] plaintiff who has prosecuted one action against a defendant through 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 v. EBI Companies, 310 Or 134, 140 (1990). Claim preclusion applies to workers' compensation proceedings. Drews, supra at 142.

At the October 12, 1989 hearing, claimant contested the closure of his claim by the July 3, 1989 Determination Order. Claimant and the employer were parties to that proceeding just as they were to the March 29, 1990 hearing.

The July 3, 1989 Determination Order led to the October 12, 1989 hearing and review by the Board which resulted in its January 16, 1991 order rejecting the contention that the Determination Order was premature and affirming the Determination Order. Whether the Board's order is a final judgment is controlled by statute. In Drews that court said:

> "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)." (footnote omitted) Drews, supra at 149.

Because neither party appealed to the Court of Appeals within 30 days of the Board's January 16, 1991 order, that order is a final judgment for claim preclusion purposes.

Lastly, we conclude that claimant's assertion of entitlement to permanent disability compensation at the March 29, 1990 hearing constituted the same "claim" for claim preclusion purposes as was presented by his assertion of premature closure at the October 12, 1989 hearing and on Board review.

In Drews the court said:

> "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 kinds 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 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." Drews, supra at 146-47.

Here, the "transaction" which gave rise to each of claimant's requests for hearing was the determination of his claim by the July 3, 1989 Determination Order. That "transaction" found that claimant had become medically stationary. Former, ORS 656.268(1) & (2)(a). It authorized the employer to terminate payment of temporary disability compensation. Former ORS 656.268(2)(c). It determined the periods for which temporary partial and temporary total disability compensation was due, and found no permanent partial or permanent total disability compensation was due. Former ORS 656.268(4). The Determination Order also established the duration of claimant's aggravation rights. Former ORS 656.273(4)(a).

Claimant's first request for hearing asserted premature closure, that is, his right to have his claim remain open and to continue to receive temporary disability compensation. The assertion of that right or remedy arose out of the July 3, 1989 Determination Order. Likewise, claimant's second request for hearing, asserting entitlement to permanent disability compensation, arose from the Determination Order. The assertion of entitlement to additional permanent disability compensation could have been asserted and litigated at the earlier hearing and on review. Unless based upon some exception to claim preclusion, claimant's second claim is barred.

One exception to claim preclusion is where, by statutory provision or rule, a final determination of a claim is deemed not conclusive. Drews, supra at 141. See also Restatement (Second) of Judgments 20(1)(c) (1982). We conclude that no such exception exists in the present situation. Former ORS 656.268 provides for a single determination of a claim which establishes if a worker is medically stationary, any additional temporary or permanent disability compensation due and, if appropriate, authorizes adjustments or offsets of compensation paid. See former ORS 656.268(10). Former ORS 656.270 provides that each Determination Order contain an explanation of the parties' rights to a hearing if either is dissatisfied with the determination. Former ORS 656.319(4) deals with a hearing with respect to objections to a determination under ORS 656.268. The statutory scheme appears to contemplate a single hearing addressing all objections to, or asserted rights arising out of a Determination Order. The statutes make no exception to the conclusive effect of a final judgment on a Determination Order. Of course, if the Board's order on the first request for hearing had set aside the Determination Order as premature, claimant would be entitled to raise the permanent disability issue at a later time for, in that circumstance, the Board's order would not have finally determined the claim. Drews, supra.

We would also note that, from a pragmatic standpoint, allowing a party to split the numerous issues (i.e., medically stationary status - premature closure, medically stationary date, temporary partial disability compensation, temporary total disability compensation, permanent partial disability compensation,

permanent total disability compensation and authorization of adjustments or offsets of compensation paid) potentially arising from a single Determination Order would be administratively and judicially unmanageable.

ORDER

The Referee's order dated May 15, 1990 is affirmed.

March 11, 1991 Cite as 43 Van Natta 507 (1991)

In the Matter of the Compensation of
MILTON L. WILSON, Claimant
WCB Case Nos. C1-00183 & C1-00184
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Emmons, et al., Claimant Attorneys
Gail M. Gage (Saif), Defense Attorney

On February 8, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

OAR 436-60-145(4) requires that a claim disposition agreement contain specified information concerning claimant and the history of the claim. A proposed disposition that does not contain the required information will not be approved by the Board. See OAR 436-60-145(5); 438-09-020(1). Such an agreement is deemed unreasonable as a matter of law. ORS 656.236(1)(a); OAR 438-09-020(2).

Here, changes were made to the proposed agreement subsequent to the time it was signed by claimant and his attorney. Under these circumstances, the proposed disposition is unreasonable as a matter of law. See OAR 438-09-020(2). Accordingly, we decline to approve the agreement and return it to the parties.

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

March 12, 1991 Cite as 43 Van Natta 507 (1991)

In the Matter of the Compensation of
JAMES E. HAMMOND, SR., Claimant
WCB Case Nos. 88-18590, 89-04743 & 89-06423
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Daron's order that: (1) upheld the SAIF Corporation's denial of claimant's occupational disease claim for a low back condition on the ground that the claim was not timely filed; (2) upheld SAIF's denial of that same condition as a residual of surgery for claimant's compensable 1986 shoulder/neck injury; and (3) set aside SAIF's denial of that

condition as an aggravation of claimant's compensable 1982 low back injury. On review, the issues are timeliness and compensability of claimant's current condition as a sequela of the shoulder/neck injury, aggravation of the back injury or occupational disease. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the last three paragraphs. We make the following additional findings.

Claimant suffered a severe logging accident during the 1960s when he first began working for the employer. Prior to the 1982 compensable injury, he experienced intermittent back pain but no significant neurological defect.

Claimant was diagnosed with severe degenerative disc disease of the lumbar spine, following the 1982 injury. As a consequence of that injury, his low back pain increased and left leg pain appeared. Following his 1983 surgery and rehabilitation for a disc herniation at L4-5 and L5-S1, claimant's sciatica was relieved. Thereafter, he experienced occasional pain in the back but no leg symptomatology.

Claimant suffered a compensable injury to the head, cervical spine and right shoulder in January 1986. He underwent considerable diagnostic testing. As a consequence of that injury, he was taken off work on April 6, 1987. Decompressive surgery was performed at C4-5 and C5-6 in 1987; shoulder surgery was performed in March 1988.

Claimant suffered an onset of severe low back and right leg pain after the shoulder surgery, without experiencing additional trauma. The pain was caused by herniated discs at L3-4 and L4-5.

FINDINGS OF ULTIMATE FACT

Claimant became disabled in March 1988 as a result of his low back condition. No physician informed him that he suffered from an occupational disease prior to that date.

Claimant first became aware that his symptoms might be compensable as an occupational disease when his attorney so informed him in April 1988. He could not have reasonably become aware of his occupational disease prior to that time.

Claimant's work activities were the major contributing cause of his L3-4 and L4-5 disc herniations for which claimant was treated in 1988.

CONCLUSIONS OF LAW AND OPINION

Compensability of the Low Back Condition as Sequelae of Surgery in the 1986 Claim

Claimant alleged that his low back problems were caused by his March 1988 shoulder surgery. The Referee found that there was insufficient evidence as to what happened at the hospital at the time of surgery to support such a conclusion. On review, claimant argues that Dr. Melgard's opinion that the ruptured disc was a result of the shoulder surgery, combined with claimant's testimony, establishes the March 9, 1988 shoulder surgery was the cause of his ruptured disc. We disagree.

Although claimant testified that he suffered low back and leg pain while recovering from shoulder surgery, the causation of claimant's back condition is

a complex medical question. Thus, while his testimony is probative, the resolution of this case turns on medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 259, 263 (1986).

There is no expert medical evidence to support claimant's contention that his back problem was caused by the shoulder surgery. To the contrary, Dr. McVay opined that claimant's back problem is not a result of his shoulder surgery.

While claimant argues that Dr. Melgard opined that the shoulder surgery caused his back problems, Dr. Melgard merely stated that claimant's back was more symptomatic after the surgery. He did not offer an opinion about the cause of the symptoms.

Claimant has not presented sufficient evidence to establish that his March 1988 shoulder surgery caused his low back problems. Accordingly, we affirm the Referee's order in this regard.

Timeliness

We next address claimant's contention that the Referee erred in finding that he had not filed his occupational disease claim timely and is, therefore, barred by ORS 656.807(1) from asserting the claim. The Referee found that claimant should have known of his occupational disease as of April 1987. Claimant argues that he had no reason to know of the occupational disease until April 1988.

ORS 656.807 provides:

> "(1) All occupational disease claims shall be void unless a claim is filed with the insurer or self-insured employer by whichever is the later of the following dates:
>
> (a) One year from the date the worker first discovered, or in the exercise of reasonable care should have discovered the occupational disease; or
>
> (b) One year from the date the claimant becomes disabled or is informed by a physician that the claimant is suffering from an occupational disease."

Our reading of the statute convinces us that the time limit for filing begins to run from the earlier of the alternatives contained therein. Therefore, we read subsection (b) in the same manner. Thus, we interpret ORS 656.807(1) to say that a claimant must file an occupational disease claim within one year of the later of: (a) the earlier date of when claimant knew or should have known he suffered from an occupational disease; and (b) the earlier date of when claimant became disabled or was informed by a physician that he was suffering from an occupational disease.

Here, claimant suffered minimal low back problems after his recovery from his 1983 surgery until March 1988. Claimant discovered it was possible that he suffered from an occupational disease when he saw his attorney in April 1988. In the exercise of reasonable care, claimant had no reason to discover that he suffered from an occupational disease before that date. Thus, the earlier date with regard to ORS 656.807(1)(a) is April 1988.

The Referee found that claimant became disabled on April 6, 1987 and should have known of the occupational disease as of that date. We disagree.

Claimant became disabled on April 6, 1987 as a result of his neck/shoulder injury, not his low back condition. The low back condition did not become disabling until March 1988, when his low back disc herniations occurred and he experienced a severe flareup of back and leg pain. We find no evidence that a physician informed claimant before March 1988 of the possibility that his low back condition was caused by work exposure other than his 1982 injury. Therefore, the earlier date with regard to ORS 656.807(1)(b) is March 1988.

The later of the dates calculated under ORS 656.807(1)(a) and (b) is April 1988. Therefore, claimant's occupational disease claim must have been filed within one year of April 1988. Claimant's occupational disease claim was filed on May 4, 1988. Thus, the Referee erred in finding that claimant's claim was not filed timely. Accordingly, we reverse the Referee's order on this issue and address the merits of the occupational disease claim.

Occupational Disease Claim

On review, SAIF, relying on Crowe v. Jeld-Wen, Inc., 77 Or App 81 (1985), argues that claimant's 1982 compensable injury precludes him from "converting" his claim to one for an occupational disease, allowing him to "bypass" the accepted claim. SAIF asserts that claimant's new claim can only be based on work exposure after the acceptance of the 1982 injury. We disagree.

Crowe v. Jeld-Wen, Inc., supra, is a responsibility case which does not apply to the present situation. In that case, the court held that the fact that activity at the claimant's second employment caused a condition acquired in the first employment to flareup or worsen does not convert an occupational injury into an occupational disease. The present case does not involve successive employments.

We, instead, rely on the court's opinion in in Kepford v. Weyerhaeuser Co., 77 Or App 363, 366 (1986). There, the court held that job injuries for which compensation had been paid should be considered along with the employment conditions in determining the major contributing cause of the claimant's occupational disease. See Alva L. Hacke, 40 Van Natta 1148 (1988), aff'd 101 Or App 598 (1990). Therefore, we consider claimant's 1982 injury along with his employment conditions in determining the major contributing cause of his occupational disease.

Because claimant's last work exposure occurred prior to January 1, 1988, the law in effect prior to that date governs in this case. Donna E. Aschbacher, 41 Van Natta 1242 (1989). See Johnson v. SAIF, 78 Or App 143 (1986). Therefore, to establish the compensability of his 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 pathological worsening of his low back 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). If claimant's condition preexisted his employment, he must prove that his work activities were the major contributing cause of a worsening of his underlying condition resulting in an increase in pain to the extent that it caused disability or required medical services. See Wheeler v. Boise Cascade Corp., 298 Or 452, 457 (1985); Devereaux v. North Pacific Ins. Co., 74 Or App 385 (1985); SAIF v. Gygi, 55 Or App 570 (1982).

Dr. McVay, orthopedic surgeon, examined claimant on August 3, 1988, as part of the Orthopaedic Consultants' panel. Dr. McVay was deposed on April 18, 1989, and stated that the cause of claimant's current back problem is a combination of his many years of truck driving and his compensable 1982 injury. Dr. McVay opined that driving a truck for long periods of time can lead to herniated

discs. She explained that the impact of striking the seat after bouncing is an important factor in this regard. Claimant testified at hearing that he he was often bounced while driving, occasionally to the point of striking his head on the top of the truck's cab. Dr. McVay's opinion is supported by claimant's treating chiropractor, Dr. Schmidt, who opined that claimant's work activities were the major contributing cause of his low back condition.

Orthopedist Norton, who examined claimant's medical record at SAIF's request, felt that claimant's problems were due solely to his degenerative back disease which, in his opinion, preexisted the 1982 injury. He based his opinion on the degenerative condition and claimant's chronic fluctuating symptoms. Norton explained in his deposition that there are no studies showing a correlation in the development of this disease in relation to specific occupations.

We find the opinion of Dr. McVay more persuasive than that of Dr. Norton. At hearing, over SAIF's objection, claimant offered and the Referee admitted several studies from medical literature which Dr. Norton acknowledged he regularly relied on. We consider these studies for their impeachment value only. Four of the studies specifically related truck driving to an increased risk of herniated discs. Therefore, we find that Dr. Norton's opinion is based on incorrect information. Further, Dr. Norton did not examine claimant, but only reviewed his file, while Dr. McVay performed a complete examination.

In light of these facts, we defer to the opinion of Dr. McVay and find that claimant's work activities were the major contributing cause of his disc herniations, which resulted in an increase in pain to the extent that it caused disability. Claimant has, therefore, established compensability of his condition as an occupational disease. Accordingly, the Referee's order is reversed with regard to this issue.

In light of our conclusion that claimant has established a compensable occupational disease, we do not address his alternative theory of compensability as an aggravation of the 1982 injury.

Attorney Fee at Hearing and on Review

Claimant has prevailed in a rejected case. Consequently, he is entitled to a carrier paid fee. ORS 656.386(1). 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 occupational disease issue is $4,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case and the complexity of the issue.

ORDER

The Referee's order dated November 21, 1989 is reversed in part and affirmed in part. That portion of the order instructing the SAIF Corporation to process claimant's low back condition as an aggravation of his 1982 injury is reversed, and SAIF's denial on that basis is reinstated and upheld. That portion of the order finding claimant's occupational disease claim untimely is reversed. SAIF's denial of claimant's low back condition as an occupational disease is set aside, and the claim is remanded to SAIF for processing as an occupational disease according to law. The remainder of the order is affirmed. For services at hearing and on Board review concerning the occupational disease claim, claimant's attorney is awarded an assessed fee of $4,000, to be paid by SAIF.

In the Matter of the Compensation of
DONALD L. WHITE, Claimant
WCB Case Nos. 89-02927 & 88-17477
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Roy W. Miller (Saif), Defense Attorney
Terrall, et al., Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

The SAIF Corporation requests review of those portions of Referee Galton's order that: (1) set aside its responsibility denial of claimant's upper back condition on and after August 22, 1988; and (2) failed to order EBI Services to reimburse SAIF for temporary total disability benefits paid to claimant after that date. EBI cross-requests review of that portion of the order that set aside its denial of compensability and responsibility for claimant's "new injury" claim for his upper back condition. On review, the issues are compensability, responsibility, reimbursement, and extent of unscheduled permanent partial disability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "FINDINGS OF FACT", with the exception of the last sentence in the third paragraph on page 2, and with the following supplementation.

Claimant's upper and mid back condition was medically stationary immediately prior to the August 22, 1988 injury at EBI's insured. He sustained no permanent impairment as a result of the March 31, 1988 injury with SAIF's insured.

Claimant filed a claim for the August 22, 1988 incident with EBI's insured on August 30, 1988.

FINDINGS OF ULTIMATE FACT

Claimant experienced no permanent loss of earning capacity due to the March 31, 1988 compensable upper and mid back injury with SAIF's insured.

Claimant's August 22, 1988 upper back injury at EBI's insured materially contributed to his disability and need for medical treatment. Moreover, the injury independently contributed to a worsening of claimant's underlying condition.

No ".307 order" issued prior to hearing because EBI denied compensability. Claimant's entitlement to compensation was at risk at the hearing.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found claimant's injury at EBI's insured compensable. We agree, based on the following reasoning.

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 (1990). 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).

EBI contends that claimant's testimony and reports to doctors regarding his injury with its insured were not credible, and that he thus had no injury when EBI was on the risk. The Referee made no credibility finding. In our de novo review of the evidence, we find that, contrary to EBI's contention, testimony by claimant's supervisor and personnel manager establishes that claimant hurt his back on August 22, 1988 after he moved a heavy power washer while working for EBI's insured, and that he was going to the doctor. Within little more than an hour the emergency room physician diagnosed a mid-back strain with muscle tightness and decreased spinal mobility. She restricted claimant to light duty work with no lifting, bending or pushing and prescribed physical therapy and medication for pain. EBI provided no evidence that the injury did not occur as reported or that the injury was not work-related. Accordingly, we find that claimant experienced a work-related injury on August 22, 1988 while employed at EBI's insured that materially contributed to his need for medical treatment. Milburn, supra.

Responsibility

The Referee found that both injuries contributed to claimant's need for medical services and temporary disability benefits. After taking administrative notice of a ".307 order" issued by the Department in a different case in which the Compliance Section apportioned temporary disability payments between two insurers, the Referee then proceeded to apportion claimant's temporary disability payments in this case in a like manner. We disagree with the Referee's analysis.

Apportionment of liability for a claimant's compensation between carriers is not permissible. Bracke v. Baza'r, 293 Or 239, 245 (1982); Inkley v. Forest Fiber Products Corp., 288 Or 337, 342 (1980); UAC v. Hacke, 101 Or App 598 (1990). Instead, responsibility for the entire aggregate disability rests with the carrier responsible under application of the "last injurious exposure rule." Bracke v. Baza'r, supra.

We now proceed to resolve the responsibility dispute under that rule. Where, as here, there is an accepted work-related injury and the evidence establishes that a later incident with a different employer is a work-related injury, there is a rebuttable presumption that responsibility lies with the employer/insurer at the time of the last work-related injury. Boise Cascade v. Starbuck, 296 Or 238, 244 (1984); Industrial Indemnity v. Kearns, 70 Or App 583 (1984); Linda L. Wise, 42 Van Natta 115, 116 (1990). Thus, the burden is on EBI to prove that the August 22, 1988 injury did not independently contribute, however slightly, to the worsening of claimant's underlying condition. Linda L. Wise, supra.

Dr. Harvey diagnosed claimant's March 1988 injury as a thoracic strain. He released claimant to work without restrictions on July 19, 1988. (Ex. 53-4, 68). On August 30, 1988, the Orthopaedic Consultants opined that, if a bone scan was negative, the August 1988 aggravation of claimant's preexisting back condition would be temporary. Dr. Harvey stated that claimant suffered an aggravation of his preexisting thoracic strain without any material worsening of his condition. (Ex. 89). Dr. Finseth, claimant's treating physician for the August 1988 injury, opined that the August injury was a definite contributing factor to claimant's current disability and resulted in a worsening of this original mid-back problem. (Ex. 89 A-1). As of October 1988 claimant was still unable to work and Finseth predicted that he would have permanent disability. (Ex. 89 A-2).

When, as here, medical evidence is divided, we give greater weight to the conclusions of claimant's treating physician, absent persuasive reasons not to

do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). In this case, the Consultants saw claimant only once in conjunction with evaluating his condition for closure of the SAIF claim. Dr. Harvey saw him once prior to terminating his treatment. Dr. Finseth, claimant's treating physician, had the opportunity to see him at frequent intervals over the next several months. She had a better opportunity to evaluate claimant's condition than Dr. Harvey or the Consultants, who examined him on a limited basis. Accordingly, we accept the opinion of the treating physician, Dr. Finseth, and find that the employment at EBI's insured worsened his underlying condition. Consequently, EBI failed to show by a preponderance of the evidence that the August 22, 1988 injury did not independently contribute to claimant's disability. Accordingly, EBI is responsible for payment of claimant's compensation from that date until claim closure. Industrial Indemnity v. Kearns, supra; Linda L. Wise, supra.

Extent of Disability

At hearing, claimant challenged the Determination Order entered March 6, 1989, that closed the original injury claim with SAIF with an award of 18 percent (57.6 degrees) unscheduled permanent disability. SAIF cross-requested a reduction in the award. In apportioning responsibility between SAIF and EBI, the Referee rescinded and set aside that Determination Order. In view of our conclusion that EBI is solely responsible for claimant's condition after the August 22, 1988 injury, we reinstate the March disability from the original injury under the SAIF claim. We rate disability as of the time just prior to the August 22, 1988 injury with EBI. See Larry K. Rose, 41 Van Natta 69, 72 (1989); Mary V. Scholl, 38 Van Natta 1450, 1453 (1986).

Because claimant became medically stationary from the injury with SAIF on July 19, 1988, and the Determination Order issued on March 6, 1989, we apply the version of the "standards" effective at the time of the Determination Order. ORS 656.283(7) and 656.295(5); OAR 438-10-010; former OAR 436-35-270 et seq. In evaluating the extent of unscheduled permanent partial disability for claimant's original low back injury, we consider the impairment due to the injury as reflected in the medical record and any credible testimony at the hearing, as modified by age, education and adaptability set forth in former OAR 436-35-270 et seq. Dr. Harvey reported that claimant had normal range of motion in the neck and shoulders, with no pain or tenderness. He stated that claimant had no residual impairment and released him to regular work. We defer to Dr. Harvey's opinion and conclude claimant sustained no permanent impairment from the injury with SAIF. There shall be no unscheduled permanent disability award if the injury did not result in impairment. Former OAR 436-35-280(1). Consequently, we rate claimant's unscheduled permanent disability at 0.

Reimbursement

Anticipating our reversal of that portion of the Referee's order that set aside its responsibility denial, SAIF requests that the Board order EBI to reimburse it for temporary total disability payments made by SAIF to claimant from September 28, 1988 through January 31, 1989. However, our jurisdiction is restricted to matter concerning a claim, which is defined as those matters in which a worker's right to receive compensation or the amount thereof is in 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). 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 Insurance Corp. v. SAIF, 99 Or App 729 (1989); Roger F. Oman, 42 Van Natta 2121 (1990).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review concerning EBI's compensability denial is $200, to be paid by EBI. In reaching this conclusion, we have particularly considered the complexity of the issue, the value of the interest involved and the fact that claimant's counsel's services regarding the compensability issue were limited to reviewing EBI's brief on review.

ORDER

The Referee's order dated May 30, 1989 is reversed in part and affirmed in part. That portion of the order that rescinded and set aside the March 6, 1989 Determination Order is reversed. The Determination Order is reinstated, but modified. In lieu of the Determination Order award of 18 percent (57.6 degrees) unscheduled permanent disability, claimant is awarded no unscheduled permanent disability. The Determination Order award of temporary total disability is modified to encompass only the period of March 31, 1988 through July 19, 1988. That portion of the Referee's order that set aside the SAIF Corporation's May 4, 1989 responsibility denial is reversed and the denial is reinstated and upheld. The $950 attorney fee assessed to SAIF is reversed. The claim is remanded to EBI Services to be processed according to law. That portion of the order set forth as "HEARING ORDER DESIGNATING PAYING AGENT" is reversed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded $200, to be paid by EBI.

In the Matter of the Compensation of
ALENE M. ALLEN, Claimant
WCB Case No. 89-10499
ORDER ON REVIEW
Tooze, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

The self-insured employer requests review of that portion of Referee Harri's order that set aside its denial of claimant's occupational disease claim for her current cervical condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact, with the exception of the Referee's finding that claimant filed her occupational disease claim on December 30, 1987.

CONCLUSIONS OF LAW AND OPINION

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

In concluding that claimant's cervical condition was compensable, the Referee applied the occupational disease law that became effective January 1, 1988. See former ORS 656.802(1)(c); Donna E. Aschbacher, 41 Van Natta 1242 (1989); Carole J. Damm, 42 Van Natta 225 (1990). Claimant's burden under that law is to prove that her work exposure was a material cause of either increased symptoms or a worsening of her underlying condition.

Although claimant signed her 801 form on December 30, 1987, there is no evidence that the form was filed with the employer on that date. Because we are unable to ascertain whether claimant's claim was filed in 1987 or 1988, we consider whether the cervical condition claim would have been compensable under the law in effect in 1987. In order to establish compensability under the pre-1988 law, claimant must prove that her work exposure was the major contributing cause of the onset, or pathological worsening, of her cervical condition. Weller v. Union Carbide Corp., 288 Or 27, 35 (1979); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983).

On August 23, 1989, Dr. Nash, claimant's treating physician, reported that, in his opinion, "the cervical neuroradiculopathy at C6-C7, primarily on the right has been significantly worsened and has produced structural changes within the nerve at C6-7 incident to the work efforts repetitively over a period of 22 years of checking." Dr. Nash also reported that, "the patient's work was the major contributing cause of this patient's condition and may indeed has (sic) resulted in pathological changes in the nerve as evidenced by neurologic examination."

In a December 1, 1989 letter, Dr. Nash wrote that claimant had been assigned work that required "near-sustained cervical motion...." Dr. Nash opined that "such repetitive efforts over a period of time, with the changes as noted in the cervical spine being apparent, would make symptomatic the cervical disc changes that without her work effort would be asymptomatic." He concluded that, "(t)he basis for this would be structural changes in the cervical spine...."

We conclude that claimant's work activity was the major contributing cause of the worsening of her underlying cervical condition. Accordingly, even if her claim is subject to the law in effect in 1987, claimant has established the compensability of her cervical condition.

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 is $850, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted (as represented by claimant's respondent's brief), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated February 1, 1990, as reconsidered March 27, 1990, is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed fee of $850, payable by the self-insured employer.

In the Matter of the Compensation of
CHRISTOPHER J. ANDERSON, Claimant
WCB Case No. 89-20011
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

The insurer requests review of those portions of Referee Bennett's order that: (1) set aside its denial of claimant's chiropractic treatment in excess of the administrative guidelines; and (2) assessed an attorney fee for claimant's counsel's services in obtaining acceptance of his lumbar claim. On review, the issues are medical services and attorney fees. We reverse.

FINDINGS OF FACT

On July 18, 1989, claimant was injured when he fell off of a table at work. As a result of the accident, claimant sustained injuries to his right knee, low back, mid-back and neck. On August 22, 1989, the insurer accepted claimant's right knee and cervical conditions.

Following the July 18 accident, claimant sought treatment from Dr. Graffeo, D.C. Claimant treated with Dr. Graffeo on the following schedule: 9 times in July, 17 in August, 14 in September, 10 in October, 8 in November, 11 in December, 8 in January and 3 times in February.

An MRI scan taken September 12, 1989, showed normal findings. Claimant was released to light duty work on September 29, 1989.

On October 16, 1989, the insurer denied claimant's chiropractic treatments in excess of the administrative guidelines.

The insurer never formally denied claimant's lumbar injury claim. On October 6, 1989, claimant's counsel filed a request for hearing on the "de facto" denial of lumbar and thoracic injuries. One month prior to the hearing, the insurer orally accepted the lumbar claim.

CONCLUSIONS OF LAW AND OPINION

Medical services

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).

In the present case, the Referee relied upon claimant's testimony and the opinion of Dr. Graffeo, claimant's treating chiropractor. The Referee concluded that chiropractic care in excess of the guidelines was reasonable and necessary.

The insurer argues that Dr. Graffeo's treatment offers, at best, temporary relief on a palliative basis. The insurer contends that, although he had received frequent treatments from Dr. Graffeo for over two months on September 29, claimant indicated that he was only 7 percent better. At the hearing in February 1990, claimant testified that he had recently gone off work because his symptoms became aggravated when he climbed over and around debris at work.

In September 1989, the Orthopaedic Consultants reported that claimant's MRI scan was normal. The Consultants felt that claimant was medically stationary and could return to his previous occupation without limitations. They recommended no further medical or chiropractic treatment.

In September 1989, Dr. Graffeo referred claimant to Dr. Radecki, M.D. Dr. Radecki reported that x-rays and an MRI scan were both normal. He recommended a home exercise and stretching program for claimant. In addition, Dr. Radecki reported to Dr. Graffeo that claimant did not require surgery and conservative therapy such as "therapeutic modalities, heat, ultrasound, etc.," which would most likely make no difference in his overall improvement.

In November 1989, Dr. Zivin reported that claimant was medically stationary with no impairment from his injury. Dr. Zivin found only "very minor restrictions of mobility and pain" and reported that MRI studies were normal.

He concluded that claimant was not in need of ongoing chiropractic treatment and the number of treatments he had already undergone was excessive.

Although Dr. Graffeo has opined that claimant's treatments are reasonable and necessary, we are not persuaded by his opinion. In his July 19, 1989 "form" letter, Dr. Graffeo indicates that objective findings substantiate the patient's subjective complaints and specific treatments (i.e., adjustments, ultrasound, etc.) are recommended. Dr. Graffeo also reports that it has been determined that, based upon the subjective complaints and the objective findings, claimant should receive treatment in excess of the guidelines.

At hearing, Dr. Graffeo testified that he used a form letter because all of the patients he treats have objective findings that substantiate their subjective complaints. Dr. Graffeo stated that, depending on the condition, all workers would require the specific treatments recommended in the form letter. He also testified that the vast majority of workers he saw required treatment in excess of the guidelines.

Because Dr. Graffeo's report is simply a form letter that routinely reports a requirement for treatment in excess of the administrative guideline, we do not find his opinion to be persuasive. We rely instead upon the well-reasoned reports of Dr. Zivin, the Orthopaedic Consultants and Dr. Radecki. Based upon the medical reports, we conclude that claimant has not established that he is entitled to treatment in excess of the guidelines.

Attorney Fees

The Referee concluded that claimant's counsel was entitled to an assessed attorney fee of $1,000 for his efforts in obtaining acceptance of claimant's lumbar claim. We disagree.

Here, the Referee did not address the merits of claimant's lumbar claim, nor did he order the claim accepted. Before an attorney fee may be assessed, claimant must finally prevail in a hearing before a Referee. See ORS 656.386(1); Duane L. Jones, 42 Van Natta 875 (1990). In the present case, we are unable to conclude that claimant finally prevailed in a hearing before a Referee. Accordingly, we reverse the Referee's award of an assessed attorney fee.

ORDER

The Referee's order dated April 2, 1990 is reversed. The insurer's denial is reinstated and upheld with regard to treatment in excess of two times per month through the date of hearing. The Referee's award of a $1,000 attorney fee for claimant's counsel's prehearing services in obtaining acceptance of the lumbar claim is reversed. The Referee's assessed attorney fee award of $2,100 for services at hearing is also reversed.

In the Matter of the Compensation of
GERALDINE M. BRADSHAW-COE, Claimant
WCB Case No. 88-20559
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Acker, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Knapp's order which unheld Liberty Northwest Insurance Corporation's denial, on behalf of Mohawk restaurant, of her

occupational disease claim for a shoulder condition. In its brief, Liberty contends that the Referee erred in denying its motion to dismiss the hearing request. On review, the issues are dismissal and responsibility. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Dismissal

The employer, Mohawk Restaurant, filed a motion to dismiss claimant's request for hearing on a denial of her injury claim because her claim had been accepted by her former employer, Columbia Plywood, as an aggravation of a previously accepted claim.

We note that by proceeding to hearing under a "new injury/occupational disease" theory, a new five-year period of aggravation rights, ORS 656.273(4)(a), would accrue if claimant were successful. There was also the potential that a greater temporary disability rate could be at issue. Thus, claimant had benefits at stake and was, therefore, entitled to prove that Columbia Plywood was wrong in accepting the aggravation claim, and that, in reality, claimant had sustained a new injury/occupational disease for which Mohawk was responsible. Accordingly, claimant was not procedurally barred from litigating her request for hearing asserting a "new injury/occupational disease" claim. Jon F. Wilson, 42 Van Natta 2595 (1990); see Karen L. Nickols, 41 Van Natta 2414 (1989).

Responsibility

The Referee found that, under former ORS 656.802(1)(c), claimant need only establish that her work activities were a material contributing cause of her condition or a worsening of her underlying condition. Additionally, he found that the statute did not change the application of the rule in Weller v. Union Carbide Corp., 288 Or 27, (1979), requiring that claimant prove that her underlying condition was worsened. He then found that claimant had not met her burden of proving that her underlying condition had worsened. We agree with the Referee's conclusion that Mohawk is not responsible for claimant's condition as a "new injury," we do so based upon the following reasoning.

Subsequent to the Referee's order and the submission of claimant's brief in case, the Board issued Donna E. Aschbacher, 41 Van Natta 1242 (1989), which held t in order to establish a compensable occupational disease, claimant need only prov that her work exposure was a material contributing cause of either increased sympt or a worsening of her underlying condition requiring medical services or resultin disability. Claimant contends that she has met her burden under that standard

However, this case involves an accepted compensable injury followed by an increase in disability during employment with a later employer/insurer. In such a case, responsibility is fixed with the employer/insurer which accepted the claim. In order for responsibility to shift, it must be established that a later employment independently contributed to a pathological worsening of the accepted condition. Spurlock v. International Paper Co., 89 Or App 461 (1988); Crowe v. Jeld-Wen, 77 Or App 81 (1985); see Hensel Phelps v. Mirich, 81 Or App 290 (1986). Accordingly, in a case such as this one, where compensability of the claimed condition is not at issue, and only responsibility for a new occupational disease as opposed to aggravation of a prior injury is in dispute, claimant or the earlier employer must prove, by a preponderance of the evidence, that claimant's work activities with the later employer independently contributed to a worsening of

her underlying condition. See Christine Y. Zorn, 43 Van Natta 237 (1991). Proof of a symptomatic worsening only is not sufficient to shift responsibility to the later employer. David L. Cisneros, 43 Van Natta 240 (1991).

Considering the abovementioned distinction, we conclude that claimant's work activities at Mohawk have not independently contributed to a worsening of claimant's underlying condition. Claimant suffered an aggravation for which Columbia Plywood has accepted responsibility. He has not proven that he suffered a new occupational disease.

ORDER

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

March 13, 1991 Cite as 43 Van Natta 520 (1991)

In the Matter of the Compensation of
JUEL L. FADNESS, Claimant
WCB Case No. 89-10074
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Menashe's order which: (1) declined to grant permanent total disability; and (2) increased his unscheduled permanent disability award for his low back condition from 44 percent (140.8 degrees), as awarded by Determination Order, to 75 percent (240 degrees). The self-insured employer cross-requests review of that portion of the Referee's order that increased claimant's unscheduled permanent disability award. On review, the issue is extent of unscheduled permanent disability, including permanent total disability. We affirm in part and modify in part.

FINDINGS OF FACT

With the exception of the last paragraph, we adopt the Referee's "Findings of Fact" with the following supplementation and clarification.

Claimant returned to work following his 1984 surgery. He had difficulty performing his job as a mechanic. Because of his back problems, and at the suggestion of co-workers, claimant took early retirement at a reduced benefit level in April 1985.

Claimant reported to his treating physician, Dr. Hill, M.D., in August 1988, that he has continued to have back discomfort since the 1984 surgery and his discomfort has gotten steadily worse in the last few months. (Ex. 28-1). In August 1988, Dr. Hill reported that claimant had "limited range of motion on flexion and extension." (Ex. 28-1). In September 1988, claimant underwent the second L4-5 laminectomy and diskectomy since the 1983 injury. (Ex. 36).

Claimant was examined in November 1988, February 1989 and July 1989 by the Orthopaedic Consultants. (Exs. 40, 42 & 46). Dr. Brown, neurologist, was the examining physician of signature on all three Consultants' reports. Surveillance films taken of claimant in August and September 1989 were shown to Dr. Brown during his October 2, 1989 deposition. (Ex. 52-5). Claimant told Dr. Brown, on July 28, that he could no longer work on his cars because of his pain. (Ex. 46-2; Ex. 52-6 & 7). The surveillance films show claimant working on his cars including climbing under the car. (Exs. 49 & 50; Tr. 205-206). During the

July 1989 Consultants' examination, claimant limped on his left leg. (Exs. 46-3, 52-7). Claimant did not limp in the surveillance film made in August and September 1989. (Exs. 49 & 50; 52-7). During his deposition, Dr. Brown noted that claimant did not limp in the surveillance films. (Ex. 52-7). Dr. Brown testified that claimant exhibited more mobility in the surveillance films than he had in the July 28, 1989 examination and had claimant moved during the examination as he did in the films, the measured limitations on range of motion would have been less. (Ex. 52-6, 52-10).

On October 21, 1988, Dr. Hill, neurosurgeon, claimant's treating physician, found claimant's condition "stable" and recommended claim closure. (Ex. 38). On August 29, 1989, Dr. Brown released claimant to work in a file clerk position offered to claimant by the self-insured employer. (Exs. 47 & 48). The "work offer" was not sent to claimant by certified mail with return receipt requested nor delivered in person. (See Ex. 47). At the time of the hearing, claimant had not accepted the modified job offer. (Tr. 146).

Claimant was a truck mechanic at the time of injury.

Claimant is not a credible witness based on the substance of his testimony.

CONCLUSIONS OF LAW AND OPINION

Credibility

The Referee made no express credibility finding. We are as capable as the Referee at assessing credibility when we do so based on the substance of a witness' testimony. Davies v. Hanel Lumber Co., 67 Or App 35 (1984). Claimant told the examining physicians at the Orthopaedic Consultants in July 1989, that he could no longer work on his cars due to his pain and discomfort from his back condition and surgeries. Additionally, claimant limped during the examination and painfully expressed inability to make certain movements during the range of motion examination. Yet, one month later, surveillance films show that claimant can work on his car, can climb under his car and walks without a limp. Accordingly, we conclude that the surveillance films impeach claimant and that claimant's statements regarding the extent of his pain and disability, whether made to physicians in January or July or at the October 1989 hearing, are not credible and not to be considered in determining the extent of claimant's disability.

Permanent Total Disability

The Referee concluded that claimant is not permanently totally disabled. Upon our de novo review of the evidence, in particular the surveillance films and Dr. Brown's opinion that claimant is physically capable of performing some work activity, we concur with the Referee that claimant has not carried his burden to prove that he is permanently totally disabled.

Claimant argues that he is permanently totally disabled under the "odd-lot" doctrine, because he is willing to re-enter the work force but is precluded from doing so because it would be futile considering his poor education, age and poor adaptability to nonphysical labor. To support his argument, claimant refers to the testimony of Dr. Rollins, Ph.D., rehabilitation. The record indicates that Dr. Rollins interviewed claimant in June 1989 and reviewed claimant's medical file. Dr. Rollins expressed his opinion of claimant's physical condition relying on his own observations and on Dr. Brown's reports created prior to Dr. Brown's viewing the surveillance films. Because Dr. Rollins is a rehabilitation expert but has not been shown to have medical expertise, his assessment of claimant's physical impairment is not persuasive.

Dr. Rollins testified that claimant can not return to his work activity at the time of his retirement in 1985. Dr. Rollins also testified that he does not know if claimant could perform any other job. However, Dr. Rollins does not think it would be futile for claimant to try the work activities described in the existing, modified work offered by the employer. (Tr. 89, 93).

Accordingly, we conclude that Dr. Rollins does not advance claimant's argument and that claimant has not shown that he is permanently totally disabled under the odd-lot doctrine.

Unscheduled Permanent Disability

The Referee increased claimant's unscheduled permanent disability award from 44 percent to 75 percent. The self-insured employer cross-requests review, asking for a reduction to 60 percent. Because the parties dispute all values under the "standards" calculations other than the values for age and formal education, we rate claimant's permanent disability de novo.

For purposes of determining injury-related permanent partial disability, former 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(1).

Because claimant's claim was closed by Determination Order on April 26, 1989, the "standards" effective at that time are used in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled 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. Former OAR 436-35-280.

Age and Education

The appropriate value for claimant's age of 66 years is 1. Former OAR 436-35-290.

The appropriate value for claimant's 6 years of formal education is 1. Former OAR 436-35-300(3).

The highest specific vocational pursuit (SVP) level demonstrated by a claimant during the ten years preceding the date of determination is used to determine a value for skills. Former OAR 436-35-300(4). For our purposes, permanent disability is determined on the date of hearing. The position which claimant successfully performed during the ten years preceding the date of hearing, which has the highest specific vocational pursuit (SVP) level, 7, was as a truck mechanic (DOT # 620-281-000). Therefore, the appropriate value for skills is 1. Former OAR 436-35-300(4).

Whether claimant is entitled to a value for training under former OAR 436-35-300(5) is dependent upon whether or not claimant has demonstrated competence in some specific vocational pursuit. Competence in some "specific vocational

pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off the job to perform other than an entry-level position. Larry L. McDougal, 42 Van Natta 1544 (1990).

Here, claimant has demonstrated competence as a truck mechanic and the appropriate value for training is 0. Former OAR 436-35-300(5).

The total value for claimant's age, education and training, is 3.

Adaptability

Under former OAR 436-35-310, adaptability values range from 0 to 10. No adaptability value is given for a claimant who has returned to his usual and customary work or accepted a work offer for usual and customary work. Neither is a value given to a claimant who has received a "work offer" for usual and customary work but who has refused or has not responded to the "work offer." Former OAR 436-35-310(2)(a) & (b). Former OAR 436-35-310(2) does not apply in this case.

An adaptability value for a claimant who is unable to return to his usual and customary work but who has returned to, or received a "work offer" for, modified work is determined from a matrix of values at former OAR 436-35-310(3). Pursuant to former OAR 436-35-270(3)(d), a "work offer" as used in former OAR 436-35-310 means delivery in person or by certified mail, return receipt requested, of a written offer of work by the employer to which there is a physician's release. A "physicians' release" refers to a release by claimant's "attending physician." Former OAR 436-35-270(3)(c).

In the present case, a work offer was signed by Dr. Brown who is not claimant's treating physician. Additionally, this work offer was transmitted to claimant by means not in evidence. We conclude, therefore, that the employer has failed to establish that the work offer was transmitted by certified mail or in person. Accordingly, we conclude that the offer is not a valid "work offer" for purposes of determining adaptability pursuant to former OAR 436-35-310. Because claimant has not returned to modified work nor received a "work offer" for such work, former OAR 436-35-310(3) does not apply in this case.

Former OAR 436-35-310(4) is used to assign an adaptability value when a worker has not received a "work offer" [See Donna Yancey, 42 Van Natta 2651 (1990)] or "as a result of the injury, the worker is not working." Claimant retired from employment in April 1985 at the age of 62 years, for reasons related to his compensable injury. His continued inability to perform his work as a mechanic is due to his compensable injury. Therefore, former OAR 436-35-310(4) is applicable in this case. See Kenneth H. Parks, 42 Van Natta 2620 (1990).

An adaptability value under former OAR 436-35-310(4) is determined by the injured worker's residual physical capacity as measured by his or her ability to lift. Here, there is no reliable evidence from which we can determine claimant's ability to lift. We, therefore, utilize the value conceded by the employer in its brief. That value is 8.

Impairment

Because he found that the surveillance films show claimant has more physical capacity than than the July 1989, Orthopaedic Consultants' examination report and that, therefore, claimant's testimony regarding his physical limitations could not be relied upon, the Referee turned to the February 28, 1989 Orthopaedic Consultants' report to evaluate claimant's loss of range of motion.

We have found that claimant is not credible and Dr. Brown has testified that, because of claimant's actions, some measurements of claimant's ranges of motion were not accurate. Therefore, we conclude that any range of motion findings by physicians whether in February or July are unreliable because such range of motion findings are necessarily based on the subjective reporting/performance of a noncredible claimant. (Ex. 54, p. 10). Consequently, there is no reliable evidence of loss of range of motion since the 1988 surgery with respect to which impairment values can be assigned under former OAR 436-35-360.

The Referee assigned a value of 10 percent for claimant's two laminectomy surgeries -- 5 percent for each surgery under former OAR 436-35-350. The employer argues that claimant should be entitled to 20 percent because claimant has had four laminectomies. Neither assertion is correct.

We only have jurisdiction to determine the extent of permanent partial disability claimant has suffered as a result of his 1983 injury. See former ORS 656.214(5). Since his 1983 injury, claimant has had two laminectomies/ discectomies at L4-5, in 1984 and 1988. Where a second surgery is performed at the same site with no evidence that the second surgery resulted in any greater residual impairment than a single such surgery, the presumed residual impairment value provided for such surgery by the "standards" is awarded once only. See Claudia J. Percy, 42 Van Natta 1209 (1990); Harold L. McAllister, 42 Van Natta 1179 (1990). The evidence does not establish that claimant's 1988 surgery increased his permanent impairment. Claimant is entitled to a value of 5 percent for low back surgery. Former OAR 436-35-350(2).

The Referee found a value of 5 percent for a chronic condition limiting claimant's ability to repetitively use his low back pursuant to former OAR 436-35-320(4). Because we conclude that there is no reliable medical evidence in the record to support this finding, and because we find claimant not credible, we conclude that claimant is entitled to no value for repetitive use limitations stemming from a chronic condition.

Claimant's total impairment value in the thoracolumbar area is 5 percent. Former OAR 436-35-360(11).

Computation of Unscheduled Permanent Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. The sum of claimant's age and education 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, 5, the result is 29 percent unscheduled permanent partial disability under the "standards". Former OAR 436-35-280(7).

Disability In Excess of the Standards Determination

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." Former 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).

Without indicating what evidence we should consider, claimant argues that there is clear and convincing evidence that claimant's loss of earning capacity is 100 percent. Based in part upon Dr. Brown's opinion as it is reflected in his medical reports made prior to his viewing the surveillance films, and in part on additional consideration of claimant's advanced age and lack of

education, the Referee found clear and convincing evidence that claimant's disability is more than as measured under the "standards."

We do not agree that Dr. Brown's opinion advances claimant's argument that he is entitled to more of an award than found under the "standards." Dr. Brown testified that claimant exhibited in the films more mobility than he had in the July 28, 1989 examination and that had claimant moved during the examination as he did in the films, his impairment measurements would have been less. Prior to his viewing the surveillance films, Dr. Brown considered claimant's advanced age and the surgeries resulting from both of claimant's compensable injuries and opined that claimant had sustained 30 percent impairment. (Ex. 42-4). After viewing the surveillance films, Dr. Brown continued to consider that claimant was very disabled, however, he did so based on claimant's advanced age, poor education and skills. (See Ex. 52).

Additionally, the Referee relied on the opinion of Dr. Rollins who stated that he thought claimant's ability to find appropriate work was slim. We disagree with the Referee's reliance upon Dr. Rollins' opinion as stated prior to Dr. Brown's viewing the surveillance films. We do not find Dr. Rollins' opinion persuasive.

Despite claimant's lack of credibility, we consider the record as a whole, and in particular medical opinions, claimant's age of 66 years at the time of hearing, his limited education and his two injury-related surgeries, to constitute clear and convincing evidence that claimant suffers more than 29 percent permanent disability. However, we do not find clear and convincing evidence that claimant's disability due to the 1983 injury is greater than 60 percent.

The Referee awarded claimant 31 percent unscheduled permanent disability in addition to the 44 percent awarded by the April 26, 1989 Determination Order. The self-insured employer only requests a reduction to 60 percent. Therefore, we conclude that claimant is entitled to a total award of 60 percent (192 degrees) unscheduled permanent disability.

ORDER

The Referee's order dated December 8, 1989 is affirmed in part and modified in part. In lieu of the Referee's increased award of unscheduled permanent disability, claimant is awarded 16 percent (51.2 degrees) unscheduled permanent disability in addition to the 44 percent (140.8 degrees) awarded by Determination Order, for a total award of 60 percent (192 degrees). The remainder of the Referee's order is affirmed. Claimant's out-of-compensation attorney fee shall be adjusted accordingly.

March 13, 1991 Cite as 43 Van Natta 525 (1991)

In the Matter of the Compensation of
DENNIS L. HUGHES, Claimant
WCB Case No. C1-00432
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Ginsburg, et al., Claimant Attorneys
Nelson, et al., Defense Attorneys

On February 20, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

A proposed disposition must be set aside if it fails to include all information required by OAR 436-60-145. OAR 438-09-020. One element of a disposition required by OAR 436-60-145 is a summary sheet listing the total amount to be paid to claimant. OAR 436-60-145(3) & (5); DIF Bulletin No. 217 (Revised 12/26/90).

Here, the consideration amount is in doubt. The summary sheet lists the consideration to claimant as $5,000 ($1,250 attorney fee and $3,750 proceeds to claimant). However, the proposed claim disposition agreement also purports to award claimant an additional $2,400 for extent of disability ($600 attorney fee, $1,800 proceeds to claimant). The proposed claim disposition also states: "should the value of scheduled injuries later be determined to properly be $305 per degree, for injuries/occupational diseases occurring prior to May 1, 1990, and where the extent of permanent disability is litigated subsequent to May 1, 1990, Liberty shall make payment of an additional two thousand four hundred dollars ($2,400) to claimant." Given that contingency, we cannot determine the amount of consideration. Inasmuch as the summary sheet fails to indicate the amount to be paid to claimant, the agreement does not comply with OAR 436-60-145 and must be disapproved. OAR 438-09-020.

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
SEYMOUR HUSSERL, Claimant
WCB Case No. 89-14521
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Menashe's order that upheld the SAIF Corporation's denials of his: (1) myocardial infarction claim; (2) angina condition claim; and (3) 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 Board adopts the Referee's "Opinion and Conclusions," with the following supplementation.

Dr. Turco reported that claimant had experienced stress associated with his termination. ORS 656.802(2) provides that, 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 generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment." (Emphasis added).

Because Dr. Turco listed claimant's termination as a condition causing stress, we conclude that, even if claimant established a mental disorder, he has not shown by clear and convincing evidence that the disorder arose out of and in the course of employment. See ORS 656.802(2)(d).

ORDER

The Referee's order dated March 15, 1990 is affirmed.

March 13, 1991 Cite as 43 Van Natta 527 (1991)

In the Matter of the Compensation of
DEAN L. WATKINS, Claimant
WCB Case No. 89-02361
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Bottini, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The self-insured employer requests review of Referee Lipton's order that: (1) set aside its January 30, 1989 partial denial of medical services; and (2) found that a Determination Order had prematurely closed claimant's jaw injury claim. The employer also objects to the Referee's evidentiary rulings declining to admit impeachment evidence and refusing to allow an offer of proof. The employer moves for remand for the taking of additional evidence. Finally, the employer moves for consolidation of the present case (WCB Case No. 89-02361) with WCB Case No. 89-24358 and requests oral argument before the Board in both cases. In his respondent's brief, claimant objects to those portions of the Referee's order that: (1) upheld the employer's June 26, 1989 partial denial of his medical services claim for broken incisors; (2) found claimant's vestibular condition not compensable; and (3) awarded a $6,000 assessed attorney fee for services at hearing. Claimant also contends that he is permanently and totally disabled. In the alternative, claimant seeks entitlement to awards of permanent disability, both scheduled and unscheduled. On review, the issues are oral argument, consolidation, evidence, remand, prospective denial, premature closure, medical services, compensability, extent of permanent disability, including permanent total disability and attorney fees. We deny the motions, affirm in part and reverse in part.

FINDINGS OF FACT

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

Between 1972 and 1983, claimant was injured in two noncompensable auto accidents, injuring his neck, low back, hip and shoulders. He underwent a noncompensable finger amputation, sustained two noncompensable falls, injured his

left foot and ankle, sustained a noncompensable head injury in an explosion, and underwent a hernia repair. As a result of the explosion, claimant sustained severe head injuries and suffered ongoing headaches and pain in his arms, back, chest, groin and abdomen. Claimant has received psychiatric treatment for various emotional problems since at least 1974. Claimant suffered from no disabling conditions at the time of his 1983 compensable injury.

On January 30, 1989, the employer issued a partial denial of further treatment by Dr. Grimm, M.D., Dr. Crow, psychologist, and Dr. Tenhulzen, D.M.D. The denial also denied further narcotic medication. In the denial, the employer asserted its right to preauthorize treatment other than that provided by Dr. Merrill, D.D.S. and Dr. Parvaresh, psychologist. (Ex. 167).

On June 26, 1989, the employer issued a partial denial of medical services for claimant's broken upper incisors.

Claimant is not credible.

At the time of claim closure, claimant's compensable bilateral temporomandibular joint (TMJ) dysfunction condition and his psychological condition could not be expected to improve with further treatment or the passage of time.

Claimant is not permanently and totally physically incapacitated. Claimant is not willing to work, nor has he made reasonable efforts to find work. It is not futile for claimant to seek suitable employment.

Claimant, 34 years of age at hearing, has a high school diploma. He has worked as a truck driver during the ten years preceding the date of hearing. His highest specific vocational preparation (SVP) value during those ten years was a 4. Claimant has demonstrated competence in a specific vocational pursuit.

Claimant has not returned to work, nor has he been offered work. Claimant is not working for reasons other than his compensable injury. His compensable injury does not prevent him from returning to his usual and customary work.

Claimant suffers from a chronic condition which limits repetitive use of his jaw. Claimant has permanent loss of earning capacity resulting from his compensable 1983 injury.

CONCLUSIONS OF LAW AND OPINION

Request for Oral Arguments/Consolidation

The employer moves for consolidation of the present case (WCB Case No. 89-02361) with WCB Case No. 89-24358 and requests oral argument before the Board in both cases. We proceed to address each request.

The Board does not ordinarily entertain oral argument. See OAR 438-11-020; OAR 438-11-015. Here, claimant objects to the employer's request for oral argument. Inasmuch as the matter has been fully briefed by the parties, the employer's request for oral argument is denied.

At the time the Board received the employer's motion for consolidation, we had already begun the review process in WCB Case No. 89-02361. Therefore, we deny the motion for consolidation.

Evidentiary Ruling/Offer of Proof/Remand

The employer objects to the Referee's evidentiary ruling declining to admit impeachment evidence and refusing to allow an offer of proof, i.e., the impeaching documents. The documents were a copy of an undated, unsigned police report reflecting claimant's 1983 assault and a copy of a petition for restraining order signed by claimant on August 20, 1984. The employer, in the alternative, seeks remand for the taking of additional evidence, i.e., the two documents which the employer attempted to have admitted as an offer of proof.

At hearing, the employer sought to impeach both claimant and his wife with the two documents which were not in the record. After the Referee sustained claimant's objection to such impeachment, the employer offered the two documents as an offer of proof. The Referee declined to admit the two documents.

ORS 656.283(7) sets the standards by which evidence is admitted in workers' compensation hearings. The statute specifically states that "the referee is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice." ORS 656.283(7). Furthermore, OAR 438-07-017 allows that documents reasonably believed relevant and material only for purposes of impeaching a witness may be offered and admitted solely for purposes of impeachment, but may not be considered by the referee as substantive evidence. The relevant statutes and rules are framed in permissive, rather than mandatory, language. Thus, referees have discretion to allow and deny admission of evidence at hearing. Shirlene E. Volcay, 42 Van Natta 2773 (1990); Jackson P. Shull, 42 Van Natta 1206 (1990); Elsie Lumpkins, 40 Van Natta 1571 (1988); See OAR 438-07-017.

Here, the employer offered the documents as an offer of proof, i.e., for purposes of impeachment. After our review of the record, we find that although the documents which the employer sought to be admitted were relevant, they are merely cumulative impeachment evidence. Consequently, we find that the Referee did not abuse his discretion in denying the employer's request to admit the impeachment evidence, i.e., the two documents.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5); See Keinow's Food Stores v. Lyster, 79 Or App 416 (1986). 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. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Osborn, 37 Or App 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986).

The employer contends that the record is incomplete because the Referee failed to admit two documents. As we have already found, the two documents represent cumulative impeachment evidence.

Accordingly, we find that the record, lacking the two documents, was not improperly, incompletely or otherwise insufficiently developed. Therefore, we deny the motion to remand.

Premature Closure

The Referee found that claimant met his burden of proving that his claim was prematurely closed. We disagree.

Claimant's 1983 injury claim was prematurely closed if his compensable condition was not medically stationary at the time the claim was closed by the

February 22, 1989 Determination Order. "Medically stationary" means no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). It is claimant's burden to establish that he was not medically stationary when the claim was closed. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981); Brad T. Gribble, 37 Van Natta 92 (1985). 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). Claimant failed to meet his burden.

When there is a dispute between medical experts, the greater weight will be given to those medical opinions 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).

We first note the employer's contention that claimant is not credible. We agree.

The Referee did not make a credibility finding. In the absence of an express credibility finding by the Referee, we make the necessary credibility findings based on the substance of the witnesses' testimony and not on demeanor. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987); See also Ledbury v. Montgomery Ward & Co., 99 Or App 631 (1989). After our de novo review of the record, we find that claimant is not credible.

Claimant reported, to his physicians, numerous and conflicting ways in which the original assault injury occurred. Claimant reported to both his attending physicians and consulting physicians, including his psychologists, inconsistent complaints, varying past medical history, prior surgeries which had never been performed and prior fractures and injuries which never occurred. Claimant also reported to his physicians and evaluators recommendations that had allegedly been made by other physicians. We do not find such recommendations were never made.

Further, claimant specifically and adamantly denied any medical treatment between 1976 and 1983, denied ever being struck by his wife, and denied physical capabilities associated with moving activities. However, we find otherwise. Claimant admitted on cross-examination that he had received treatment between 1976 and 1983 and that he had been struck by his wife. Moreover, an investigator credibly testified that claimant's physical capabilities were far in excess of that testified to by claimant. See Tr. 77-80, 91-95, 225-228. Finally, claimant admitted that he, at times, exaggerated his symptoms and that he may have reported inconsistent histories to his various physicians. (Tr. 89 and 102).

In light of the multitude of inconsistencies in the record, we conclude that claimant is not a credible witness. Therefore, without considering claimant's testimony, we proceed to analyze the medical record to determine whether claimant's claim was properly closed.

Claimant's claim was closed by a February 22, 1989 Determination Order. His injury occurred in 1983. Since the 1983 injury, claimant has been treated or evaluated by at least 23 medical doctors, at least seven oral physicians, and at least seven psychologists or psychiatrists. Further, he has been an inpatient and/or outpatient at the Providence Medical Center, the Portland Pain Center, and the Oregon Health Sciences University where he was treated for drug dependency, weight loss, depression and pain control.

The physicians who actually treated claimant or who had participated in evaluations of claimant's condition, near the time of claim closure, the crucial

time to determine whether the claim was prematurely closed, and who would be in the best position to determine the status of claimant's condition, include: Dr. Hemenway, M.D.; Dr. Moore, M.D.; Dr. Anderson, D.M.D.; Dr. Grimm, M.D.; Dr. Iverson, M.D.; Dr. Merrill, D.S.D.; Dr. Parvaresh, psychologist; and the Orthopaedic Consultants, including Dr. Watson, neurologist, Dr. Coletti, Jr., orthopedic surgeon, and Dr. Klein, psychologist. See David E. Gates, 40 Van Natta 798 (1988).

As noted earlier, a medical opinion is only as good as the medical history upon which it is based. Therefore, since we have found that claimant is not a credible historian, and therefore unreliable, we do not find any medical opinion in the record which relies upon claimant's rendition of his medical history to be persuasive. Each of the physicians listed above, with the exception of the physicians representing the Consultants, rendered opinions based, in significant part, on claimant's statements. Consequently, we do not find them persuasive. Somers, supra; Miller, supra.

The Consultants, on the other hand, reviewed all of claimant's prior medical records, including all of claimant's earlier physicians' reports, which in turn included claimant's inconsistent histories. After taking into consideration those inconsistencies and claimant's past history of being subject to "protracted illnesses characterized by pain and psychological overtones, coupled with medication use . . . since his late teens," noting that physical and neurological examinations have revealed no outstanding abnormalities, and noting that claimant's "subjective complaints are virtually totally inconsistent with objective findings," Drs. Watson and Coletti opined that they could not "conceive of any medical treatment or passage of time which [could] improve [claimant's] condition, apart from recommendations already made to discontinue medication dependence." (Ex. 154).

On the same day, after making the same observations as Drs. Watson and Coletti, Dr. Klein opined that claimant would not benefit from further psychiatric treatment. (Ex. 157).

Furthermore, claimant's treating physician, Dr. Merrill, and Dr. Parvaresh, an evaluating psychologist, opined that claimant was medically stationary as early as November 1988. (Exs. 151, 153 and 162).

There is no persuasive medical opinion in the record that indicates that claimant's condition would improve with treatment or with the passage of time. Therefore, we conclude that claimant has failed to meet his burden of proving that he was not medically stationary on the date of claim closure. Consequently, we conclude that the February 22, 1989 Determination Order properly closed claimant's claim.

January 30, 1989 Denial - Medical Services

The Referee found that the denial, in its entirety, was an improper attempt to limit claimant's treatment. We agree.

Specifically, the denial denied authorization for further medical treatment by Dr. Grimm, M.D., Dr. Crow, Ph.D., and Dr. Tenhulzen, D.M.D. on the basis that the treatment was unreasonable and unnecessary and because claimant had already exceeded the limit by choice of treating physicians. The denial also denied further narcotic medication and asserted the employer's rights to preauthorize treatment other than treatment provided by Drs. Merrill, D.D.S. and Parvaresh, psychologist.

Prospective denials are impermissible. An insurer may not prospectively deny medical services beyond the date of its denial. Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989). Here, it is clear the employer's denial of future medical and narcotic treatment is an impermissible prospective denial. Therefore, inasmuch as the denial is prospective, it is set aside.

The denial, however, also asserted the employer's right to preauthorize treatment by other than Drs. Merrill and Parvaresh.

OAR 436-10-060(4) provides that once a worker has made an initial choice of attending physician and subsequently changed two times, the carrier shall inform the worker by certified mail that any subsequent changes must have the approval of the carrier or the director. There is nothing in the record to establish that the employer complied with the administrative procedures set forth in OAR 436-10-060(4). Therefore, that portion of the January 30, 1989 denial which asserted the employer's right to preauthorize treatment is improper.

Consequently, we conclude that the employer's January 30, 1989 denial should be set aside in its entirety.

June 26, 1989 Partial Denial

The Referee found that claimant's compensable 1983 injury was not a material cause of claimant's broken incisors and upheld the employer's denial of medical services associated therewith. We agree.

Claimant essentially argues that his incisors were broken as a result of a fall. Claimant alleges that the fall was caused by a vestibular or inner ear condition which he asserts was caused by his compensable injury.

Claimant asserts that the June 26, 1989 denial represented a medical services denial. At hearing, the parties also litigated the issue of a "de facto" denial of compensability of the alleged vestibular condition. Consequently, we proceed to analyze the compensability of claimant's alleged vestibular condition and related problems: bilateral perilymph fistulas and hearing loss.

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). Here, claimant must show not only that his 1983 compensable injury was a material contributing cause of his alleged vestibular condition and related conditions, but must also establish that the 1983 injury was a material contributing cause of his need for reasonable and necessary medical services associated therewith. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 697-98 (1987). Material contributing cause means a substantial cause, but not necessarily the sole cause or even the most significant cause. Van Blokland, supra, 87 Or App at 698.

We find that the causation of claimant's falls is speculative. In fact, the medical record does not establish whether claimant actually has any of his alleged ear problems: a vestibular disorder, hearing loss or perilymph fistulas. But, even assuming claimant suffers from these ear conditions, there is no persuasive evidence to establish that claimant's inner ear conditions were materially caused by his compensable injury.

Claimant first complained of falling episodes some four years after the compensable injury. Claimant's alleged hearing loss is not supported by any objective medical reports. In fact, one of claimant's physicians removed

claimant's hearing aids specifically noting that they were not needed. With respect to claimant's alleged bilateral perilymph fistulas, Dr. Epley did report that claimant had a "probable" perilymph fistula. Regardless of this finding, however, there is no reliable evidence in the record to establish that the perilymph fistula was caused by claimant's compensable injury. See Exs. 109, 111, 112, 131, 179 and 190. Finally, Dr. Epley reported that there was no objective evidence of vestibular dysfunction. (Ex. 190). We rely on Epley's opinion as claimant's treating physician. Weiland v. SAIF, 64 Or App 810 (1983).

The only opinion in the record supporting causation of claimant's inner ear conditions is a November 1986 report by Dr. Black. (Ex. 76). Dr. Black, however, had an inaccurate and incomplete history of the mechanism of the injury. Therefore, we do not find Dr. Black's opinion to be persuasive. Somers, supra; Miller, supra.

Consequently, we find that claimant has failed to meet his burden of proving that his falling problem, i.e., alleged vestibular problem, perilymph fistulas or hearing loss, was materially caused by his compensable injury. Therefore, we affirm that portion of the Referee's order upholding the employer's "de facto" denial of those conditions. Furthermore, because we find claimant's ear conditions not compensably related to claimant's 1983 injury, we also find that related medical services are not compensable as well. Thus, we affirm the June 26, 1989 denial.

Extent of Permanent Disability

Because we earlier found claimant's claim was properly closed by Determination Order, we proceed to determine whether, and to what extent, claimant suffered permanent impairment resulting from his compensable injury.

The employer contends that claimant suffered no permanent impairment resulting from his TMJ condition, possible minimal impairment resulting from claimant's inability to cope with the pain associated with the TMJ condition, and that claimant's other conditions were not materially caused by the compensable injury. Claimant asserts entitlement to permanent total disability, and, in the alternative, both scheduled and unscheduled permanent disability.

After our review of the record, we find that, since the compensable injury, claimant has complained of pain including: bilateral TMJ dysfunction, hearing loss, bilateral perilymph fistulas, vestibular problems, vision loss, cervical and lumbar impairment, periods of left upper and lower extremity paralysis, abdominal pain, gastrointestinal problems and psychological trauma. While claimant's initial reports of the compensable injury included an assault by one individual who hit claimant in the face, claimant's symptoms and complaints since the injury have spread to include much more. Claimant essentially contends that all of his current conditions are a result of his compensable injury. We disagree.

In order to evaluate the extent of permanent disability, we proceed to determine whether claimant's current conditions were materially caused by his compensable injury.

We have already found that claimant's current conditions associated with his inner ear are not compensable. We turn to the other conditions.

Claimant suffered from cervical and lumbar back injuries, shoulder and hip injuries, severe headaches, dizziness, a hernia, a finger amputation, and arm, eye, chest, groin and abdomen pain associated with an explosion, all prior to

his compensable injury. Claimant has exhibited symptoms of depression since 1974 and, after his compensable injury, was treated at Emanual Hospital Pain Center for depression associated with divorce and drug dependency. (Ex. 28).

Based on this record, we find that the causation of claimant's current conditions is of sufficient medical complexity that we cannot decide it without expert opinion. Uris v. Compensation Department, 247 Or 420, 424-26 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

As previously noted, claimant is not credible. Further, the medical opinions are only as reliable as the history provided by claimant to his physicians. Consequently, reliable and persuasive medical opinions in this record are scarce.

Claimant first reported neck and shoulder problems several months after the original injury. Those symptoms progressively became worse until the time of hearing. He first reported low back symptoms in September 1984, just after he had two noncompensable lipomas removed from his low back. Claimant complained of back pain continually from that date forward. Further, it was that same month which claimant first reported that his original injury included blows to his back. (Ex. 27). There is no persuasive medical opinion in the record, from any physician, opining that claimant's neck, shoulder and back conditions or his asserted left-sided paralysis were caused by his compensable injury. With respect to claimant's complaints of upper and lower, left-sided paralysis, there is simply no evidence to establish that such a condition objectively exists, let alone is related to claimant's compensable injury.

With respect to claimant's abdominal condition, claimant had abdominal problems prior to his injury, and those symptoms continued to the date of hearing. Claimant also suffers from ulcers diagnosed as early as December 1984. (Exs. 30 and 33). Claimant first reported gastrointestinal symptoms associated with his injury in January 1985, two years after his compensable injury. Claimant's condition has been reported to be functional and there is no objective evidence except for the ulcers. Id. Again, there is no persuasive evidence establishing that claimant's compensable 1983 injury materially caused any of his abdominal conditions.

Claimant's alleged loss of vision is likewise suspect. Claimant admitted a history of ongoing eye problems since the 1976 explosion. While claimant did report on the date of injury that he sustained a cut above his left eye, he did not receive any ongoing medical treatment for that eye injury. There is no evidence of a current eye condition or a loss of vision.

Therefore, with respect to claimant's neck, shoulder, back, alleged upper and lower left-sided paralysis, abdominal and vision conditions, we find that claimant has failed to meet his burden of proving that his 1983 compensable injury was a material contributing cause thereof.

With respect to claimant's psychological condition, the employer, in its brief, essentially concedes that such condition is compensably related to or caused by claimant's compensable injury, but only insofar as claimant needs psychiatric treatment to deal and/or cope with the chronic pain caused by his compensable jaw injury. We too, after our de novo review, are persuaded that claimant's psychological condition, i.e., that associated with his chronic jaw pain, and need for treatment was caused in material part by the compensable jaw injury. Despite our finding that claimant is not credible, the medical evidence establishes the severity of claimant's TMJ condition and the damage the injury caused to claimant's jaw. He was required to undergo several TMJ surgeries,

each of which caused severe pain. Claimant was referred to several psychologists in order to help deal with his chronic jaw pain. See, e.g., Exs. 28, 52 and 76.

Therefore, under these circumstances, we find that claimant's compensable jaw injury materially caused claimant's need for psychiatric treatment associated with claimant's chronic jaw pain.

Finally, because claimant's bilateral TMJ condition was accepted as compensable, we need not address it.

Consequently, we find that claimant has established that he suffers from two conditions which were materially caused by his compensable injury: his TMJ condition and his related psychological condition. Each of these two conditions, then, will be used to determine claimant's permanent disability resulting from his compensable injury.

Permanent Total Disability

Claimant contends that he is permanently and totally disabled. We disagree.

In order to prove entitlement to permanent total disability benefits, claimant must prove that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a). Claimant must prove this by a preponderance of the evidence. Harris v. SAIF, 292 Or 683 (1982). There are two types of permanent total disability: (1) that arising entirely from physical or mental incapacity; and (2) permanent disability, under the "odd-lot" doctrine, arising from less than total physical incapacity plus non-medical factors, such as age, education, work experience, training and mental capacity, which together result in permanent total disability. Welch v. Bannister Pipeline, 70 Or App 699 (1984); Wilson v. Weyerhaeuser Co., 30 Or App 403 (1977); Shaw v. SAIF, 78 Or App 588 (1986).

In addition, claimant has the burden of establishing that he has made reasonable efforts to obtain work at a gainful and suitable occupation, unless it is shown that efforts would be futile. ORS 656.206(3); Butcher v. SAIF, 45 Or App 318 (1983). However, even if a work search would be futile, claimant must establish that, but for the compensable injury, he would have been willing to seek regular gainful employment. SAIF v. Stephen, 303 Or 41 (1989).

Claimant is not permanently and totally physically incapacitated as a result of his jaw condition. Thus, his jaw condition does not prevent him from performing suitable and gainful employment. Furthermore, that portion of claimant's psychological treatment associated with his chronic jaw pain likewise does not prevent claimant from performing suitable and gainful employment. In this regard, we note Dr. Klein's and Dr. Parvaresh's opinions finding no impairment from claimant's medically stationary psychiatric condition.

We also find that claimant is not permanently and totally disabled under the "odd-lot" doctrine. The only physicians to render opinions regarding permanent disability were Dr. Grimm, Dr. LeBray, Dr. Parvaresh and the Consultants. As stated earlier, Drs. Grimm, LeBray and Parvaresh each had inaccurate histories upon which to rely. Therefore, their opinions are not found to be persuasive. Miller, supra. Also, as stated earlier, the opinion of the Consultants is thorough and well-reasoned in that it took into consideration each of claimant's earlier physicians' reports and claimant's inaccurate histories. Thus, we rely on the Consultants' opinion. Somers, supra.

In November 1988, the Consultants opined that claimant was medically stationary, from both a physical and psychological standpoint. Further, they opined, collectively, that claimant was capable of work, though they doubted that claimant was motivated to return to work. (Ex. 154). Finally, we note Dr. Parvaresh's November 1988 opinion, though based on an inaccurate history, reports that claimant was capable of working from a psychiatric standpoint. (Ex. 153). Each of these physicians found that claimant could return to his regular work. Even claimant's initial treating dental specialist, Dr. Stecher, opined that claimant's TMJ condition would not prevent claimant's return to regular work. See Exs. 72 and 117.

There is no reliable or persuasive medical opinion in the record which convinces us that claimant is permanently and totally disabled. Claimant stopped working after his first TMJ surgery in April 1984. He has not sought work since a failed attempt to perform dispatching work. Claimant quit that work for reasons unrelated to his injury. He is not motivated to return to the work force. Moreover, there is no evidence to establish that a work search would be futile.

Consequently, we find that claimant has failed to meet his burden of proving permanent total disability. We proceed to rate the extent of claimant's scheduled and unscheduled permanent disability.

Extent of Scheduled Permanent Disability

In this regard, we note that claimant's bilateral TMJ condition is not ratable as a scheduled permanent disability. See ORS 656.214(5). Consequently, as there is no evidence that claimant has suffered a permanent loss of use or function resulting from his compensable injury, we do not award any scheduled permanent disability.

Extent of Unscheduled Permanent Disability

Unscheduled permanent disability is rated on permanent loss of earning capacity. Both claimant's TMJ condition and psychological conditions are ratable under the "standards."

Claimant's condition was medically stationary on February 8, 1989. His claim was properly closed by Determination Order on February 22, 1989. We apply the standards effective at the time of the Determination Order in rating permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-270 through OAR 436-35-440 apply to a rating of claimant's unscheduled permanent disability.

Impairment

Claimant suffers from a chronic condition limiting repetitive use of his jaw. Therefore, we find claimant entitled to 5 percent for such loss of use or function. Former OAR 436-35-320(4).

After our review of the psychological medical record, we find that claimant has failed to establish any permanent psychological impairment resulting from his compensable injury.

Former OAR 436-35-400(1) requires that in order to obtain a disability rating for a mental illness, a permanent state of mental disorder must be diagnosed by a psychiatrist or psychologist. The psychologists who treated or evaluated claimant near the time of hearing included Dr. Parvaresh, Dr. LeBray, and Drs. Amsden and Weins of the Oregon Health Sciences University. As previously

noted, the opinions of Drs. Parvaresh and LeBray are not persuasive because they are based on an inaccurate history. Somers, supra; Miller, supra.

After our review of the report authored by Drs. Amsden and Weins, we find that their opinion is likewise based on an inaccurate history. Further, they did not render a specific opinion regarding permanent impairment. Therefore, we do not rely on their opinion. Miller, supra.

Consequently, the only reliable medical opinion regarding permanent psychological impairment is that of the Consultants. Dr. Klein opined that claimant suffered from either a factitious disorder and/or from a personality disorder. Personality disorders, however, are not ratable unless the record establishes that the disorder interferes with the worker's long-standing ability to adapt to ordinary activities and stresses of daily living. Former OAR 436-35-400. There is no such evidence in the record. Therefore, we find that claimant is not entitled to a disability value for his personality disorder.

Finally, we note the employer's contention that claimant may be entitled to an impairment value of 0 to 5 percent for a psychoneurosis condition. However, the employer bases this on Dr. Parvaresh's report that claimant suffers from a probable adjustment reaction regarding pain in his jaw. We do not consider this portion of Parvaresh's opinion persuasive because it is primarily based on an unreliable history. Miller, supra. Therefore, because there is nothing else in the record to establish permanent psychological impairment resulting from the compensable injury, we decline to award claimant any unscheduled disability for his psychological condition.

Claimant's total impairment, therefore, is 5 percent for his chronic condition limiting repetitive use or function of his jaw.

Age and Education

The appropriate value for claimant's age of 34 years is 0. Former OAR 436-35-290.

The appropriate value for claimant's 12 years of formal education is 0. (Ex. 40). Former OAR 436-35-300(3).

Claimant's highest SVP demonstrated during the ten years preceding the date of determination was a 4, for working as a truck driver. Therefore, the appropriate value for skills is 3. Former OAR 436-35-300(4).

Whether claimant is entitled to a value for training under former OAR 436-35-300(5) is dependent upon whether or not claimant has demonstrated competence in some specific vocational pursuit. Competence in some "specific vocational pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off the job to perform other than an entry level position. Larry L. McDougal, 42 Van Natta 1544 (1990).

Here, claimant has demonstrated competence in the specific vocational pursuit of truck driving. Therefore, the appropriate training value is a 0. Former OAR 436-35-300(5).

Claimant's total age and education value, therefore, is 3.

Adaptability

Claimant has not returned to either his usual and customary work or modified work. He has not refused an offer of either usual and customary work or

modified work. Claimant is not working for reasons other than his compensable injury. Consequently, claimant's adaptability may not be based on former OAR 436-35-310(2), (3) or (4). Under these circumstances, we find that the appropriate adaptability value is 1.

Computation of Unscheduled Permanent Disability

When claimant's age value 0 is added to his education value 3, the sum is 3. When that value is multiplied by claimant's adaptability value 1, the product is 3. When that value is added to claimant's impairment value 5, the result is 8 percent unscheduled permanent partial disability. Former OAR 436-35-280(7).

Finally, we find no clear and convincing evidence to establish that claimant sustained permanent loss of earning capacity in excess of that calculated under the standards.

Attorney Fee

Claimant contends entitlement to a larger assessed attorney for services at hearing. We disagree. After considering the factors set forth in OAR 438-15-010(4) and applying them to the case at hearing, we find that a reasonable fee for claimant's counsel's services at hearing concerning the employer's January 30, 1989 medical services denial was $6,000. We base this conclusion on the time devoted to the case, the complexity of the issue involved and the value of the interest involved.

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 employer's January 30, 1989 medical services denial is $1,000, to be paid by the employer. 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 September 20, 1989 is affirmed in part and reversed in part. The February 22, 1989 Determination Order is reinstated. Claimant is awarded 8 percent (25.6 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. For services on Board review concerning the January 30, 1989 medical services denial, claimant's attorney is awarded a reasonable assessed fee of $1,000, payable by the employer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
JOHN B. ZABELL, Claimant
WCB Case No. 89-18615
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
David Jorling, Defense Attorney

Reviewed by Board Members Cushing and Myers.

The self-insured employer requests review of that portion of Referee Shebley's order which granted claimant permanent total disability for a low back

injury, whereas a Determination Order had awarded 32 percent (102.4 degrees) unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT

In October 1985, claimant sustained a compensable injury to his low back. The injury was a lumbar strain superimposed on degenerative joint disease at L5-S1. The claim was closed by a January 1986 Determination Order which awarded claimant 20 percent unscheduled permanent disability. In late January 1986, claimant began vocational rehabilitation associated with the October 1985 injury. Despite low aptitudes in math, business detail and manual dexterity, a plan was formulated to attempt to return claimant to work as an accounting clerk.

Initially, the vocational plan was not approved by the Rehabilitation Review Section due to a concern that it was inappropriate given claimant's test scores. Thereafter, the plan was approved and claimant began taking courses at a community college. Claimant was cooperative and made efforts to complete his course work. However, due to failing grades, he was unsuccessful. In January 1988, following disapproval of an extension by the Rehabilitation Review Section, the vocational plan was terminated.

Although the vocational plan was disapproved, claimant continued to work towards receiving his accounting clerk certificate. He ultimately received his accounting clerk certificate, however, he was physically unable to perform such a job due to his compensable injuries and preexisting disabilities.

Thereafter, claimant was put into a training program as a police clerical assistant. Claimant continued to cooperate with vocational efforts, however, this plan was terminated in October 1988 after it was determined that claimant did not possess adequate skills to be competitive in this occupation. Following termination of the police clerical assistant plan, claimant was placed in an on-the-job training program as an accounting assistant with the Bureau of General Services.

The accounting assistant position was not a position that existed prior to claimant's training program. Claimant actively participated in this program, but due to health problems, he began missing time and was ultimately reduced to working four hours per day. In June 1989, the employer offered claimant an accounting assistant position. This offer was based on an approval by a consulting physician, Dr. Tilson, who felt claimant was capable of it from an orthopedic standpoint. Dr. Tilson, however, specifically noted that he was not considering claimant's non-orthopedic disabilities. Claimant declined to take the position for medical reasons.

In May 1989, a Determination Order closed claimant's claim and increased his unscheduled permanent disability award to 32 percent.

Claimant is 48 years old and has a GED. Claimant's past occupations include work as a dishwasher, garbage collector and janitor. At the time of his compensable injury, he was working as an auto-servicer.

Prior to the 1985 compensable injury, claimant sustained compensable injuries to his right knee, neck, back, shoulders and arms. These injuries resulted in awards of 20 percent scheduled permanent disability for the right knee and 5 percent unscheduled permanent disability. Claimant also suffers from morbid obesity, sleep apnea, alveolar hypoventilation syndrome, vascular insufficiency, carpal tunnel syndrome, severe psoriasis, high frequency hearing loss

and bladder incontinence all of which preexisted the 1985 industrial injury and were disabling prior to the 1985 injury.

Claimant also has diabetes and angina-like chest pains, but these conditions did not preexist the 1985 industrial injury.

FINDINGS OF ULTIMATE FACT

As a result of the compensable injury and his preexisting disabilities, claimant is physically incapacitated from regularly performing work at a gainful and suitable occupation.

CONCLUSIONS OF LAW AND OPINION

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

In order to establish entitlement to permanent total disability benefits, claimant must prove that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a).

As a result of his 1985 compensable low back injury, claimant has mild impairment and is permanently restricted from lifting more than 20 pounds. In addition, claimant suffers from numerous other physical disabilities which preexisted the compensable injury and are therefore taken into consideration in determining claimant's medical impairment. See ORS 656.206(1)(a); Emmons v. SAIF, 34 Or App 603 (1978).

Prior to the 1985 compensable injury, claimant sustained other compensable injuries to his knees, neck, upper back, shoulders and arms. These injuries resulted in awards of 20 percent scheduled permanent disability for loss of use or function of the right knee and 5 percent unscheduled permanent disability. Claimant also suffers from morbid obesity, sleep apnea, alveolar hypoventilation syndrome, vascular insufficiency, carpal tunnel syndrome, severe psoriasis, high frequency hearing loss and bladder incontinence. These conditions preexisted the 1985 compensable injury and were disabling.

Dr. Karlin, claimant's treating internist, opined that claimant was permanently and totally disabled from a physical standpoint. He indicated that claimant could not perform even minimal physical activity and further noted that it was unlikely that claimant could remain in a sedentary position for any length of time. Dr. Karlin specifically noted that claimant's diabetes and angina-like chest pains played a small role in claimant's overall disability. Dr. Karlin's opinion is supported by Drs. Baldwin and Rendlemen who examined claimant in 1987 in conjunction with his Social Security hearing.

Dr. Tilson, reported that claimant was capable of working, but noted that his recommendation was based solely on claimant's orthopedic problems and did not take into account non-orthopedic problems. Dr. Feldstein opined that claimant was capable of working four hours per day, but also indicated that this was only from an orthopedic standpoint. Dr. Feldstein indicated that she would defer to Dr. Karlin's opinion with regard to claimant's overall impairment. Finally, the Medical Consultants Northwest also reported that claimant would be capable of working from an orthopedic standpoint, but noted that claimant's orthopedic problems were only a small part of claimant's overall medical problems. The Consultants ultimately concluded that it would be very difficult for claimant to return to work in light of his numerous medical problems.

We conclude that claimant is permanently incapacitated from regularly performing work at a suitable and gainful occupation due to his October 1985 compensable injury and preexisting disabilities. In reaching this conclusion, we rely on the opinion of Dr. Karlin. Dr. Karlin, as claimant's treating internist, was in the best position to comment on the effect of claimant's overall physical impairment and we find his opinion persuasive. See Givens v. SAIF, 61 Or App 490 (1983). Further, although the opinions of Drs. Tilson, Feldstein and the Consultants seem contrary, all specifically limited their opinions to claimant's orthopedic problems and did not consider non-orthopedic disabilities. Accordingly, claimant has established that he is permanently and totally disabled.

Assuming arguendo that claimant is not permanently and totally disabled from a medical standpoint, we would nevertheless conclude he is permanently and totally disabled under the "odd-lot" doctrine. See Wilson v. Weyerhaeuser, 30 Or App 403 (1988). Claimant is 48 years of age and his work history is quite limited. He has low aptitudes in math, business detail and manual dexterity. Although claimant was cooperative with all vocational efforts, those efforts were unsuccessful due in large part to his educational deficiencies. In this regard, we agree with the Referee's conclusion that vocational expert Ross was more persuasive than Mr. Funk. Finally, we note that claimant was willing to seek work and cooperated fully with vocational efforts on his behalf.

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 concerning the permanent total disability issue is $1,500, 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 respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 30, 1990 is affirmed. For services on review concerning the permanent total disability issue, claimant's counsel is awarded an assessed attorney fee of $1,500, payable by the self-insured employer.

March 14, 1991 Cite as 43 Van Natta 541 (1991)

In the Matter of the Compensation of
JAMES D. BRUSSEAU, II, Claimant
WCB Case No. 89-22996
ORDER ON REVIEW (REMANDING)
Vick & Gutzler, Claimant Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Neal's order that: (1) upheld the SAIF Corporation's denial of his medical services claim for his current back condition; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial. In his brief, claimant contends that the Referee abused her discretion by refusing to admit Exhibit 13A into evidence. On review, the issues are evidence, medical services and penalties and attorney fees. We remand.

At the hearing, held March 20, 1990, SAIF objected to admission of a November 28, 1989 medical report authored by claimant's treating chiropractor.

Claimant provided the report to SAIF on March 12, 1990. However, in a letter dated November 22, 1989, SAIF had originally requested discoverable information. The letter provided that the request would continue until all issues concerning the pending request for hearing had been resolved.

For purposes of discovery, OAR 438-07-015(4) provides that:

> "Documents acquired after the initial exchanges shall be provided to the other parties within seven (7) days after the disclosing party's receipt of the documents."

At hearing, SAIF asserted that the document had been prepared for litigation and should not be admitted into evidence because it was "too late." Claimant's counsel admitted that he did not have an excuse for the late disclosure. The Referee then ruled that, because claimant had no excuse for the untimely production of the document, the report would not be admitted. Neither a specific inquiry nor a determination was made as to material prejudice to SAIF resulting from the untimely disclosure of the report.

On review, claimant admits that the document was not provided within seven days after it was received, however, he contends that exclusion is not proper unless the other party is prejudiced. Claimant asserts that, at hearing, SAIF was unable to state why the exhibit should be excluded.

OAR 438-07-018(4) provides that:

> "Subject to ORS 656.287(1), at the hearing the referee may in his or her discretion allow admission of additional medical reports or other documentary evidence not disclosed as required by OAR 438-07-015. In the exercise of this discretion, the referee shall determine whether material prejudice has resulted from the timing of the disclosure and, if so, whether there is good cause for the failure to timely disclose that outweighs any prejudice to the other party or parties. Following a finding of material prejudice, a referee may exclude a document or continue the hearing for such action as is appropriate to cure the material prejudice caused by the late disclosure of the document." (Emphasis added)

SAIF contends that the Referee had discretion to either allow or exclude evidence not properly disclosed under the discovery rules. SAIF argues that it was prejudiced by the late document, as it was deprived of four months' preparation time.

We agree that where disclosure of a document is untimely, OAR 438-07-018(4) allows the Referee discretion to admit or exclude the document. We review the exercise of such discretion only for abuse. However, without a record as to both prejudice and good cause and/or findings by the Referee as to each of those matters, we are unable to review for abuse of discretion.

Here, the Referee inquired of claimant's attorney regarding the cause for the delay in providing discovery. We infer that she found no "good cause," because she excluded the exhibit without further discussion. That implied finding as to good cause would have been sufficient under former OAR 438-07-005(4). See Lena M. Fisher, 41 Van Natta 2221 (1989) [finding of good cause is a requisite

to admission under former OAR 438-07-005(4).] However, OAR 438-07-018(4), which first became effective April 1, 1989, provides also that the Referee shall determine whether material prejudice resulted from the timing of the disclosure. Because SAIF was not allowed a reasonable opportunity to make a record regarding material prejudice and because the Referee did not make a determination as to material prejudice, we find this record "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(3).

Consequently, the Referee's order is vacated and this matter remanded to Referee Neal for further proceedings to determine whether the November 28, 1989 medical report should be admitted or excluded under OAR 438-07-018(4) and, if admitted despite material prejudice, whether further action consistent with the rule is appropriate. These proceedings shall be taken in any manner that achieves substantial justice. Thereafter, the Referee shall issue a final, appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
VALERIE K. CORTEZ, Claimant
WCB Case No. 89-03233
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Gary T. Wallmark (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Irving's order which set aside its denial of claimant's occupational disease claim for her psychological condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

ULTIMATE FINDINGS OF FACT

Claimant suffered a mental disorder, an adjustment disorder with mixed features of anxiety and depression, the cause or worsening of which arose out of and in the course of her employment as a school bus driver. Claimant's condition was diagnosed as an adjustment disorder by Dr. Mead, psychiatrist. That condition is a mental disorder generally recognized in the psychological community. That mental disorder required medical treatment and resulted in disability.

The employment conditions which caused claimant's mental disorder, such as students screaming at her, arguing with her and being disrespectful, existed in a real and objective sense.

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.

CONCLUSIONS OF LAW AND OPINION

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

Claimant had to drive the school bus under stressful driving conditions while students harassed her, yelled at her, called her names and continued to be disrespectful of her authority. These conditions existed in a real and objective sense. Although claimant's supervisor's investigation and corrective action pursuant to parent and student complaints was not unreasonable, his failure to support claimant's position and educate parents was an additional real and objective stressor to claimant.

The record as a whole establishes that stressful conditions, excluding corrective and disciplinary actions, materially contributed to claimant's mental disorder. Dr. Mead, claimant's treating psychiatrist, whose opinion is based upon an accurate history of claimant's work environment, opined that these causative work conditions are not generally inherent in every working situation. There is no evidence to the contrary. Therefore, we conclude that the causative working conditions are not generally inherent in every working situation.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review. We consider the factors set forth in OAR 438-15-010(4) in arriving at such a reasonable fee. Here, we conclude that $900 is reasonable. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), and the value of the interest involved.

ORDER

The Referee's order dated June 9, 1989 is affirmed. Claimant's counsel is awarded a reasonable assessed fee of $900, payable by the SAIF Corporation.

March 14, 1991 Cite as 43 Van Natta 544 (1991)

In the Matter of the Compensation of
LEONARD R. DORAMUS, Claimant
WCB Case No. 88-20184
ORDER ON REVIEW
Bischoff, et al., Claimant Attorneys
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

The SAIF Corporation requests review of those portions of Referee Livesley's order that: (1) increased claimant's unscheduled permanent disability award for a low back condition from 31 percent (99.2 degrees), as awarded by Determination Order, to 59 percent (188.8 degrees); and awarded 10 percent (15 degrees) scheduled permanent disability for loss of use or function of the left leg, whereas the Determination Order awarded no scheduled permanent disability. The issue on review is extent of permanent partial disability, scheduled and unscheduled. We modify.

FINDINGS OF FACT

We adopt the Referee's 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.

Because claimant's condition became medically stationary on December 8, 1989, and his claim was closed by Determination Order on January 24, 1990, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq.

Unscheduled Disability

Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled 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. Former OAR 436-35-280.

In this matter the parties do not dispute the values given for claimant's age (1), formal education (0) or training (1). SAIF disputes the values given by the Referee for claimant's SVP and adaptability, and the impairment value given for the second surgery and loss of range of motion.

Specific Vocational Pursuit

SAIF argues that claimant should have an SVP of 7 because he has experience as a rough carpenter. There is evidence in the record that claimant did successfully work as a self-employed remodeler within the last ten years; however, the description of the duties that claimant performed doing that job do not fit within the description of a rough carpenter in the DOT. Claimant did work as a rough carpenter, but that was more than ten years ago.

The highest specific vocational pursuit (SVP) level demonstrated by a claimant during the ten years preceding the date of determination is used to determine a value for skills. Former OAR 436-35-300(4). For our purposes, permanent disability is determined on the date of hearing. The position which claimant successfully performed during the ten years preceding the date of hearing, which has the highest specific vocational pursuit (SVP) level, was a fork lift driver, SVP 3 (DOT # 921.683-050). Therefore, the appropriate value for skills is +3. Former OAR 436-35-300(4).

Adaptability

The adaptability value for a claimant who is not working as a result of his or her compensable injury/condition 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).

SAIF argues that claimant's adaptability rating should be +4 rather than +6 as determined by the Referee. We agree. The latest medical report in this

record that addresses claimant's limitations, indicates that claimant should avoid heavy lifting and should have the option to sit and stand at light work. The value for light work for an injured worker who has not returned to work would be a +4. Former OAR 436-35-310(4)(c).

Impairment

The Referee assigned a value of 5 percent for loss of repetitive use of the lumbar spine, 8 percent for claimant's March 1988 laminectomy and facetectomy, 5 percent for claimant's repeat surgery in February 1989, and 14 percent for lost range of thoracolumbar motion. SAIF argues that the impairment value given by the Referee should not have included a value for the second surgery and that the most recent range of motion findings would result in a smaller loss compared to the value of 14 percent given by the Referee.

Dr. Karasek, the treating physician, reported in February 1990 that claimant's range of motion was approximately 80-90 degrees forward, 15 degrees of extension and 20 degrees of lateral bending and 20 degrees of rotation. 80 degrees of forward flexion would be equal to a loss of 1 percent. 15 degrees of extension would equal a loss of 1.5 percent. 20 degrees of lateral bending, bilaterally, and 20 degrees of rotation, bilaterally, would equal a loss of 2 percent for each motion on both the left and right side. These values are added for a total of 10.5 percent for lost range of motion. Former OAR 436-35-360(6) thru (10).

SAIF next argues that the Referee should not have given a second value for the repeat surgery at the L5-S1 level. The need for surgery was for recurrent disc herniation. The Board has held that absent any additional impairment resulting from the second surgery, a claimant is entitled to be given only one value for repeat surgery at the same level. Jimmy D. Basham, 42 Van Natta 1045 (1990). The medical records do not support a finding of additional impairment from the second surgery; therefore, claimant is not entitled to a separate value for the second surgery. He would receive 5 percent for the laminectomy and 3 percent for the facetectomy for a total of 8 percent.

Claimant's total combined impairment value for the surgery, (8 percent), chronic condition (5 percent) and the loss of range of motion (10.5 percent) would be 21.8 percent. Former OAR 436-35-360(11).

Computation of Unscheduled Permanent 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 4, the product is 20. When that value is added to claimant's impairment value 21.8, the result is 41.8 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 42 percent.

Scheduled Disability

Former OAR 436-35-010 through 436-35-260 apply to the rating of claimant's scheduled permanent disability.

The Referee gave claimant an award of 10 percent loss of use or function of the left leg based on OAR 436-35-230(7). That section of the standards deals with dermatological conditions and is not applicable to this claimant. We can

only assume that the section noted was in error because in his findings the Referee noted that claimant has left leg pain S-1 distribution with numbness down the sole of the foot. Pain is only considered to the extent it results in measurable impairment. Former OAR 436-35-010(2)(b). We find no persuasive evidence that this leg pain results in impairment. Moreover, the loss of surface sensation in claimant's leg is not considered disabling. Former OAR 436-35-230(1). However, claimant is entitled to a 5 percent value for the numbness in his foot. Former OAR 436-35-200(1). Accordingly, claimant is entitled to a total award of 5 percent scheduled permanent disability for loss of use or function of the left foot.

ORDER

The Referee's order dated May 1, 1990, as reconsidered May 21, 1990, is modified in part and affirmed in part. In lieu of the Referee's award of unscheduled permanent partial disability, claimant is granted an award of 11 percent (35.2 degrees) unscheduled permanent disability, in addition to the Determination Order award of 31 percent (99.2 degrees), for a total award of 42 percent (134.4 degrees). In lieu of the Referee's award of 10 percent (15 degrees) scheduled permanent disability for loss of use or function of the left leg, claimant is awarded 5 percent (6.75 degrees) scheduled permanent disability for loss of use or function of the left foot. The remainder of the order is affirmed.

March 14, 1991 Cite as 43 Van Natta 547 (1991)

In the Matter of the Compensation of
KAREN F. GUTHRIE, Claimant
WCB Case No. 90-05015
ORDER ON REVIEW
John O'Hara, Claimant Attorney
Nelson, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The insurer requests review of that portion of Referee Peterson's order that set aside its denial of claimant's back injury claim. In her brief, claimant argues that the insurer has not timely filed a request for review in accordance with statutory requirements. On review, the issues are jurisdiction and compensability. We affirm.

FINDINGS OF FACT

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

The Referee's order was dated August 1, 1990. Thereafter, the Referee issued an amended order on August 13, 1990, which amended claimant's social security number, date of injury and workers' compensation division number.

On August 29, 1990, the insurer mailed a request for review to the Board. The request stated that the insurer was seeking Board review of "...Referee Peterson's order dated August 1, 1990. Review is requested within thirty days of publication of the Referee's order pursuant to the provisions of ORS 656.289." The request, which carried the appropriate WCB Case Number, also indicated that copies had been provided to all parties to the proceeding before the Referee.

On November 15, 1990, the Board mailed a computer generated letter to the parties acknowledging the request for review.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

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 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2).

Compliance with ORS 656.295 requires that statutory notice of the request for review shall be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983). The necessary function of notice statutes is to inform the parties of the issues in sufficient time to prepare for adjudication. Nollen v. SAIF, 23 Or App 420, 423 (1975) rev den (1976).

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).

Here, claimant asserts that the insurer has requested review of the Referee's August 1, 1990 order and failed to request review of the August 13, 1990 amended order. Under such circumstances, claimant contends that we lack jurisdiction to consider this matter. We disagree.

The insurer's August 29, 1990 request did state that it was seeking review of "Referee Peterson's order dated "August 1, 1990." However, the request also stated that it was being submitted within 30 days of the publication of the Referee's order. Inasmuch as the insurer also requested Board review within 30 days of Referee Peterson's August 13, 1990 amended order, we conclude that the request encompasses both orders. Consequently, we conclude that we have jurisdiction. Rudolph A. Beeman, 42 Van Natta 55 (1990).

Compensability

We adopt the conclusions and reasoning concerning the issue of compensability as set forth in the Referee's order.

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 concerning the compensibility issue is $750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief) the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 1, 1990, as amended, August 13, 1990, is affirmed. For services on review concerning the compensability issue, claimant's counsel is awarded an assessed attorney fee of $750, to be paid by the insurer.

In the Matter of the Compensation of
TRUDY G. LANGSTON, Claimant
WCB Case No. 89-22732
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Julene M. Quinn (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Peterson's order that upheld the SAIF Corporation's denial of her occupational disease claim for respiratory and facial skin conditions. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant started working for the employer in 1985 and first noticed facial symptoms, which resembled a rash, in the winter of 1986, after she was moved to the fourth floor of the employer's building. Her symptoms improved over weekends and during vacations; they flared within hours, when she returned to work. (Tr. 57, 61, 70-71, 79, 80). Claimant also experienced pulmonary symptoms, associated with her workplace.

Claimant treated with Dr. Kazmierowski, for both conditions, until late 1988. She began treating with Dr. Green, who specializes in allergies and environmental medicine, in the fall of 1988. By that time, claimant had had a bronchial cough for eight months. (Tr. 60-62).

Claimant has preexisting allergies to dust, molds, pollens, animal danders, milk and wheat. (Tr. 55, 85). She had no prior skin problems, except some acne 10 years ago, when she went through a stressful divorce. (Tr. 66, 91). Claimant's prior skin and respiratory symptoms differed from those which started in 1986. (Tr. 89).

An industrial hygienist from Oregon OSHA tested the air in the employer's building, and in claimant's workplace in particular, and found no "statistically significant" contaminants present.

Claimant's last day at work was September 18, 1989. (Tr. 72). Her condition improved "dramatically" thereafter. (Ex. 28-2).

The SAIF Corporation denied claimant's occupational disease claim for her respiratory and facial skin conditions on October 6, 1989.

ULTIMATE FINDING OF FACT

Claimant's exposure to environmental conditions in her workplace was the major contributing cause of her respiratory problems and dermatological condition requiring medical services.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that the Referee dismissed claimant's hearing request. No party requested that he do so. Moreover, we are aware of no other authority supporting a dismissal, absent such a request. Therefore, we reinstate claimant's hearing request and proceed to the merits.

For an occupational disease claim, the date of "injury" is the date upon which claimant was last exposed to employment conditions which allegedly caused the disease. Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986).

Claimant's last work exposure occurred on September 19, 1989. Therefore, the occupational disease law, which became effective January 1, 1988, is applicable. See Johnson, supra, at 146-48; Donna E. Aschbacher, 41 Van Natta 1242 (1989).

To be compensable under the applicable law, claimant's occupational disease must fall within one of the three subsections of former ORS 656.802(1). Because the claim involves neither "overuse trauma" nor a mental condition, it is not properly analyzed under subsections (b) or (c). See Ronald Dickson, 42 Van Natta 1102 (1990).

A claim is properly analyzed under former ORS 656.802(1)(a) when it involves "ingestion of, inhalation of or contact with dust, fumes, vapors, gasses, radiation or other conditions or substances." Inasmuch as the medical evidence in this case indicates that claimant's condition is either idiopathic or caused by exposure to irritants, we analyze her claim under subsection (a).

To establish compensability, under former ORS 656.802(1)(a), claimant must establish that her work exposure was the major contributing cause of her respiratory and dermatological conditions. Priscilla O. Dean, 42 Van Natta 1573 (1990); see Dickson, supra. This case presents a complex medical question. The resolution of the issue depends 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 decided that claimant failed to prove that her condition is work-related because: the exact causal conditions remain unidentified; although the suspected irritants -- formaldehyde and fiberglass -- are present (at low levels) in claimant's workplace, claimant does not test "allergic" to either; and the treating doctor has allegedly not considered various potential off-work causes.

At the outset, we note that claimant's claim does not fail, as a matter of law, because a specific cause is not identified. See Volk v. Birdseye, 16 Or App 349 (1974). In this case, the evidence is persuasive and undisputed that the onset, waxing and waning and resolution of claimant's conditions correlate directly, in time and place, with exposure to her work environment. We analyze the medical evidence with that fact in mind.

Drs. Haberman and Bell, dermatologists, examined claimant and reviewed her medical history. Both physicians opined that claimant suffers from acne rosacea, an idiopathic condition. Haberman noted that, although claimant does not test "allergic" to fiberglass, that material could nonetheless be an irritant exacerbating claimant's "primary skin condition." (Ex. 15-2). Haberman also suspected that the topical medication which claimant used might worsen her skin condition. However, there is no evidence relating any of claimant's various treatments to a worsening of either condition.

Dr. Bell opined that environmental factors "do not cause rosacea-like symptoms." (Ex. 18-2). He observed claimant's condition after she had been off work for two weeks, compared it to earlier photographs, and concluded that claimant had not improved since she was off work. This observation is not corroborated by other medical examiners. In fact, Drs. Feldstein and Green, who examined claimant after Bell, noted "remarkable" and "dramatic" improvements. (Exs. 19-2, 21-1). We conclude that, inasmuch as Dr. Bell only saw claimant once two weeks after her last exposure to her work environment, his opinion about claimant's condition over time is not persuasive.

Dr. Montanaro, allergist, reviewed claimant's medical history and the environmental report concerning claimant's workplace. He opined that claimant's oral corticosteroid treatment may have caused or worsened her skin condition.

However, claimant treated intermittently with oral medication and there is no evidence correlating her skin symptoms with this, or any other treatment.

Montanaro also noted Bell's opinion that claimant's condition had not improved after she stopped working. He opined that if claimant had suffered from a workplace irritant, the effects would have been transient and she would have recovered by the time of Bell's examination. (Ex. 29-2). He concluded that claimant's condition is not related to her work exposure. Inasmuch as we do not consider Bell's observation to be reliable, we are not persuaded by Montanaro's opinion which is based, in part, on Bell's opinion. In this regard, we also note that Montanaro evidently overlooked the treating doctor's chart notes which document, over a three-year period, that claimant's condition worsened when she worked, and cleared up when she did not work. Neither Haberman, Bell nor Montanaro offered an explanation for the documented pattern and correlation between claimant's work exposure and her worsened symptoms.

Dr. Green, who specializes in allergies and environmental medicine, treated claimant for over a year at a frequency of approximately once per month. From the outset, Green noted that claimant's condition improved when she was away from her workplace. Green opined that claimant "has not followed the pattern of acne rosacea, which is a chronic essentially unrelenting facial dermatitis. . . . The clear waxing and waning with work exposure and avoidance of work is totally inconsistent with the diagnosis of acne rosacea, an idiopathic illness." (Ex. 27). Over the period of his treatment, Green reported that claimant's symptoms flared when she was at work and cleared when she was off work. (Exs. 1-8, 1-11, 21, 27, 29, 30, 31). His chart notes reflect that he considered and ruled out other potential causes. (See Ex. 1). Green concluded that claimant's work exposure was the major cause of her dermatological and respiratory problems. (Ex. 32; see Ex. 26).

We ordinarily give great weight to the opinion of the treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, because Green had an accurate history and the very significant advantage of observing and treating claimant over time, we see no reason not to rely on his well-reasoned opinion. See Somers v. SAIF, 77 Or App 259, 263 (1986). Therefore, we conclude that claimant has carried her burden of proving that her work exposure was the major contributing cause of her respiratory and dermatological conditions.

Claimant's counsel is entitled to a reasonable assessed fee for his services at hearing and on review. 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 is $2,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case at hearing and on review, the complexity of the issue, and the value of the interest involved.

ORDER

Claimant's request for hearing is reinstated. The Referee's order dated May 23, 1990 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for further processing according to law. Claimant's attorney is awarded a reasonable assessed fee of $2,500, payable by SAIF.

In the Matter of the Compensation of
ELENA RAMIREZ, Claimant
WCB Case No. 89-12737
ORDER ON REVIEW
Ginsburg, et al., Claimant Attorneys
Carol Taaffe (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation requests review of those portions of Referee Mills' order that: (1) found that claimant's claim for her right foot, right leg and back conditions was prematurely closed; and (2) granted claimant permanent total disability, whereas a Determination Order awarded no permanent disability. In her brief, claimant contests those portions of Referee Mills' order that found that claimant was not wrongfully denied pain center treatment by SAIF. Claimant also requests penalties and related attorney fees on an underpaid time loss rate and SAIF's alleged failure to process the claim for pain center treatment and authorize that treatment. On review, the issues are premature closure, extent of permanent disability, including permanent total disability, medical services, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings with the exception of paragraph eight and the following supplementation.

On January 11, 1988, Dr. Lipe, podiatrist, began treating claimant.

From March 1, 1988 through June 9, 1988, Dr. Simpson, D.C., examined and treated claimant ten times. (Exs. 6, 7).

FINDINGS OF ULTIMATE FACT

Further material improvement in claimant's condition could not reasonably be expected when her claim was closed by the January 31, 1989 Determination Order.

Claimant is not permanently and totally incapacitated as a result of her compensable injury. She has not carried out reasonable work search efforts, and such efforts would not be futile.

Claimant has sustained a 90 percent loss of earning capacity as a result of her compensable neck and back injury.

Claimant has sustained a 22 percent loss of use or function of her right foot as a result of her compensable injury.

Pain center treatment is reasonable and necessary treatment for claimant's compensable right foot condition, but not her neck and back condition.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

A claim may be closed if claimant's compensable condition is medically stationary, i.e., no further material improvement would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17). It is claimant's burden to establish that she was not medically stationary when the claim was closed. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981); Brad T. Gribble, 37 Van Natta 92 (1985).

The Referee found that the January 31, 1989 Determination Order prematurely closed claimant's claim by accepting Dr. Simpson's, D.C., medically stationary date of December 19, 1988. The Referee instead relied on the opinion of treating chiropractor, Dr. Young, that claimant was medically stationary on February 22, 1989. We disagree.

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

Here, there are persuasive reasons not to defer to Dr. Young. He stated on October 12, 1988 that it was unlikely that claimant would improve with the type of treatment she had previously received. There are no medical reports in the record documenting any different type of treatment between the time Dr. Simpson found claimant medically stationary on December 19, 1988 and the time Dr. Young found her medically stationary on February 22, 1989.

Further, Dr. Young based his opinion on his belief that claimant's symptoms were entirely organic in nature so that further treatment of her physical condition was likely to result in improvement. (Exs. 10B-3 & 4, 23-2, 10A-2). We are, instead, persuaded by the opinion of Dr. Turco, psychiatrist, that claimant was expressing emotional problems through musculoskeletal symptoms in her neck and back. We defer to Dr. Turco because of his special expertise in this area and because his opinion is consistent with reports of functional overlay from three separate vocational/occupational rehabilitation counselors, Dr. Simpson and the Western Medical Consultants. Accordingly, we conclude Dr. Young's medically stationary opinion is not persuasive because it is premised on the erroneous assumption that claimant's symptoms are entirely organic in nature.

We, instead, rely on Dr. Simpson's December 19, 1988 medically stationary date. With the exception of Dr. Young's opinion, the medical record supports Dr. Simpson's medically stationary date. The Referee incorrectly discounted Simpson's opinion on the ground that he saw claimant only in an independent capacity. The record shows that Dr. Simpson saw claimant at least ten times, including providing her with palliative care during seven treatments over a three week period. (Exs. 7, 12). His opinion is thorough, well-reasoned, based on a complete history and examination, and consistent with the fact that claimant's condition had not improved with many months of treatment.

Finally, we disagree with the Referee's reasoning that Dr. Simpson's report was internally inconsistent in that he noted restrictions in claimant's range of motion and agreed claimant was limited to sedentary work, but nevertheless found that claimant had no permanent impairment and was medically stationary. In fact, Dr. Simpson opined that there were no purely objective signs of impairment, not that there was no permanent impairment. (Ex. 12-3).

For these reasons, we find that claimant was medically stationary on December 19, 1988 and that her claim was not prematurely closed.

Permanent Total Disability

Claimant must prove by a preponderance of the evidence that she is permanently totally disabled. Harris v. SAIF, 292 Or 683 (1982). Although disabled, claimant is not totally incapacitated on a physical or medical basis alone. Consequently, claimant can prevail only by proving that she 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 her 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 she is willing to enter the work force and that she 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 Referee awarded claimant permanent total disability on the basis of the odd lot doctrine, based in part on his finding that claimant had satisfied the seek work requirement. However, the record shows that claimant applied for work at only three places and, of these, only two were within her sedentary limitations. On this record, claimant has not established that she has made reasonable work search efforts.

Further, she has not established that a work search would be futile. Although Dr. Young opined that claimant is essentially unemployable, his opinion is not persuasive because it is based in part on claimant's psychogenic pain disorder. No medical opinions in the record relate this disorder to the work injury, and there is no evidence the problem preexisted the injury.

Similarly, the opinion of vocational counselor Hughes does not persuade us that work search efforts would be futile. He opined that claimant is unable to competitively engage in the work force based on her inability to speak English, her age (46), her education (3 to 4 years) and her physical impairment. Hughes relied on Dr. Young's opinion regarding claimant's physical impairment, which is not persuasive for the reasons discussed above. In addition, Mr. Hughes' contact with claimant was limited to meeting with her in preparation to testify. (Tr. 17). Also, Mr. Hughes based his opinion on a physical capacities evaluation performed by the Occupational Medicine Center (OMC), which does not support the conclusion that claimant is unemployable. The OMC therapist found that claimant worked at a sedentary level during the three hour evaluation, which indicates that she was at least capable of part-time work. (Ex. 23AAA-5).

Furthermore, Ms. Ayeerza, vocational counselor from Cascade Rehabilitation Counseling, identified light duty assembly and electronics assembly as potential jobs for claimant and Dr. Young approved these jobs, at least on a part-time basis. (Exs. 16-2, 18A). Finally, one of the eight employers surveyed by Cascade indicated it would hire claimant despite her language limitations. (Exs. 18-5, 18-6).

In summary, we conclude claimant has not made reasonable efforts to reenter the work force, and that such efforts would not be futile. Therefore, we find that claimant is not permanently totally disabled.

Permanent Partial Disability

For purposes of determining injury-related permanent partial disability, former 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.

Because claimant's condition became medically stationary on December 19, 1988, and her claim was closed by Determination Order on January 31, 1989, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-010 through 436-35-260 apply to the rating of claimant's scheduled permanent disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent disability.

Unscheduled Permanent Partial Disability - Spine

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.

SAIF argues that claimant's spinal symptoms are not related to her work injury. We disagree. SAIF accepted claimant's cervical, thoracic and lumbar back strains and right foot/leg pain in a stipulation dated November 28, 1988. (Ex. 11). We, therefore, proceed to rate claimant's spinal impairment under the "standards."

Age and Education

The appropriate value for claimant's age of 46 years is 1. Former OAR 436-35-290.

The appropriate value for claimant's 3 to 4 years of formal education is 1. Former OAR 436-35-300(3).

The highest specific vocational pursuit (SVP) level demonstrated by a claimant during the ten years preceding the date of determination is used to determine a value for skills. Former OAR 436-35-300(4). For our purposes, permanent disability is determined on the date of hearing. Claimant's highest SVP level was 2, as a nursery laborer (DOT # 405-687-014). Therefore, the appropriate value for skills is 4. Former OAR 436-35-300(4).

Whether claimant is entitled to a value for training under former OAR 436-35-300(5) is dependent upon whether or not claimant has demonstrated competence in some specific vocational pursuit. Competence in some "specific vocational pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off the job to perform other than an entry level position. Larry L. McDougal, 42 Van Natta 1544 (1990).

Here, claimant has not demonstrated competence in a specific vocational pursuit. Therefore, the appropriate training value is a 1. Former OAR 436-35-300(5).

Adaptability

The adaptability value for a claimant who is not working as a result of his or her compensable injury/condition 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).

Here, claimant is not working as a result of her compensable injury and no offer of employment has been made. Dr. Young restricted claimant to sedentary

work with further limitations on claimant's ability to stand, walk, sit, twist, and kneel. We find these limitations unpersuasive because they are based solely on claimant's subjective reports to Dr. Young, who did not consider claimant's functional overlay. We rely, instead, on Dr. Simpson and the Western Medical Consultants, who considered claimant's noncompensable functional overlay in determining her residual physical capacity. They restricted claimant to sedentary work and did not report the additional limitations noted by Dr. Young. Therefore, the appropriate adaptability value is 8. Former OAR 436-35-310(4)(d).

Impairment

Dr. Young provides the most current range of motion measurements for claimant's thoracolumbar spine. (Ex. 23-3). Unlike Dr. Young's restrictions on standing, walking, etc., there is no persuasive evidence that his range of motion measurements are not accurate because of claimant's functional overlay. See Deborah L. Sherfield, 42 Van Natta 1025 (1990). Young found that claimant retained flexion of 40 degrees (5 percent); extension of 10 degrees (2 percent); left lateral flexion of 18 degrees (2.4 percent); right lateral flexion of 5 degrees (5 percent); and bilateral rotation of 15 degrees (6 percent). Former OAR 436-35-360. These values are added for a total thoracolumbar loss of range of motion of 20.4 percent. Former OAR 436-35-360(10).

Dr. Simpson provides the most current range of motion findings for claimant's cervical spine. (Ex. 12-2). Simpson found that claimant retained cervical flexion of 35 degrees (.67 percent); extension of 10 degrees (3.33 percent); left rotation of 10 degrees (3.5 percent); right lateral flexion of 35 degrees (.67 percent); and left lateral flexion of 15 degrees (2.0 percent). (Ex. 12-2). Former OAR 436-35-360. Adding these values provides a total cervical impairment of 10.17 percent. Former OAR 436-35-360(10).

The cervical and thoracolumbar residuals are combined, not added, for a total impairment of the spine of 28.5 percent. Former OAR 436-35-360(11).

Computation of Unscheduled Permanent 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 6, the sum is 7. When that value is multiplied by claimant's adaptability value 8, the product is 56. When that value is added to claimant's impairment value 28.5, the result is 84.5 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, 85 percent.

Scheduled Permanent Partial Disability - Right Foot/Leg

Claimant has a bone spur on her foot as a result of her work injury, verified by objective findings. (Ex. 7A). Dr. Young reported reduced ranges of right foot motion and restricted repetitive use in that foot. The record contains no other right foot range of motion measurements. We defer to Dr. Young's opinion regarding claimant's right foot impairment. Although his opinion is based in part on claimant's subjective reports of disabling foot pain, there is no evidence that claimant's foot pain is attributable to functional overlay.

Dr. Young found that claimant retained dorsiflexion of 5 degrees (5.5 percent); plantar flexion of 30 degrees (4 percent); eversion of 3 degrees (3.4 percent); and inversion of 5 degrees (4.5 percent). These values are added for

a total loss of range of motion of 17.4 percent. Former OAR 436-35-010(7) rates claimant's loss of repetitive use at 5 percent.

The value for loss of range of motion is combined, not added, with the value for loss of repetitive use for a total scheduled disability of 21.5 percent. Former OAR 436-35-190(11). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-010(6). Claimant's scheduled permanent disability under the "standards" is, therefore, 22 percent.

Clear and Convincing Evidence

Either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by a claimant is more or less than the entitlement indicated by the "standards." Former 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 is unable to read, write, or speak English. The vocational record, particularly the opinion and testimony offered by vocational expert Hughes, establishes that claimant's inability to communicate in English has a profound impact on her ability to obtain gainful employment. Specifically, Hughes testified that "only about two percent of the job market" was open to claimant assuming that she was capable of sedentary or light work. Under such circumstances, we find it highly probable that based on the record as a whole that claimant's loss of earning capacity exceeds the 85 percent unscheduled permanent disability award allowable under the standards. Accordingly, we hold that claimant has suffered a 90 percent loss of earning capacity.

Denial of Medical Services

Claimant argues that SAIF denied treatment in a pain center, and she requests that the denial be set aside. The Referee declined to authorize treatment because he found nothing in the record to support a finding that pain center treatment was not authorized or was denied by SAIF. Furthermore, the Referee reasoned that SAIF had authorized many other services including vocational assistance.

The record establishes that claimant filed a claim for pain center treatment. On April 18, 1988, Dr. Lipe notified SAIF of her suggestion that claimant be referred to a pain center for pain in claimant's right foot and leg. (Ex. 5P). On October 11, 1989, Dr. Young recommended pain center treatment for claimant's ankle and low back pain. (Ex. 23-4). There is no evidence that SAIF authorized the services or that claimant received any pain center treatment. On review, SAIF does not refute claimant's contention that it did not authorize the treatment. Given these facts, claimant has established that she filed a claim for pain center treatment that is in "de facto" denied status.

Turning to the merits of the claim, the fact that many other services were provided is not relevant to whether pain center treatment is reasonable and necessary. Claimant's treating physician has opined that pain center treatment is reasonable and necessary treatment for the disabling pain she experiences in her neck, back and right foot. There is no contrary medical opinion, and SAIF makes no argument that the treatment is not reasonable and necessary. Therefore, we conclude that claimant is entitled to pain center treatment for her compensable injury, and we reverse the Referee's ruling on this issue.

Penalties and Attorney Fees

On review, claimant requests penalties and attorney fees for SAIF's failure to process her pain center treatment claim and authorize that treatment, and for its payment of an incorrect rate of temporary total disability compensation. However, since these issues were not raised at hearing, we do not address them on review. See Anderson v. West Union Village Square, 44 Or App 687 (1980); Theodore W. Lincicum, 40 Van Natta 1760 (1988).

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 denial of pain center treatment is $1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 19, 1990 is reversed in part and affirmed in part. That portion of the Referee's order which found claimant's claim prematurely closed is reversed. The Determination Order's medically stationary date of December 19, 1988 is affirmed. In lieu of the Referee's award of permanent total disability, claimant is awarded 22 percent (29.7 degrees) scheduled permanent disability for loss of use or function of her right foot, and 90 percent (288 degrees) unscheduled permanent disability for her cervical and thoracolumbar injuries. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. However, the SAIF Corporation is permitted to credit any attorney fee paid pursuant to the Referee's permanent total disability award against the attorney fee awarded herein. SAIF's "de facto" denial of pain center treatment is set aside and the claim is remanded to SAIF for processing according to law. The remainder of the Referee's order is affirmed. For services at hearing and on review concerning the pain center denial, claimant is awarded a reasonable assessed attorney fee of $1,000, to be paid by SAIF.

In the Matter of the Compensation of
WILLIAM E. SANDERS, Claimant
WCB Case No. 88-05942
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Mongrain's order that: (1) denied his request to keep the record open for the introduction of additional evidence; (2) upheld the insurer's partial denial of claimant's L2-L3 spinal stenosis condition; and (3) upheld the denial of claimant's medical services claim for low back surgery relating to the L2-L3 spinal stenosis. On review the issues are remand, compensability and medical services. We affirm.

FINDINGS OF FACT

The hearing was originally set for July 6, 1988, but was postponed due to the possibility of a medical panel convening. When the Medical Director declined to convene a medical panel, the hearing was rescheduled for August 8,

1988. At the August hearing, claimant moved for a postponement for the purpose of allowing claimant an opportunity to obtain an evaluation from a consulting physician. The motion was granted.

The hearing was convened on November 10, 1988. However, claimant had retained new counsel, who moved for a postponement indicating claimant was not prepared to go forward. The Referee granted the postponement. At the November hearing, the Referee stated he fully expected the parties to be ready to go forward on the reset date of December 16, 1988. He further indicated he would not entertain a request to hold the record open, but suggested he might do so for the defense if it were prejudiced by late arriving evidence offered by claimant.

At the December hearing, claimant requested admission of two documents, namely, exhibits 126 and 127. Both these exhibits were obtained shortly before hearing by claimant, but were disclosed timely. However, the insurer had not had an opportunity to view or respond to the exhibits. Therefore, the Referee admitted the exhibits, but granted the insurer's request to depose Dr. Raaf. Claimant did not object.

After the deposition, claimant requested the record be held open for rebuttal evidence of Dr. Raaf's deposition. The Referee denied the request. Claimant now moves for remand in order to allow him to submit additional medical reports for the purpose of rebutting Dr. Raaf's deposition, relying on OAR 438-06-091(3).

CONCLUSIONS OF LAW AND OPINION

Motion for Remand

Claimant contends that the Referee erred in not reopening the record for the admission of further evidence in order to allow claimant rebuttal of Dr. Raaf's deposition. He requests the Board remand to the Hearings Division. We deny the motion.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." See ORS 656.295(5). To merit remand for consideration of additional evidence it must be clearly shown that material evidence was not obtainable with due diligence at the time of hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

OAR 438-06-091(3) provides that a Referee "may continue a hearing...[u]pon a showing of due diligence if necessary to afford a reasonable opportunity for the party bearing the burden to obtain and present rebuttal evidence..." See OAR 438-06-091(3) and (4). As a preliminary matter, we note that the administrative rule is couched in permissive language and contemplates that the exercise of authority to continue a hearing, or as here, reopen a hearing, rests within a Referee's discretion. See David F. Grant, 42 Van Natta 865 (1990). We also note that the Referee was not bound by technical or formal rules of procedure, and had statutory authority to conduct the hearing in any manner that would achieve "substantial justice." See ORS 656.283(7); William G. Mattison, 41 Van Natta 2331 (1989).

Here, the hearing was postponed twice in order to allow claimant the opportunity to prepare his case. At the November hearing, the Referee indicated that he would not allow claimant a postponement in December, although he left the door open with regard to defense counsel. At the December hearing, as a result of the Referee's admitting claimant's recently received exhibits, Dr. Raaf's deposition was allowed to cure any potential prejudice to the insurer. The deposition was duly taken. Claimant does not allege that new issues were

raised as a result of the deposition. Nonetheless, claimant requested an opportunity to rebut this testimony by way of additional medical evidence. Partly, this request was based on the fact claimant was unable to obtain the desired reports by the time of the December hearing.

With regard to the need to get additional reports, we find that claimant had sufficient opportunity to prepare his case. Claimant was made aware at the November hearing that it was highly unlikely that a third postponement or continuance would be granted in December. Indeed, we note that the very purpose of the December hearing was to allow claimant an opportunity to obtain additional medical reports or evaluations. Accordingly, we conclude that claimant did not exercise due diligence.

Second, we do not find that the interest of substantial justice has been ill served by declining to allow claimant an opportunity to rebut Dr. Raaf's deposition. We note that claimant did not object to the deposition of Dr. Raaf at the hearing. Furthermore, no new issues were raised as a result of the deposition. Finally, claimant had an opportunity to cross examine Dr. Raaf at the deposition. Under these circumstances, we conclude that the Referee did not abuse his discretion in declining to reopen the record to receive rebuttal evidence and that the record is sufficiently, completely and fully developed without such evidence.

Compensability and Medical Services

We adopt the "Conclusions of law and Opinion" as set forth in the Referee's order.

ORDER

The Referee's order dated April 19, 1989 is affirmed.

March 14, 1991 Cite as 43 Van Natta 560 (1991)

In the Matter of the Compensation of
VINCENT B. SWEENEY, Claimant
WCB Case No. 90-09754
ORDER OF ABATEMENT
Dennis O'Malley, Claimant Attorney
David J. Lillig (Saif), Defense Attorney

The Board has received claimant's request for reconsideration of our Order on Review dated February 20, 1991, that: (1) affirmed the Referee's ruling that the SAIF Corporation must fully comply with an unappealed July 28, 1989 Determination Order; (2) reversed the Referee's increased award of 8 percent unscheduled permanent partial disability and related attorney fee; and (3) affirmed the Referee's assessed penalty and related attorney fee for SAIF's allegedly unreasonable claims processing. Specifically, claimant requests that the issue of attorney fees at the hearing level be reconsidered.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and the SAIF Corporation is requested to file a response to the motion within ten days.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID K. BOYER, Claimant
WCB Case Nos. 86-16928 & 86-11274
ORDER ON REVIEW
Thomas O. Carter, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Nichols, Howell and Crider.

Claimant requests review of that portion of Referee Tenenbaum's order which upheld the self-insured employer's denial of claimant's occupational disease claim insofar as it denied his left heel/foot condition. The employer cross-requests review of those portions of the order which: (1) set aside its denial of claimant's occupational disease claim insofar as it denied claimant's right heel/foot condition; and (2) increased claimant's scheduled permanent disability award for loss of use or function of the right heel/foot from 5 percent (6.75 degrees), as awarded by a Determination Order, to 20 percent (27 degrees). On review, the issues are compensability and extent of scheduled permanent partial disability. We affirm.

FINDINGS OF FACT

Claimant, 51 years old at hearing, has worked as a school custodian and head custodian for the employer for approximately 25 years. This work has required him to walk and stand on concrete floors most of the day.

In February 1985, claimant sought medical treatment from Dr. Wilson, his treating orthopedic physician, for a painful right heel of several months duration. The doctor diagnosed right os calcis (heel) spur and plantar fasciitis.

On February 20, 1985, claimant completed an 801 form alleging pain in the right foot and bone spur. The employer deferred the claim at that time. On June 10, 1985, the employer submitted a 1502 form indicating its acceptance of the February 20, 1985 "incident."

On June 24, 1985, claimant was seen in Industrial Medicine consultation by orthopedic physician Tilson. Claimant's complaints were limited to the right foot. Tilson concurred in Dr. Wilson's diagnosis and noted that claimant's preexisting foot condition had been symptomatically worsened by his work activities.

On July 11, 1985, the employer wrote to claimant advising him that his February 1985 claim for his right foot condition, including bone spur, had been accepted.

Approximately one year after his right foot became painful, claimant began to experience pain in his left foot. On December 6, 1985, Dr. Wilson advised the employer that claimant was "also having left heel pain;" the diagnosis continued to be right plantar fasciitis with os calcis spur. On January 6, 1986, however, Dr. Wilson advised the employer that claimant's diagnosis was now chronic bilateral os calcis spurs with plantar fasciitis.

On February 21, 1986, Dr. Wilson filed an occupational disease claim on behalf of claimant, indicating to the employer that claimant now had right and left os calcis spurs on x-ray.

On March 19, 1986, claimant filed an 801 form alleging left heel spur and calcium foot problems in addition to his previously alleged right heel/foot problem. The employer similarly deferred this claim.

Claimant was seen for independent medical examination by orthopedic physician Puziss on May 19, 1986. Dr. Puziss diagnosed bilateral heel spurs with bilateral plantar fasciitis, obesity, and suspected metabolic phenomena. He attributed 50 percent of the causation of claimant's condition to excessive weight bearing--due both to claimant's obesity and standing on concrete for many years. Dr. Puziss further noted that in all medical probability, as yet undetermined idiopathic factors also were 50 percent responsible for causing claimant's conditions.

Claimant was seen for rheumatological evaluation on June 23, 1986 by Dr. Kappes. Testing confirmed hyperuricemia (elevated uric acid levels) as a significant metabolic cause for claimant's musculoskeletal symptoms. After reviewing Dr. Kappes findings, Dr. Puziss concluded that work activities were not the major contributing factor causing claimant's bilateral foot condition; he reiterated that claimant's condition was due to a combination of obesity (25 percent), standing and walking on concrete (25 percent), and metabolic factors (50 percent).

Thereafter, on July 31, 1986, the employer denied claimant's left and right heel/foot conditions.

On October 31, 1986, the employer administratively closed claimant's 1985 right foot claim. A Determination Order issued November 25, 1986, finding claimant to be medically stationary on January 6, 1986, and awarding him 5 percent scheduled permanent partial disability.

FINDINGS OF ULTIMATE FACT

The employer initially accepted the compensability of claimant's right foot condition. It subsequently denied the claim more than 60 days after it had notice or knowledge of the claim and prior to claim closure.

Claimant has sustained a 20 percent loss of use or function of the right foot as a result of his compensable condition.

CONCLUSIONS OF LAW AND OPINION

Compensability of Right Foot Condition/July 1986 Denial of Right Foot Claim

We adopt the Referee's reasoning and conclusions regarding the impropriety of the employer's July 1986 "back-up" denial of claimant's right foot condition with the following supplementation.

The employer argues that it only accepted a temporary exacerbation of claimant's right foot condition as evidenced by its June 10, 1985 acceptance of the "February 20, 1985 incident." The employer's argument is without merit. See ORS 656.005(7)(a); former ORS 656.802(a). Insurers/employers are not required to accept or deny "incidents;" they are required to accept or deny claims for injuries and diseases.

The employer also argues that the evidence establishes that claimant's right foot condition was never compensable because work activities were not the major contributing cause of a worsening of that underlying condition. Claimant filed an 801 form alleging pain in the right foot of several months duration and bone spur. On July 11, 1985, the employer officially notified claimant of its acceptance of that right foot condition. Thereafter, on July 31, 1986, the employer purported to deny both claimant's left and right foot conditions.

Once accepted, a carrier cannot subsequently deny the compensability of a claim. 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 illegal activity. Ebbtide Enterprises v. Tucker, 303 Or 459 (1987); Bauman v. SAIF, 295 Or 788 (1983). No such showing has been made in this case. Therefore, we concur in the Referee's conclusion that the employer's July 1986 denial was improper as to claimant's right foot condition. Consequently, the employer is barred from denying the compensability of claimant's right foot condition.

We also note that the employer's denial was an inpermissible pre-closure denial of responsibility for an accepted condition. The employer denied claimant's compensable right foot condition on July 31, 1986, and first closed the claim 3 months later. Such a denial is invalid. Roller v. Weyerhaeuser Co., 670 Or App 583 (1984); Safstrom v. Riedel International Inc., 65 Or App 728 (1983).

Extent of Scheduled Permanent Partial Disability of the Right Foot

We affirm and adopt the Referee's reasoning and conclusions that claimant has sustained a 20 percent permanent loss of use or function of the right foot as a result of his compensable condition.

Compensability of Left Foot Condition

Claimant asserts that his left foot condition is compensable as an occupational disease under former ORS 656.802(1)(a). That subsection defines an "occupational disease" as:

> "Any disease or infection which arises out of and in the scope of the employment, and to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment therein."

When, as here, multiple causes combine to produce one indivisible disease,[1] it is claimant's burden to prove that his work activities were the major contributing cause of either the onset or the worsening of his underlying condition. Runft v. SAIF, 303 Or 493, 498 (1987); McGarrah v. SAIF, 296 Or 145, 166 (1983); Dethlefs v. Hyster Co. 295 Or 298, 309, 310 (1983); Ross v. Flightcraft, Inc. 100 Or App 315, 317 (1990); Mal v. Unique Building Maintenance Co., 93 Or App 703, 706 (1988); Blakely v. SAIF, 89 Or App 653, 656 (1988).

In determining whether claimant has met the burden of proving that work conditions were the major contributing cause of a disease, we compare employment conditions to non-employment conditions, explanations, or exposures.[2] McGarrah v. SAIF, supra, at 166; James v. SAIF, 290 Or 343, 350 (1981); SAIF v. Lucas, 94 Or App 132, 135 (1988); SAIF v. Noffsinger, 80 Or App 640, 646 (1986); SAIF v. Mitchell, 63 Or App 488, 493 (1983); SAIF v. James, 61 Or App 30, 33 (1982); Penifold v. SAIF, 60 Or App 540, 544 (1982); SAIF v. Gygi, 55 Or App 570, 574 (1982).

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1. See Comment, Workers' Compensation Reform, 24 Willamette L. Rev. 341, 354 (1988) ("An indivisible disease is a disease that results from two kinds of causative agents- one work related and one non-work related."). See also 1B Larson, Workmen's Compensation Law, 41.64, 7-465 (1985) ("Dual causation of occupational disease.").

In the present case, the Referee found that claimant had failed to prove that employment conditions were the major contributing cause of any worsening of his left foot condition. See Weller v. Union Carbide, 288 Or 27 (1979). On review, we find no evidence that claimant's left foot condition preexisted his work for the employer. Therefore, we do not apply a Weller "worsening" analysis to this claim. Instead, we find that claimant has failed to prove that employment conditions were the major contributing cause of his left foot condition.

The issue of whether work activity is the major contributing cause of claimant's left os calcis spur and plantar fasciitis is a complex medical question. Therefore, 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), rev den 300 Or 546 (1986). Claimant has been examined by four medical specialists--Drs. Wilson, Tilson, Puziss and Kappes. At the outset, we note that treating orthopedist Wilson and examining orthopedist Tilson merely noted that claimant's preexisting condition had been symptomatically worsened by his work activity. Neither offered an opinion as to whether work activities as opposed to non-work activities were the major contributing cause of the onset of claimant's underlying left foot condition.

Both Drs. Puziss and Kappes have concluded that claimant's work activity for the employer was not the major contributing cause of claimant's current condition. Rheumatologist Kappes examined claimant and performed metabolic testing. He found little evidence that work activities significantly contributed to claimant's plantar fasciitis and other musculoskeletal conditions. Rather, he concluded that claimant's symptoms were due to a metabolic disturbance in uric acid levels.

Dr. Puziss has also performed extensive testing on claimant, including review of Dr. Kappes' reports of his rheumatological evaluation. Moreover, in his reports, Dr. Puziss has thoroughly analyzed and discussed work and non-work factors as they contribute to claimant's current left foot condition. Contrary to claimant's contention, Dr. Puziss does not opine that work activities for the employer were the major contributing cause of claimant's left foot condition. Dr. Puziss initially noted that multiple work and non-work causes have combined to produce claimant's current indivisible disease. Later, after reviewing Dr. Kappes' reports, he reiterated that claimant's foot condition was due to a combination of obesity (25 percent), standing and walking on concrete (25 percent), and metabolic factors (50 percent). There are no opinions to the contrary.

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2. We do not agree with the argument that the definition of "occupational disease" at former ORS 656.802(1)(a) establishes a third class of "causes" of disease which is excluded from consideration of "major contributing cause," because such causes are inherent to the claimant. Such a position would be inconsistent with case law. See, e.g., Blakely v. SAIF, 89 Or App 653 (1988) (underlying abnormal median nerve and/or natural aging process not excluded but considered as possible cause(s) of carpal tunnel syndrome); Marshall v. Boise Cascade Corp., 82 Or App 130 (1986) (hypertension and/or hypersecretion of pituitary hormone considered as to the cause(s) of hearing loss); Bush v. SAIF, 70 Or App 118 (1984) (natural aging considered as a possible cause of worsening of varicose veins); Mitchell v. SAIF, 63 Or App 488 (1983) (evidence of diabetes as potential cause of mental illness considered).

Furthermore, the situation in which factors peculiar to an individual cause a disease is quite different from that in which an individual is susceptible to development of a disease. This case involves the former situation.

Accordingly, we disavow our discussion in Michelle Rabideau, 40 Van Natta 2025 (1988) of a hypothetical, "idiopathic" class of excluded causes.

On this record, we conclude that claimant has failed to prove that his work activities for the employer, in comparison with non-work related conditions, were the major contributing cause of his left os calcis spur and plantar fasciitis.

Inasmuch as claimant submitted no brief concerning the issues raised by employer's cross-request, we conclude that he is not entitled to an attorney fee. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated May 19, 1987 is affirmed.

Board Member Crider dissenting.

I dissent from that portion of the order which upholds the denial of claimant's left foot and heel condition. I differ with the majority's understanding of the test for determining compensability of occupational diseases under former ORS 656.802.

An occupational disease is "[a]ny disease or infection which arises out of and in the scope of the employment and to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment therein." Former ORS 656.802(1)(a). In other words claimant must prove both: (1) that the disease "arise[s] out of and in the scope of the employment;" and (2) that the disease is one "to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment therein." Dethlefs v. Hyster Co., 295 Or 298, 307 (1983).[1]

The first requirement--that the disease "arise out of and in the scope of the employment"--is nearly identical to the "arising out of and in the course of employment" language found in the definition of a "compensable injury." See former ORS 656.005(8)(a). Comparing the "disease" and "injury" definitions, the Court of Appeals held, in SAIF v. Noffsinger, 80 Or App 640, 645, rev den 302 Or 342 (1986), that the unitary work-connection analysis from Rogers v. SAIF 289 Or 633, 642 (1980) applies to the "arising out of and in the scope of employment" language of the occupational disease statute. That is, if the relationship between the disease and the employment is sufficient, then the disease arises out of and in the scope of employment.

In the injury context, a sufficient work-connection is established by proof that work being performed in the employment is a material contributing cause of the injury. See, e.g., Olson v. SIAC, 222 Or 407, 414-415 (1960). Likewise, I conclude that proof

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1) The majority disavows Michelle Rabideau, 40 Van Natta 2025 (1988) in which we articulated our understanding that this is a two part test; however, the majority in concluding that the first part of the test is subsumed into the second part, does not discuss SAIF v. Noffsinger, 80 Or App 640, 645, rev den 302 Or 342 (1986) in which the court stated:

> "If the relationship between the disease and the employment is sufficient, then the disease arises out of and in the scope of employment. Of course, because [former] ORS 656.802(1)(a) requires that the disease be one 'to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment therein,' the claimant must also prove that work conditions, when compared with non-work conditions, were the major contributing cause of the disease." (Citations omitted).

Certainly, the Noffsinger court considered the test to be a two part test.

of material causation is sufficient to establish that a disease arose out of and in the scope of employment within the meaning of former ORS 656.802(1)(a). In determining whether work activities materially contributed to a disease, the fact-finder must consider all factors which contributed to the disease, including those peculiar to the individual.[2] Thus, even if a condition manifests itself at work, the condition cannot be compensable if it was caused exclusively by conditions peculiar to the individual and the work has no material relationship to the causation of the disease.

However, if work connection is proven, claimant must then satisfy the second requirement for establishing an occupational disease. Claimant must prove that the disease is one "to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment therein." Former ORS 656.802(1)(a). It is from that language that the courts formulated the "major contributing cause" test. See McGarrah v. SAIF, 296 Or 145, 166 (1983); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Blakely v. SAIF, 89 Or App 653, 656, rev den 305 Or 672 (1988); SAIF v. Noffsinger, supra, 80 Or App at 645-46; SAIF v. Gygi, 55 Or App 570, 574, rev den 292 Or 825 (1982). Stated simply, that test requires claimant to prove that work conditions or exposures were the major contributing cause of either the onset or the worsening of the underlying disease.[3] See id.

The "major contributing cause" test is merely the second part of the two-part occupational disease analysis; it does not, as the majority implies, supplant the requirement that claimant first prove a material work connection. See note 1 infra.

In applying the "major contributing cause" test, the fact-finder must weigh on-the-job conditions and exposures against off-the-job conditions and exposures. See, e.g., Dethlefs v. Hyster Co., supra, 295 Or at 310. The majority apparently concludes that conditions peculiar to and generated from within an individual are off-the-job conditions to which an individual is ordinarily subjected or exposed. I submit that that interpretation violates the letter and the spirit of the statute.

It is a well settled premise of workers' compensation law that the employer takes the worker as he finds him. Barrett v. D & H Drywall, 300 Or 325, 328 (1985), clarified 300 Or 553 (1986); Surratt v. Gunderson Brothers, 259 Or 65, 74 (1980); Keefer v. SIAC, 171 Or 405, 412 (1943); Nomeland v. City of Portland, 106 Or App 77 (1991), Aquillon v. CNA Insurance, 60 Or App 231 (1982). Those cases apply the axiom to hold an employer liable for disability resulting from a preexisting condition so long as the industrial injury contributed to the disability. The underlying principle is articulated in Keefer v. SIAC, supra, 171 Or at 415:

2.) I avoid using the term idiopathic because "idiopathic" is defined in two very different ways--as "self-originated" and "of unknown causation." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 649 (26th ed. 1981). Because both meanings of the word have been used in Workers' Compensation law, I avoid its use for the sake of clarity.

3.) I agree with the majority that there is no evidence that claimant's left foot condition preexisted his employment. Accordingly, claimant need not prove a "worsening of the underlying disease" in order to prevail. See Weller v. Union Carbide, 288 Or 27 (1979); Devereaux v. North Pacific Ins. Co., 74 Or App 388, 391 (1985).

> "The Oregon Workmen's Compensation Law *** prescribes no standard of physical fitness to which the employee must conform, and compensation is not based on any implied warranty of perfect health."

The majority opinion eliminates this principle in the occupational disease context. Under the majority approach, in a case like this wherein the evidence establishes that all forces external to claimant which contribute to the disease are work-related, the claim is not compensable because conditions intrinsic to claimant have a large effect on the development of the disease.

The effect of the majority's approach will weigh most heavily upon those workers whose personal circumstances, while not alone causing the disease in question, render the worker more vulnerable to causative agents to which they are exposed at work. Thus, under the majority's approach, a worker whose congenital deformity combines with repetitive trauma at work to cause stress fractures or strain will not be compensated for the disease unless the worker's doctor can persuasively state that the trauma is a more important causative factor than the deformity. A worker whose sensitivity to a substance combines with daily exposure to the substance at work to cause a chronic bronchitis will not be compensated for the disease unless the worker's doctor can persuasively state that the work exposure is a more important causative factor than the sensitivity. A worker whose dormant rheumatoid arthritis combines with daily exposure to extremely high temperatures on the job to cause active arthritic disease will not be compensated unless the worker's doctor can persuasively state that the heat is a more important causative factor than the rheumatoid arthritis in causing the arthritic disease.

In each of these situations, the worker was more likely than the average worker to suffer a disease as a result of a particular exposure. Yet the worker would not have suffered the disease but for the work exposure. Indeed, no activity in which the worker engaged in off-work bore any relationship to the causation of the disease. Nevertheless, most physicians properly will be reluctant to apportion causative force to two symbiotic causes of entirely different type--one a personal characteristic and the other an external force. Consequently, under the majority's approach, these workers, who cannot produce a warranty of perfect health, will go uncompensated.

The law, as I understand it, however, does not require either the physician or the adjudicator to apportion cause in this way.[4] Rather, the law accepts the worker's vulnerability. The major contributing cause test--which compares on-work to off-work exposures--should produce and does produce a finding of compensability in cases such as the above. See e.g., Tucker v. Liberty Mutual Insurance, 87 Or App 607 (1987); Preston v. Wonder Bread, 96 Or App 613 (1989).

In this case, considering only the forces external to claimant, he has proven that his work activities were the major cause of his occupational disease. Claimant's elevated uric acid levels combined with extensive weight-bearing to

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4.) Citing to a number of court cases, the majority asserts that the exclusion of factors peculiar to the individual from the "major contributing cause" test is inconsistent with case law. See majority opinion n 2. Based on my reading of those same cases, however, it is not at all clear whether the courts considered these factors (e.g., natural aging, hypertension, diabetes) in the "major contributing cause" test or whether those factors were considered only in the material work-connection test. Inasmuch as the latter approach is entirely consistent with mine, the cited cases do not conflict with my understanding of the law.

produce a disabling foot condition. Claimant was required to stand and walk on hard surfaces on an almost continuous basis at work. There is no evidence that he engaged in any significant weight-bearing activities off the job which could have contributed to his foot condition. Although the standing and walking had enhanced deleterious effect on claimant because he was overweight, we must take the worker as we find him. Therefore, because weight-bearing activities at work outweighed weight-bearing activities away from work as factors in causation of the disease, I would find claimant's occupational disease claim for the left foot condition compensable . See Dethlefs v. Hyster Co., supra; SAIF v. Noffsinger, supra.

March 15, 1991 Cite as 43 Van Natta 568 (1991)

In the Matter of the Compensation of
ROY J. CHAMBERS, Claimant
Own Motion No. 66-0223M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation voluntarily reopened claimant's claim for medical benefits relating to his November 1, 1945, industrial injury. Claimant's aggravation rights have expired. Claimant was awarded permanent total disability benefits. SAIF requests Board authorization of reimbursement from the Reopened Claims Reserve for its payment of medical benefits.

For conditions resulting from a compensable injury occurring before January 1, 1966, the Board may authorize the payment of medical benefits. ORS 656.278(1)(b). Here, we find that the ambulance and transportation services, mileage and nursing home care are reasonable and necessary medical services which are required by claimant who is permanently and totally disabled. We conclude, therefore, that claimant's claim should be reopened for those medical services. See OAR 438-12-037(1)(b). Accordingly, claimant's claim is reopened for the provision of ambulance and transportation services, mileage and nursing home care for the month of February, 1991, in an amount not to exceed $2,426.50.

Furthermore, claimant's claim shall remain open for the further provision of nursing home care by SAIF for a period of one (1) year beginning March 1, 1991, at an approximate rate of $72 per day. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. After provision of these services, SAIF shall close the claim pursuant to OAR 438-12-055.

IT IS SO ORDERED.

March 15, 1991 Cite as 43 Van Natta 568 (1991)

In the Matter of the Compensation of
DANNIE W. CRAWLEY, Claimant
Own Motion No. 90-0127M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation voluntarily reopened claimant's claim for an alleged worsening of his September 5, 1974, industrial injury. SAIF requests Board authorization of reimbursement from the Reopened Claims Reserve for its payment of temporary disability benefits. We deny authorization for reimbursement.

The relevant facts follow. Claimant compensably injured his right ankle and foot on September 5, 1974. The claim was processed and closed on November 18, 1976. On May 1, 1986, claimant entered an authorized training program and his claim was reopened for the payment of temporary disability benefits. Training was suspended, however, when claimant underwent right foot surgery on February 8, 1987, and was unable to continue training. The carrier voluntarily paid temporary disability benefits during claimant's recovery from surgery. Claimant had additional foot surgeries on September 16, 1987, April 27, 1989, and February 7, 1990. Vocational assistance services were terminated November 1, 1989. Claimant was declared medically stationary on May 25, 1990, by Drs. Rothstein and Dinneen, who examined claimant at the carrier's request. A Determination Order issued on October 30, 1990, awarding temporary disability benefits from May 1, 1986, through February 7, 1987. The carrier now requests that the Board reopen claimant's claim and authorize reimbursement for temporary disability benefits it voluntarily paid from February 8, 1987, the date of surgery, through May 25, 1990, the date he was allegedly medically stationary.

Inasmuch as the carrier voluntarily reopened claimant's claim under the Board's own motion authority in 1987, it is unnecessary for the Board to order reopening of the claim. Furthermore, were we to award temporary disability benefits under our own motion authority, we would decline to authorize reimbursement of benefits paid since February 8, 1987.

ORS 656.625(1) provides that the Director "shall establish a Reopened Claims Reserve within the Insurance and Finance Fund for the purpose of reimbursing the additional amounts of compensation payable to injured workers that results from any award made by the board pursuant to ORS 656.278 after January 1, 1988." Notwithstanding any other provision of law, any reimbursement from the Reopened Claims Reserve shall be in such amounts as the Board prescribes and only to the extent that funds are available in the reserve. ORS 656.625(1). These provisions became operative January 1, 1988. Oregon Laws 1987, ch 884, 63; Andy Webb, 40 Van Natta 586 (1988).

We have authorized reimbursement to carriers which voluntarily reopened claims on or after January 1, 1988, provided the circumstances satisfied the requirements for temporary disability awards under ORS 656.278(1). However, we have declined to authorize reimbursement to a carrier which voluntarily reopened a claim before January 1, 1988. Raymun B. Savalas, 43 Van Natta 38 (1991). In Savalas, we reasoned that a claim reopening before January 1, 1988, does not qualify as an award made "pursuant to ORS 656.278 after January 1, 1988," as provided in ORS 656.625. We concluded, therefore, that ORS 656.625 does not permit reimbursement of benefits paid pursuant to a pre-1988 reopening. Adhering to that reasoning here, we conclude that the carrier's voluntary reopening of claimant's claim in 1987 does not qualify for reimbursement from the Reopened Claims Reserve. See id. Accordingly, the carrier's request for reimbursement is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
BETTY S. FRANKLIN, Claimant
WCB Case No. 89-13985
ORDER OF ABATEMENT
Pozzi, et al., Claimant Attorneys
Darryl Nelson, Defense Attorneys

Claimant has moved for abatement of our February 27, 1991 order, which reversed that portion of a Referee's order that set aside the insurer's medical services denial. Contending that the parties intend to resolve this matter pursuant to a Claim Disposition Agreement and Disputed Claim Settlement, claimant seeks abatement of our order to await submission of the settlement agreements.

Based on the representations contained in claimant's motion, the Board withdraws its February 27, 1991 order. The insurer is requested to submit its response to claimant's motion within 10 days from the date of this order. In addition, the parties are requested to keep the Board fully apprised of further developments in this case.

IT IS SO ORDERED.

In the Matter of the Compensation of
NELLIE M. LEDBETTER, Claimant
WCB Case Nos. 88-10890 & 87-19614
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Howell and Speer.

The self-insured employer requests review of those portions of Referee Brazeau's order which: (1) set aside its denial of claimant's claim for her psychological condition; and (2) granted permanent total disability whereas a Determination Order awarded 40 percent (128 degrees) unscheduled permanent disability for a low back condition. In its brief, the employer also moves the Board for an order "remanding" claimant's psychological condition claim to the Evaluation Section for an extent of disability evaluation. On review, the issues are jurisdiction, compensability and permanent total disability. We affirm.

FINDINGS OF FACT

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

Claimant suffers from a somataform pain disorder and paranoid disorder with passive-aggressive personality presentation. (Ex. 108-5). Claimant's paranoia causes her to be suspicious of others and to mistrust those in her environment for real or imagined reasons. Claimant's paranoia and inability to trust those in her environment make it very difficult to work with her psychiatrically and vocationally. (Ex. 108-14). Claimant's condition causes her to be confused, distractible and to have delusions and memory problems. (Ex. 108-57).

Claimant is physically unable to return to her job at the time of injury. Claimant's work history indicates no transferable skills. Claimant has been in

vocational programs on and off since her compensable injury in 1983. She has not worked since 1984 when she held a part-time job which failed because of claimant's unrealistic expectations and "acting out" pursuant to her paranoia. (See Exs. 40 & 94). Although claimant has never succeeded in vocational assistance, she has never been involved in any activities which would be considered as non-cooperative. (Ex. 106-5). Claimant cooperated to the best of her ability in vocational assistance efforts, had expressed a willingness to work and a willingness to relocate if necessary. (Ex. 94-5, 106-5).

FINDINGS OF ULTIMATE FACT

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

Efforts to obtain work would be futile.

But for the compensable injury, claimant would be willing to seek regular gainful employment.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matter

We note that except for 6 exhibits received into evidence by the Opinion and Order, no exhibits were marked or received formally. However, the Referee made reference to some of the exhibits in his opinion and the parties make reference to exhibits in their briefs. All the exhibits listed as intended to be received are included in the record as certified by the Referee to us under ORS 656.295(3). There are no evidentiary objections in the record. Accordingly, we conclude that the Referee intended to admit --and implicitly did admit-- all exhibits offered by the parties. See Kevin L. Neilsen, 42 Van Natta 1380 (1990); William v. Bellamy, 42 Van Natta 651 (1990); P.D. Hildebrandt, 40 Van Natta 2057 (1988).

Therefore, we consider all the exhibits as a part of the record for the purposes of our review. ORS 656.295(5).

Compensability of Psychological Condition

We adopt the Referee's "Conclusions and Opinion" regarding the compensability of claimant's preexisting psychological condition.

Jurisdiction

As a threshold issue, the self-insured employer contends that because claimant's psychological condition had never been formally accepted, it was not considered at the time of the June 1988 Determination Order. Therefore, the employer argues, it was error for the Referee to rate the extent of claimant's disability taking into consideration claimant's psychological condition as a compensable consequence of her injury. Rather, the employer contends that claimant's claim must first be "remanded" to the Evaluation Section for a new evaluation. We conclude that the Referee had the authority to determine the extent of claimant's disability.

First, we do not necessarily agree that the Evaluation Section did not consider claimant's emotional condition when it determined her claim. At the time of the June 1988 Determination Order, the employer had not denied claimant's emotional condition. Former OAR 436-30-005(4) provided that the Evaluation Section's "determination" establish disability which was a result of the

compensable disabling injury. We have no reason to believe the Evaluation Section did not do that. In any case, upon claimant's request for a hearing from the June 1988 Determination Order, and upon the Referee's determination that claimant's psychological condition was compensable, the Referee had the authority to determine all matters concerning claimant's claim, including the extent of disability stemming from the compensable injury, taking into consideration all compensable consequences of the compensable injury. ORS 656.283 & 656.708; see Michael D. McGinnis, 42 Van Natta 1969 (1990).

Permanent Total Disability

On the merits, the Referee concluded that claimant is permanently totally disabled. We agree and adopt his discussion of this issue with the following supplementation.

Claimant must prove by a preponderance of the evidence that she is permanently totally disabled. Harris v. SAIF, 292 Or 683 (1982). One essential element to an award of permanent total disability is that claimant must establish that even though not working, she is willing to seek work and has made reasonable efforts to obtain work unless it is shown that such efforts would be futile. Even if a work search would be futile, claimant must establish that but for the compensable injury, she would have been willing to seek regular gainful employment. ORS 656.206(3); SAIF v. Orr, 101 Or App 612 (1990); SAIF v. Stephen, 303 Or 41 (1989); Butcher v. SAIF, 45 Or App 318 (1983). Findings of futility are reserved for the extreme situation where, for example, the record shows the individual is physically totally disabled or is not capable of retraining. See Georgia Pacific Corp. v. Perry, 92 Or App 56 (1988).

The underlying facts in the Referee's "Findings of Fact" could suggest that claimant has not made reasonable efforts to obtain work and is not willing to retrain. However, we are persuaded by the record as a whole, particularly the deposition of claimant's treating psychiatrist, Dr. Henderson, that claimant's paranoia, which became "unmasked with her injury and the stress of it," precludes vocational retraining and makes a work search futile. Claimant has a preexisting psychological disorder. She worked until 1983 when the compensable injury materially caused a worsening of her psychological condition. The vocational rehabilitation evidence indicates that since the compensable injury claimant's worsened somataform pain disorder and paranoid disorder prevent her from succeeding in a vocational rehabilitation program and from obtaining suitable employment. Moreover, we are persuaded that, but for the compensable injury and its psychological sequelae, claimant would have been willing to seek regular gainful employment. (See Exs. 94, 106 & 108, 108-45).

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 is $800, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the significant complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated December 19, 1989, as reconsidered March 13, 1990, is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $800, to be paid by the employer.

In the Matter of the Compensation of
RALPH S. PETTEFER, Claimant
WCB Case No. 89-24969
ORDER ON REVIEW
Thomas E. Ewing, Assistant Attorney General

Reviewed by Board Members Speer and Howell.

Claimant, pro se, requests review of Referee Spangler's order that upheld the Inmate Injury Fund's denial of his claim for medical services. 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

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

In order to prove entitlement to injury-related benefits, claimant, an inmate, must show that his injury was sustained in the course of "authorized employment." ORS 655.510(1); see Dept. of Justice v. Spear, 94 Or App 677 (1989), aff'd on other grounds Dept. of Justice v. Spear, 308 Or 594 (1989). In this case, to sustain his burden, claimant must show that "compensation has been established" for his activities at the greenhouse at the time of his injury. ORS 655.505(1)(c); ORS 421.408; see OAR 291-137-045.

On this record, we are unable to determine whether compensation had been established for claimant's work at injury. Therefore, claimant has not proven entitlement to the benefits which he seeks.

ORDER

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

In the Matter of the Compensation of
PHILLIP D. PRINCE, Claimant
WCB Case Nos. 89-17681 & 89-09699
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Brian L. Pocock, Defense Attorney
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The self-insured employer requests review of Referee McCullough's order which: (1) set aside its denials of compensability of and responsibility for claimant's bilateral hearing loss; and (2) upheld the SAIF Corporation's denial insofar as it denied responsibility for the condition. On review, the issues are compensability and responsibility. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" with the exception of the second full paragraph on page three of the Opinion and Order.

CONCLUSIONS OF LAW AND OPINION

Compensability

Relying on a statement from Dr. Ediger recommending that claimant reduce his noise exposure at work and at home, the Referee inferred that the doctor felt that claimant's noise exposure at work had been at least a material contributing cause of his present hearing loss condition. (Ex. 16-3). We disagree. The implication that noise exposure at work could worsen claimant's hearing does not necessarily support the conclusion that prior work-related noise exposure caused a loss of hearing.

In that same report, Dr. Ediger stated that claimant did not have measurable hearing loss as defined by OAR 436-35-250, and goes on to state "these test findings do not suggest that Mr. Prince has 'measurable' hearing loss as a result of his work as a firefighter." In neither of his reports does Dr. Ediger relate claimant's job exposure to his hearing loss. (Exs. 16, 23).

Dr. Hiatt examined claimant in August 1989. He reviewed reports by Dr. Ediger and Dr. Howell. It was his opinion that claimant did not have a compensable hearing loss because, after comparing audiograms between 1977 and 1989, and taking into consideration presbycusis, his hearing loss equals zero percent. Additionally, he felt that the difference between claimant's left and right ear was not related to on-the-job noise. (Exs. 22, 26).

Claimant was examined by Dr. Howell in March 1989. She did not have an explanation for the asymmetry of hearing loss in the two ears. She did feel that noise exposure had probably been a contributing factor to claimant's hearing loss, but did not feel that it accounted, alone, for the pattern of his hearing loss. Dr. Howell did not relate claimant's noise-related hearing loss to his job, and she did acknowledge noise exposure away from the job. (Ex. 13A).

After a de novo review of the medical evidence, we do not find that claimant has met his burden of proving that his hearing loss arose out of his employment. Because we do not find claimant's claim compensable, we do not reach the issue of responsibility.

ORDER

The Referee's order dated May 30, 1990 is reversed. The self-insured employer's denials of May 15, 1989 and June 14, 1989 are reinstated and upheld. The SAIF Corporation's denial dated March 26, 1990 is reinstated and upheld in its entirety. The Referee's assessed fee award of $2,100 is reversed.

In the Matter of the Compensation of
DEAN A. TSCHANTRE, Claimant
WCB Case No. 89-17108
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Lester R. Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

The SAIF Corporation requests review of that portion of Referee Harri's order which found that claimant had timely requested a hearing. On review, the issue is timeliness of hearing request. We affirm.

FINDINGS OF FACT

Claimant filed a claim for a shoulder injury on March 22, 1989. SAIF denied the claim by a letter dated May 15, 1989. There is no evidence in the record as to when that denial letter was mailed to claimant.

Claimant received the denial letter on May 31, 1989. (Ex. 6-2). Claimant, pro se, sent a letter requesting a hearing to SAIF, but not the Workers' Compensation Board. SAIF received the request on July 17, 1989 and forwarded it to the Board on August 30, 1989.

ULTIMATE FINDING OF FACT

Good cause existed for claimant's failure to file his request for hearing within 60 days of receipt of SAIF's denial.

CONCLUSIONS OF LAW AND OPINION

The test for determining if good cause exists has been equated with the standard of "mistake, inadvertence, surprise or excusable neglect" under ORCP 71(B)(1) and former ORS 18.160. Anderson v. Publishers Paper Co., 78 Or App 513, 517, rev den 301 Or 666 (1986); see also Brown v. EBI Companies, 289 Or 455 (1980). Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985).

SAIF sent a denial of claimant's shoulder condition to him by letter dated May 15, 1989. The record contains a return receipt showing that the letter was received on May 31, 1989. However, there is no evidence in the record to prove when the letter was mailed. Because there is no presumption that a letter is mailed on the day it is dated, or on the day it was written, and absent proof of the date of mailing, the date of receipt begins the 60 day period within which to request a hearing. Madewell v. Salvation Army, 49 Or App 713 (1980).

Here, claimant received the denial letter on May 31, 1989. The 60 day period within which claimant was required to file his hearing request ended on July 31, 1989. Claimant's request for hearing was received by SAIF on July 17, 1989, within the 60 day period. However, it was not filed with the Board until August 30, 1989. ORS 656.283(3); former OAR 438-05-046(1). The request was filed 91 days after the denial, not within the 60 day limit required by statute, however, we conclude that claimant has established good cause for his failure to timely file the request.

Former OAR 438-05-075 states "[i]f a claimant sends a request for hearing or Board review to the employer or insurer, the employer or insurer shall promptly forward the request to the Board. That rule required SAIF to promptly forward claimant's misdirected request to the Board. SAIF received the request for hearing within 47 days of its denial. If it had promptly forwarded the request to the Board, the Board would have received claimant's request within the 60 day period, rather than 91 days later. Because the delay in filing between the 47th day and the 91st day resulted from SAIF's failure to promptly forward the request for hearing as required by the rule, we conclude that good cause existed for claimant's failure to timely file his request for hearing. See Giusti Wine Co. v. Adams, 102 Or App 329 (1990). The hearing request is not barred. See former ORS 656.319(1)(b).

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 is $500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), and the value of the interest involved.

ORDER

The Referee's order dated April 23, 1990, as reconsidered June 7, 1990, is affirmed. Claimant's attorney is awarded a reasonable attorney fee of $500, payable by the SAIF Corporation.

In the Matter of the Compensation of
FRED L. SNIDER, Claimant
WCB Case No. 87-12658
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Malagon, et al., Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

The self-insured employer requests review of those portions of Referee Gruber's order which: (1) set aside its partial denial of claimant's left perilymph fistula condition; (2) awarded claimant's attorney an assessed fee of $11,000; and (3) awarded the attorney associated by claimant's attorney a separate assessed fee of $13,000 for prevailing on the compensability issue. On review, the issues are compensability and amount of attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

The Board adopts the Referee's "Conclusion and Reasoning" with respect to this issue.

Attorney Fee

Claimant's attorney is entitled to an assessed attorney fee. ORS 656.386(1). The way in which that fee is distributed to counsel associated by claimant's attorney is a matter to be decided between the two of them, not this forum.

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 issue of compensability of claimant's left fistula surgery is $16,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (including the fact that some of the time devoted to the case by the two attorneys was duplicative) in preparation for the hearing, including the time required for taking depositions, and as represented by claimant's respondent's brief on appeal. We have also considered the complexity of the issue of compensability of perilymph fistulas, the value of the surgery to claimant and the risk of claimant's attorney going uncompensated.

ORDER

The Referee's order dated December 27, 1989, as reconsidered February 9, 1990, is affirmed in part and modified in part. That portion awarding claimant's attorney and the associated attorney separate fees is modified. For services at hearing and on review, claimant's attorney is awarded a reasonable assessed fee of $16,000, payable by the self-insured employer. The remainder of the order is affirmed.

In the Matter of the Compensation of
MARK S. CLANCY, Claimant
WCB Case No. 89-07992
ORDER ON REVIEW
Ron Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant, pro se, requests a review of Referee Bennett's order which: (1) upheld the SAIF Corporation's "de facto" denial of his aggravation claim for a low back condition; (2) increased claimant's unscheduled permanent disability award for a low back injury from 11 percent (35.2 degrees), as awarded by a Determination Order, to 20 percent (64 degrees); (3) found that claimant was not entitled to temporary total disability benefits from July 18, 1987 through April 5, 1988; and (4) declined to assess a penalty and related attorney fee for SAIF's allegedly unreasonable "de facto" denial. On review, the issues are aggravation, temporary total disability benefits, extent of unscheduled permanent disability, penalties and attorney fees. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's facts as contained in his "Findings" and "Opinion" sections with the following corrections. Claimant injured his back while moving 500 pounds of metal shelving up stairs with a hand truck, not while lifting bookcases. Claimant has demonstrated competence as a furniture-mover driver. Therefore, he has acquired on-the-job training sufficient to perform other than entry level employment.

In addition, we supplement with the following findings of fact. Claimant underwent a subcutaneous discectomy at L5-S1 with incomplete removal of the disc material; claimant has a residual disc herniation at the same level.

Claimant's condition became medically stationary February 16, 1989.

FINDINGS OF ULTIMATE FACT

Claimant's compensable injury is not a material contributing cause of his recurrent L5-S1 herniation and new L4-5 herniation.

Claimant has sustained a 20 percent permanent loss of earning capacity as a result of his compensable low back injury.

SAIF's failure to process claimant's aggravation claim within 60 days was unreasonable. There are no amounts due under the aggravation claim. SAIF's failure to process the aggravation claim was not a resistance to the payment of compensation.

CONCLUSIONS OF LAW AND OPINION

Aggravation

The Referee concluded that claimant had not established that his current condition was materially related to his industrial injury and, therefore, found that he had not sustained an aggravation. We agree.

In order to establish a compensable aggravation, claimant must prove that: (1) his condition has worsened since the last arrangement of compensation, so that he is more disabled, either temporarily or permanently; and (2) his compensable injury was a material contributing cause of the worsened condition. ORS 656.273(1); Grable v. Weyerhaeuser, 291 Or 387, 400-01 (1981); Smith v. SAIF, 302 Or 396, 399 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989). When,

as here, the claim involves an unscheduled body part, "more disabled" means increased loss of earning capacity. Smith v. SAIF, supra.

The courts have held that a claimant's testimony and reported complaints may be sufficient to establish a compensable aggravation claim. See Garbutt v. SAIF, 297 Or 148, 151-52 (1984). Claimant seeks to establish the compensability of a new herniated disc at L4-5 and a recurrent herniation at L5-S1. He testified that he developed leg pain and difficulty walking after a follow-up examination as a part of his work-hardening program. Subsequent MRI scan and examination by Dr. Misko, claimant's treating neurosurgeon, merely establish that claimant has the disc conditions alleged, and that claimant related the new symptoms to "the maneuvers" he performed during the follow-up examination.

Although clamant's testimony is probative on the issue of causation, we do not find it persuasive in the absence of any corroborating medical evidence relating either the recurrent herniation at L5-S1 or the new L4-5 disc to the compensable injury. Accordingly, we conclude that claimant has not established that his industrial injury materially contributed to his alleged worsening. Consequently, we affirm the Referee that the evidence does not support a finding that claimant suffered an aggravation of his compensable September 1986 injury.

Temporary Total Disability (TTD) from July 18, 1987 through April 5, 1988

We affirm and adopt the Referee's reasoning and conclusion that claimant was not disabled during this period.

Extent of Permanent Partial Disability

The Referee increased claimant's unscheduled permanent disability award for his low back injury from 11 percent to 20 percent. On de novo review, we calculate a different value.

The Referee did not specify which "standards" he was applying. For purposes of determining work-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's condition became medically stationary on February 16, 1989, and his claim was closed by Determination Order on April 10, 1989. Therefore, we apply the "standards" effective January 1, 1989 in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled 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. Former OAR 436-35-280.

Age and Education

We agree with the Referee that the appropriate value for claimant's age of 37 years is 0; the appropriate value for claimant's 12 years of formal education

is 0; and the appropriate value for his skills at the SVP 4 level is 3. Former OAR 436-35-290; former OAR 436-35-300(3); former OAR 436-35-300(4).

We do not agree with the Referee that claimant "has no training, and therefore receives a value of 1 for training." Whether claimant is entitled to a value for training under former OAR 436-35-300(5) is dependent upon whether or not claimant has demonstrated competence in some specific vocational pursuit. Competence in some "specific vocational pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off the job to perform other than an entry level position. Larry L. McDougal, 42 Van Natta 1544 (1990).

Here, claimant has demonstrated competence in a specific vocational pursuit, namely as a furniture-mover driver. Therefore, the appropriate training value is a 0. Former OAR 436-35-300(5).

Adaptability

We agree with the Referee that the appropriate value for claimant's ability to perform heavy work with limitations in twisting and bending is 1. Former OAR 436-35-310(4).

Impairment

The Referee awarded claimant a 16 percent impairment value under the "standards." We assign a different value.

Claimant underwent a percutaneous discectomy at L5-S1, with removal of most of the disc, for a value of 4 percent. Former OAR 436-35-350(2). We agree with the Referee that claimant is also entitled to 4 percent for his recurrent disc derangement at the same L5-S1 level. The record demonstrates that claimant suffers additional impairment from the recurrent herniation beyond that caused by the surgery. See id. ("any" unoperated disc bulge); see also Claudia J. Percy, 42 Van Natta 1209 (1990) and Harold L. McAllister, 42 Van Natta 1179 (1990) (claimant entitled to two awards for two surgical procedures at the same site when claimant suffers a greater degree of impairment as a result of the second procedure). Claimant retains 75 degrees flexion of the thoracolumbar spine for an award of 1.5 percent. Former OAR 436-35-360(6). Finally, he has lost the repetitive use of his low back for an award of 5 percent. Former OAR 436-35-320(4).

The value for claimant's surgery (4) and the value for the reherniation (4) are added for a total of 8. Richard J. Roth, Jr., 42 Van Natta 1315 (1990). That value is combined not added, with the values for lost range of motion (1.5) and lost repetitive use (5), for a total impairment value of 13.91 percent. Former OAR 436-35-360(11).

Computation of Unscheduled Permanent Disability

Having determined each value necessary to compute a claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value 0 is added to his education value 3, the sum is 3. When that value is multiplied by claimant's adaptability value 1, the product is 3. When that value is added to claimant's impairment value 13.91, the result is 16.91 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, 17 percent.

However, as SAIF has not requested a reduction in claimant's disability award of 20 percent, on review, we do not disturb that award. Daniel M. Alire, 41 Van Natta 752 (1989).

Penalties and Attorney Fees for Alleged "De Facto" Denial

We affirm the Referee's conclusion that no penalties and attorney fees are warranted with the following comments.

Claimant filed an aggravation claim with SAIF on June 26, 1989, which SAIF has never accepted or denied. SAIF should have accepted or denied this aggravation claim within 60 days. Accordingly, we conclude that SAIF unreasonably failed to timely process claimant's aggravation 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 claimant's aggravation claim not to be 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 aggravation claim and there is no evidence of other compensation unpaid, 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 for SAIF's "de facto" denial. Lloyd L. Cripe, 41 Van Natta 1774 (1989).

ORDER

The Referee's order dated November 24, 1989 is affirmed.

March 7, 1991 Cite as 43 Van Natta 581 (1991)

In the Matter of the Compensation of
TERRY MAGGARD, Claimant
WCB Case No. C1-00274
ORDER DENYING RECONSIDERATION
Coons & Cole, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

The self-insured employer requests reconsideration of our February 12, 1991 Order Disapproving Claim Disposition Agreement. Specifically, the employer seeks approval of the claim disposition agreement (CDA) on the ground that it had provided separate notice regarding the claim disposition pursuant to OAR 436-60-145(4)(g). In sum, a letter was sent to claimant which incorporated the language required by the administrative rule.

The claim disposition agreement was acknowledged on February 4, 1991 in accordance with our standard procedures under former OAR 438-09-025(2) & (3).

On February 12, 1991, we issued an order disapproving the CDA. We disapproved the CDA because the notice required pursuant to OAR 436-60-145(4)(g) is neither in the agreement nor incorporated by reference into the agreement. A proposed disposition that does not contain the required notice will not be approved by the Board. See OAR 436-60-145(5); 438-09-020(1). The required notice was neither in the agreement nor had it been incorporated by reference. Consequently, we set aside the CDA.

On February 15, 1991, the employer moved for reconsideration of the disapproval order, alleging that the claim disposition agreement provided that notice

had been given to claimant and that a separate letter had been sent to claimant which incorporated the language required by the administrative rule.

Here, our sole objection to the claimant disposition agreement has not been resolved. Pursuant to former OAR 436-60-145(6)(d), it was sufficient for a CDA to recite that the required notice had been sent. Nevertheless, pursuant to OAR 436-60-145(4)(g), which applies to this agreement, the notice language must actually appear in the actual agreement or be incorporated by reference in the agreement. The notice enclosed with the Motion for Reconsideration is not contained in the disposition agreement nor incorporated by reference.

Accordingly, the request for reconsideration is denied. We adhere to our February 12, 1991 order. Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

March 13, 1991 Cite as 43 Van Natta 582 (1991)

In the Matter of the Compensation of
MICHAEL A. WHITE, Claimant
WCB Case No. C1-00163
ORDER WITHDRAWING ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Zbinden & Curtis, Claimant Attorneys
Charles E. Lundeen, Defense Attorney

Reviewed by Board Members Myers and Cushing.

On February 25, 1991, we approved the parties' Claim Disposition Agreement (CDA). It has since been brought to our attention that, on February 21, 1991, we received claimant's counsel's February 20, 1991 letter, which stated that claimant "no longer wishes to agree" to the CDA. Inasmuch as we find claimant requested disapproval of the CDA within 30 days of its submission to the Board, we withdraw our approval order and disapprove the CDA. We base our decision on the following reasoning.

A CDA shall receive Board approval unless: (1) the Board finds that the proposed disposition is unreasonable as a matter of law; (2) the Board finds the proposed disposition is the result of an intentional misrepresentation of material fact; or (3) within 30 days of submitting the disposition for approval, the worker requests the Board to disapprove the disposition. ORS 656.236(1)(a), (b), and (c). The third disapproval ground is relevant for our analysis.

The parties' CDA was received by the Board on January 24, 1991. Thus, under OAR 438-09-025(2), claimant had 30 days from January 24, 1991 to request disapproval of the agreement. See ORS 656.236(1)(c). On February 21, 1991, the Board received claimant's counsel's February 20, 1991 letter stating that claimant did not wish to agree to the proposed disposition. Although received by the Board before the expiration of the statutory 30-day period, the letter was not routed to the file before we approved the CDA on February 25, 1991.

Claimant's counsel's letter does not expressly declare that claimant was seeking Board disapproval of the CDA. However, since the letter does state that claimant "no longer wishes to agree" to the CDA, it is clear that he was, in effect, requesting that the Board not approve the disposition.

The letter was filed on February 21, 1991, the date it was received by the Board's Salem office. See OAR 438-05-046(1)(a). February 21, 1991 is within 30 days of January 24, 1991, the date the CDA was submitted. Because claimant requested Board disapproval within 30 days of the submission of the CDA, the

disposition should not have received approval. See ORS 656.236(1)(c). In other words, we lacked authority to approve the CDA.

Consequently, our February 25, 1991 approval is withdrawn as invalid and the parties' CDA is disapproved pursuant to ORS 656.236(1)(c). Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence any payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i), and (6)(e). Furthermore, in the event that proceeds from the CDA have been distributed, they should be immediately returned to the insurer.

IT IS SO ORDERED.

March 18, 1991 Cite as 43 Van Natta 583 (1991)

In the Matter of the Compensation of
JOSE JAIMES, Claimant
WCB Case No. C1-00207
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Philip Garrow, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

On February 22, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

We will 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 the existing statutes or rules. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990).

According to the terms of the claim disposition agreement, SAIF furnished claimant, who is unable to read or understand English, with a Spanish translation of the agreement and notice of rights of compliance with OAR 436-60-145(3). The translation is supposed to be attached to the agreement as "Exhibit A" along with a translator's affidavit swearing to its accuracy. Claimant evidently relied on the translation in construing the meaning and effect of the agreement before signing it. Yet, on pages 6 and 7 of the agreement, it provides that "Exhibit A does not constitute a part of the text of the agreement between the parties and, if there is a dispute as to the meaning of the stipulation, Exhibit A shall not be considered in resolving that dispute." We further note that Exhibit A which includes the Spanish translation of the proposed disposition is not in the file.

ORS 656.236(1) permits parties to dispose of any or all matters regarding a claim, except for medical services, "subject to such terms and conditions as the director [of the Department of Insurance and Finance] may prescribe." Correspondingly, our rules require that a claim disposition agreement contain the terms, conditions, and information as prescribed by the Director pursuant to OAR 436-60-145. See OAR 438-09-020(2)(a).

Implicit in the above requirements is that the claimant must understand the terms, conditions and information contained in the agreement. Indeed, the Director's rules provide that, if the claimant does not read or comprehend

English, the insurer must provide the aforementioned notice in a manner which ensures the claimant understands the meaning of a claim disposition. See OAR 436-60-145(2). Though not expressly stated, it follows that the terms, conditions and information in the agreement must also be provided in a manner which ensures that the claimant understands them.

Here, because claimant does not understand English, the Spanish translation is necessary to and, in fact, embodies claimant's understanding of this claim disposition. Without it, we cannot be certain that the terms and conditions in the English-written agreement are the same to which claimant has assented. To ensure that they are the same, the translation must constitute a part of the text of the agreement and be considered in any dispute as to its meaning and effect. By attempting to exclude the translation, the parties have failed to comply with ORS 656.236 and OAR 436-60-145. Accordingly, we decline to approve the agreement and it is therefore returned to the parties.

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
CLIFFORD A. LEASURE, Claimant
WCB Case Nos. 89-07895, 89-17330, 89-17282, 89-17281 & 89-17329
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Meyers & Radler, Defense Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Wagner Mining, a self-insured employer, requests review of those portions of Referee/Arbitrator Bennett's order which set aside its denial of compensability and responsibility for claimant's left arm condition. Cascade Corporation, also a self-insured employer, cross-requests review of those portions of Referee Bennett's order which found it responsible for claimant's right arm claim pursuant to an order issued under ORS 656.307. On review, the issues are compensability and responsibility for the left arm condition and responsibility for the right arm condition. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of his findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

We adopt those portions of the Referee's opinion labeled "responsibility for the right arm condition."

The Referee found the left arm condition compensable as an occupational disease and assigned responsibility to Wagner based on his interpretation of the

last injurious exposure rule. We conclude that claimant has failed to prove the compensability of the left arm condition.

The Referee acknowledged that no physician opined that the work activities at either Cascade or Wagner had caused the left arm condition or the symptoms in the left arm. Furthermore, no physician opined that claimant's work as a whole caused the left arm problems.

The Referee relied on claimant's testimony that his left arm hurt more after working at Wagner's to establish a causal link. We find the lay testimony insufficient to carry claimant's burden of proof because we conclude that this case presents a complex medical question of causation which may not be resolved by lay testimony alone. See Uris v. Compensation Department, 247 Or 420 (1967).

ORDER

The Referee's order dated November 27, 1989 is affirmed in part and reversed in part. Those portions of the Referee's order which set aside Wagner's denial of the left arm condition are reversed. The Referee's $600 assessed attorney fee award, payable by Wagner, is reversed. Wagner's denial of the left arm condition is reinstated and upheld. The balance of the Referee's order is affirmed.

March 19, 1991 Cite as 43 Van Natta 585 (1991)

In the Matter of the Compensation of
GILBERT R. BROWN, Claimant
WCB Case No. 89-04348
ORDER ON REVIEW
Wilbur C. Smith Jr., Claimant Attorney
Davis, et al., Defense Attorneys

Reviewed by Board Members Crider and Brittingham.

The insurer requests review of those portions of Referee Mulder's order which: (1) admitted certain exhibits submitted by claimant 5 days before hearing; and (2) set aside its denial of claimant's aggravation claim for a psychological condition. Claimant cross-requests review of those portions of the order which: (1) declined to award temporary total disability/interim compensation; (2) declined to assess penalties and attorney fees for failure to pay interim compensation; and (3) declined to assess penalties and attorney fees for the allegedly unreasonable denial. On review, the issues are evidence, aggravation, temporary disability/interim compensation, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact." In addition, we supplement with the following findings.

Claimant compensably injured his low back on November 22, 1983 requiring an L5-S1 laminectomy and discectomy in December 1984. The claim was closed by a February 19, 1988 Determination Order.

Claimant developed emotional problems as a result of his pain and inability to work. A July 1988 order issued by a prior Referee found claimant's psychological condition to be related to his compensable injury.

Since 1987, claimant has been receiving vocational assistance. He anticipated possible return to work as a weighmaster. In early February 1989, claimant interviewed for the job. Two weeks later, when he received notice that he

had not been selected for the position, he became depressed with suicidal ideation and required hospitalization.

In response to claimant's March 2, 1989 aggravation claim, the insurer issued its March 29, 1989 denial of claimant's depression condition and treatment therefor. At the time of the denial, Dr. Conant-Norville, psychiatrist, and Dr. Baxter, treating psychiatrist, had related claimant's increased emotional distress and hospitalization in February 1989 to claimant's compensable back injury. The reports did not identify any nonwork-related stressors in February 1989 and there is no other evidence in the record relating the current condition to off-work stressors.

The insurer did not pay temporary disability benefits/interim compensation following claimant's March 2, 1989 request to reopen his claim and before its March 29, 1989 denial.

A hearing on the March 1989 aggravation denial was held before Referee Mulder. The insurer submitted no exhibits prior to hearing. Five days before the hearing, claimant submitted Exhibits 1-145 to the insurer and the Referee. At hearing, the insurer objected to the admission of all exhibits as untimely. The Referee admitted all exhibits.

By final enforcement order of January 4, 1990, as reconsidered January 24, 1990, Referee Thye instructed the insurer to pay claimant temporary total disability [TTD] benefits beginning February 18, 1989, pursuant to Referee Mulder's order setting aside the insurer's aggravation denial.

FINDINGS OF ULTIMATE FACT

Claimant timely disclosed all exhibits to the insurer.

Since the last arrangement of compensation, claimant has suffered an exacerbation of his compensable psychiatric condition. Claimant's exacerbation resulted in diminished ability to work and total disability in excess of 14 days and inpatient hospitalization.

Claimant was in the work force and actively seeking work through the date he became unable to work. Claimant was unable to work after February 18, 1989.

The insurer's denial of claimant's aggravation claim was unreasonable.

Dr. Conant-Norville's February 27, 1989 report of claimant's hospitalization, which was forwarded to the insurer on March 2, 1989, provided the insurer with knowledge of claimant's medically verified inability to work resulting from a worsening of his compensable condition. The insurer's failure to pay temporary total disability was unreasonable.

CONCLUSIONS OF LAW AND OPINION

Evidence

The insurer requests that we find that the Referee erred in admitting all exhibits submitted by claimant five days prior to hearing. The rules do not require exclusion of the exhibits in this case.

OAR 438-07-018(1) requires the insurer to submit all relevant and material documents 20 days prior to hearing. It requires claimant to submit additional exhibits 10 days before hearing. In this case, the insurer submitted no exhibits; therefore, claimant offered all exhibits. Claimant's submission was untimely. However, nothing in the rules precludes admission of documents which

are untimely submitted, provided that they have been timely disclosed. Oliver F. Coons, 42 Van Natta 1845 (1990); Dolores P. Hoffman, 42 Van Natta 549, 550 (1990); see OAR 438-07-015(4) and OAR 438-07-018(4). The insurer makes no assertion that any of the documents were not disclosed timely. Under these circumstances, the Referee correctly received claimant's Exhibits 1-145.

Aggravation Claim

The Referee found that claimant's injury-related psychiatric condition worsened in February 1989. We agree.

To establish a compensable aggravation claim, claimant must prove a worsened condition resulting from the compensable injury. ORS 656.273(1); Smith v. SAIF, 302 Or 396 (1986). A "worsened condition" means increased symptoms, or a pathological change, resulting in diminished earning capacity. Perry v. SAIF, 307 Or 654, on remand 99 Or App 52 (1989). If the last arrangement of compensation anticipated future exacerbations accompanied by a diminished earning capacity, claimant must also prove: (1) that his earning capacity was diminished longer or in greater degree than was anticipated; or (2) that his exacerbation resulted in 14 consecutive days of total disability or inpatient hospitalization. Gwynn v. SAIF, 304 Or 345 (1987), on rem 91 Or App 84 (1988); Edward D. Lucas, 41 Van Natta 2272 (1989).

Here, claimant has had psychological problems since 1984 which previously were found to be related to his compensable low back condition. On review, the insurer argues that claimant did not experience a worsening of his psychological condition in February 1989. In the alternative, the insurer appears to argue that claimant's worsened psychological condition was the result of nonwork-related stressors. We reject both of the insurer's arguments.

Drs. Conant-Norville, Manley, and Baxter, all agree that claimant experienced the onset of severe depression in early 1989 requiring psychiatric hospitalization. Furthermore, all three physicians have related claimant's increased emotional distress and hospitalization to his compensable back injury. As there is evidence that claimant was both disabled for more than 14 days and hospitalized due to a worsening of his compensable injury, claimant's aggravation claim is compensable.

Entitlement to Temporary Total Disability/Interim Compensation

The Referee found claimant not entitled to interim compensation because claimant was not working at the time of the psychiatric hospitalization. On review, claimant asserts that he was entitled to both interim compensation pending issuance of the denial and temporary total disability benefits if this Board affirms the compensability of his aggravation claim. We agree.

We have concluded above that claimant's aggravation claim is compensable. He is, therefore, substantively entitled to temporary disability benefits from the onset of disability. Silsby v. SAIF, 39 Or App 555 (1979). In addition, claimant is procedurally entitled to temporary disability compensation, called "interim compensation", pending acceptance or denial of his claim. Such compensation is due within 14 days after the date upon which the employer or insurer received notice or knowledge of medically verified inability to work resulting from a worsened condition, unless the aggravation claim has been denied. See Former ORS 656.273(6); Berkey v. Fairview Hospital, 94 Or App 28 (1988).

The facts are not in dispute. On March 2, 1989, claimant provided the insurer with Dr. Conant-Norville's February 27, 1989 report documenting claimant's hospitalization for depression on February 18, 1989. Furthermore, there were no

reports attributing claimant's current psychiatric condition to nonwork-related causes. It is to be inferred that when claimant was in the hospital, he was unable to work. See, e.g., Merlyn E. Langley, 42 Van Natta 2745 (1990). Accordingly, we find that Dr. Conant-Norville's February 27, 1989 report of claimant's hospitalization provided the insurer with notice of claimant's medically verified inability to work, and established that claimant was disabled as of February 18, 1989.

Notwithstanding a finding that claimant was unable to work, in order to receive TTD, including interim compensation, claimant must also be in the work force at the time of the aggravation. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Cutright v. Weyerhaeuser, 299 Or 290 (1985); Joyce E. Mitts, 42 Van Natta 2745 (1990). A claimant is deemed 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.

In this case, claimant's inability to work was due to his injury-related physical and psychological problems, and not due to his voluntary withdrawal from the work force. Although claimant was not employed at the time he became disabled, he was receiving vocational assistance and was very eager to return to work. Accordingly, we conclude that claimant was a member of the work force at the time of the aggravation of his prior work-related injury. Dawkins, supra.

As this Board has found claimant's aggravation claim to be compensable, any time loss is due claimant in the form of temporary total disability. Silsby v. SAIF, supra. As noted, beginning February 18, 1989, claimant was unable to work as a result of a worsening of his compensable psychological condition. Furthermore, claimant was in the work force at the time of the aggravation of his prior work-related injury. Dawkins, supra; Cutright, supra. Accordingly, claimant is entitled to TTD benefits beginning February 18, 1989.

Penalties and Attorney Fees for Nonpayment of Interim Compensation and Unreasonable Denial of Aggravation Claim

The standard for determining an unreasonable denial is whether the carrier had a legitimate doubt as to its liability. Unreasonableness and "legitimate doubt" are to be considered in the light of all the evidence available at the time. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988), citing Norgard v. Rawlinsons, 30 Or App 999, 1003 (1977); see Carol J. Knapp, 41 Van Natta 851, 854 (1989).

The insurer concedes that claimant "submitted several current reports from three sources, all of which appear to support his claim of worsening." Nevertheless, the insurer contends that its denial of claimant's aggravation claim was not unreasonable because a review of prior reports from 1985 through 1988 shows numerous nonwork-related stressors. Furthermore, the insurer posits, "[i]t cannot be assumed that any of these three reporters [had] all of the relevant facts, or [was] willing to weigh them in rendering an opinion of the relative contribution of the work and nonwork stressors in claimant's recent episode."

These "nonwork stressors" were a history of family problems and drug use. However, there are no reports in this record suggesting that claimant's current condition is related to anything other than his compensable condition. In fact, the only contemporaneous reports in the record are those from Drs. Conant-Norville, Manley, and Baxter, all of whom attribute claimant's recent psychological problems to his compensable injury.

Accordingly, based on the record before us, we find nothing that would have provided the insurer with a legitimate doubt concerning the compensability of claimant's aggravation claim at the time of its denial. Consequently, we

assess a penalty and penalty-related attorney fees for the insurer's unreasonable denial. ORS 656.262(10); ORS 656.382(1).

Alternatively, claimant is entitled to a penalty and related fee for the insurer's failure to pay interim compensation. A penalty and attorney fee may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." The insurer failed to pay interim compensation in a timely manner although claimant provided the insurer with proper notice of his inability to work on March 2, 1989. Accordingly, on this basis, the insurer is liable for a penalty and related attorney fee based on the interim compensation due for the period March 2, 1989 through March 29, 1989, when the insurer issued its denial. Id.

Finally, after considering the factors set forth in OAR 438-15-010 (4) and applying them to this case, we find that reasonable fees concerning the insurer's unreasonable resistance to the payment of compensation and for claimant's counsel's services on review concerning the insurer's request for review are $500 each, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's respondent's brief), the complexity of the issues, and the value of the interests involved.

ORDER

The Referee's order dated July 28, 1989 is affirmed in part and reversed in part. That portion of the order which declined to award claimant interim compensation/temporary total disability benefits is reversed. Claimant is awarded temporary total disability compensation beginning February 18, 1989, less amounts paid, until such compensation may be lawfully terminated. Claimant's counsel is awarded 25 percent of the temporary disability compensation awarded by this order, not exceeding $3,800, payable by the insurer directly to claimant's attorney. This fee shall not be reduced in accordance with amounts previously paid claimant for the aforementioned period. Those portions of the order which declined to assess penalties and penalty-related attorney fees for nonpayment of interim compensation and for unreasonable denial of claimant's aggravation claim are reversed. The insurer shall pay to claimant a penalty of 25 percent of the temporary disability compensation due between April 18, 1989 and the time of hearing, without consideration of any payment of compensation to claimant for the same period. Claimant's attorney is awarded a penalty-related attorney fee of $500, to be paid by the insurer. For services on review concerning the insurer's request for review, claimant is awarded a $500 attorney fee, payable by the insurer. The remainder of the order is affirmed.

March 19, 1991 Cite as 43 Van Natta 589 (1991)

In the Matter of the Compensation of
GUADALUPE V. GONZALEZ, Claimant
WCB Case Nos. 87-10501 & 87-19193
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Schwabe, et al., Defense Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Liberty Northwest Insurance Corporation, as insurer for Agripac, Inc., requests review of those portions of Referee Michael Johnson's order that: (1) set aside its denial of claimant's "new injury" claim for her low back

condition; and (2) upheld the aggravation denial for the same condition issued by Liberty Northwest, as insurer for General Foods Corporation. On review, Liberty Northwest, as insurer for Agripac, moves to strike claimant's reply brief. The issues on review are motion to strike, compensability and responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation. In February 1987 ownership of the food processing plant, where claimant worked seasonally, changed from General Foods to Agripac.

On June 10, 1987, an MRI ordered by Dr. DeShaw, claimant's then treating chiropractor, revealed a mild L5-S1 disc bulge. (Ex. 36).

On July 16, 1987, a CT scan ordered by Dr. Davies, claimant's then treating osteopathic physician, was performed. The body of the report discussed a disc herniation central to slightly right at L5-S1. The conclusion erroneously listed the disc herniation at L4-L5. (Ex. 44). On July 22, 1987, claimant began treating with Dr. Hoppert, orthopedist. (Ex. 48).

On September 16, 1987, claimant began treating with Dr. Poulson, orthopedist, who continued as claimant's treating physician as of the hearing. (Ex. 55). Claimant reported lumbar pain radiating to both lower extremities. (Exs. 59, 60). Poulson noted continuing limited range of motion. (Exs. 55, 58).

On October 12, 1987, a myelogram and a post-myelogram CT scan (with contrast) were performed. (Exs. 59, 60). Both showed asymmetric filling of the S1 nerve roots, not explained by any anatomic abnormality such as disc herniation. (Id). An EMG performed on February 2, 1988 was normal. (Ex. 73).

CONCLUSIONS OF LAW AND OPINION

MOTION TO STRIKE CLAIMANT'S REPLY BRIEF

Liberty Northwest, as insurer for Agripac, hereinafter Agripac/LNW, argues that, as a respondent, claimant is not entitled to file a reply brief in response to the brief filed by Liberty Northwest, as insurer for General Foods, hereinafter General Foods/LNW. We agree.

Claimant argues that, in effect, General Foods/LNW cross-appealed by disputing the Referee's findings regarding compensability, and that former OAR 438-11-020(2) entitles her to file a reply to that cross-appeal.

In fact, General Foods/LNW did not "file a cross-request for review" on the compensability issue. Therefore, former OAR 438-11-020(2) does not entitle claimant to file a cross-reply. Moreover, we decline to exercise our discretion under the rule to "otherwise authorize" claimant's reply brief. The brief filed by General Foods/LNW did not raise factual or legal issues not previously raised in the appellant's brief filed by Agripac/LNW. On this basis, we grant Agripac/LNW's motion to strike claimant's reply brief and we do not consider claimant's reply brief on review.

COMPENSABILITY/RESPONSIBILITY

The Referee found claimant's current condition compensable both as an aggravation claim against General Foods/LNW and as a new injury claim against Agripac/LNW. The Referee assigned responsibility to Agripac/LNW. We disagree.

To establish compensability of her aggravation claim, claimant must prove: (1) her back condition has worsened, by increased symptoms or a worsened underlying condition, rendering her more disabled, either temporarily or permanently; and (2) a causal connection between the worsened back condition and the 1984 compensable back injury with General Foods/LNW. See Smith v. SAIF, 302 Or 396, 399 (1986); Grable v. Weyerhaeuser Company, 291 Or 387, 400-01 (1981); Stepp v. SAIF, 78 Or App 438 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989). Because an unscheduled body part is involved, "more disabled" means increased loss of earning capacity. See Smith v. SAIF, supra. If claimant suffered a symptomatic exacerbation and the prior award contemplated future symptomatic exacerbations accompanied by a diminished earning capacity, then claimant must also prove either that her earning capacity was diminished longer or in greater degree than was anticipated, or that her earning capacity resulted in 14 consecutive days of total disability or inpatient hospitalization. Gywnn v. SAIF, 304 Or 345 (1987), on rem 91 Or App 84 (1988); Edward D. Lucas, supra.

Here, the 1984 injury claim was last closed by a March 14, 1985 Determination Order that did not award permanent disability; therefore, we find that future exacerbations resulting in a loss of earning capacity were not contemplated. See Louis A. Duchene, 41 Van Natta 2399, 2400 (1989). Consequently, any subsequent change in claimant's condition resulting in temporary or permanent loss of earning capacity would be sufficient to prove increased disability.

Claimant's symptoms after the 1984 injury included moderate low back pain. Her back was not completely well but she was released to and able to perform her regular work. (Ex. 12; Tr. 99).

In May 1986 and again in May 1987, Dr. DeShaw, her treating chiropractor, noted that claimant still had pain in her low back. (Ex. 65-1). Over the next few weeks she continued to receive treatment for low back pain and her symptoms increased, including bilateral pain to her thighs, until Dr. DeShaw took her off work on June 2, 1987. There is no release to return to work in the record and, on March 14, 1988, Dr. Poulson stated that claimant was unable to work at the present time. (Ex. 74).

We conclude that the increased symptoms and the inability to work for more than nine months establishes a worsening of claimant's compensable condition and an increased loss of her earning capacity. As to the issue of causation, we rely on the well-reasoned opinion of Dr. Hoppert, former treating orthopedist, who concluded that claimant suffered an aggravation of her 1984 injury. (Ex. 75). We note that Hoppert's opinion is supported by that of Dr. Davies, former treating osteopathic physician, and Dr. DeShaw. (Ex. 71).

Accordingly, claimant has established a compensable aggravation of her accepted 1984 back injury with General Foods/LNW. Consequently, General Foods/LNW remains responsible for that condition unless the later employment with Agripac/LNW independently contributed, however slightly, to a pathological worsening of the accepted condition. Spurlock v. International Paper Co., 89 Or App 461 (1988); Crowe v. Jeld-Wen, 77 Or App 81 (1985); Fred Meyer v. Benjamin Franklin Savings & Loan, 73 Or App 795 (1985); see Hensel Phelps v. Mirich, 81 Or App 290 (1986).

The Referee concluded that Agripac/LNW had the burden of proving that work activity with Agripac did not independently contribute to claimant's condition. He determined that the evidence was in equipoise, and concluded Agripac/LNW was responsible because it had not met its burden of proof. The Referee based his analysis on the reasoning in Donald D. Davis, 40 Van Natta 2000, 2002 (1988). However, this reasoning was disavowed in Linda L. Wise, 42 Van Natta 115, 117 (1990), to the extent burden of proof was placed on second carrier which has no

accepted claim and no work-related injury. Moreover, we disagree that the evidence is in equipoise.

Only Dr. Poulson, the current treating orthopedist, found an independent contribution at Agripac. He opined that "the incident of June 2, 1987" independently contributed to a worsening of claimant's condition and increased the underlying pathology because her increased pain lasted more than 3 months. (Ex. 74).

The Board generally gives greater weight to the conclusions of a treating physician; however, it will not so defer when there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds, 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986). Here, there are persuasive reasons not to defer to Dr. Poulson. All of his chart notes relate claimant's current condition to her 1984 injury with no indication of a "June 2, 1987 incident", and he does not explain why he changed his opinion. (Exs. 55, 56, 58). See Raul Herrara, 40 Van Natta 1281 (1988). His opinion is conclusory and based on increased symptoms without any objective evidence of a pathological worsening.

In particular, his opinion is not supported by the October 1987 contrast CT scan and myelogram, or the February 1988 EMG he ordered. None of these tests showed evidence of a disc herniation. (Exs. 59, 60, 73-2). An earlier June 10, 1987 MRI and July 16, 1987 CT scan did suggest a disc herniation. However, we find the October 1987 and February 1988 tests more persuasive because they are more recent and the October 1987 CT scan was done with contrast. Moreover, although both Drs. Hoppert and Davies were aware of the July 16, 1987 CT scan, neither stated that this indicated a pathological worsening of claimant's condition as a result of work at Agripac.

On this record, we find that claimant's work at Agripac did not cause a pathological worsening of her underlying condition. Consequently, General Foods/LNW is responsible for claimant's condition.

In reaching this decision, we reject the employers' argument that neither carrier is responsible for claimant's condition because her report of worsened symptoms during her last day of work with Agripac is not credible.

We disagree that the resolution of the compensability and responsibility issues turns on the reliability of claimant's history. Even assuming that claimant's back and leg pain did not worsen on her last day of work at Agripac, the record otherwise establishes a compensable aggravation claim: (1) claimant experienced intermittent flare-ups of low back pain following claim closure, and since May 1987 she received regular treatment for her 1984 work injury; (2) Dr. DeShaw found increased symptoms as a result of which claimant was less able to work; and (3) the medical records establish that her 1984 work injury remains a material contributing cause of her increased symptoms. Furthermore, regardless whether claimant's symptoms increased during work activity with Agripac, General Foods/LNW remains responsible because the work with Agripac did not independently contribute to claimant's condition.

Accordingly, we reverse the Referee's responsibility ruling and assign responsibility to General Foods/LNW.

ASSESSED ATTORNEY FEES

The Referee instructed Agripac/LNW to pay claimant's attorney a $1,800 assessed fee concerning its compensability and responsibility denial. The Referee also instructed General Foods/LNW to pay an $800 assessed fee concerning its compensability denial. As we have found that General Foods/LNW is

responsible for claimant's condition, it is also responsible for any assessed fee for services at hearing concerning both the compensability and responsibility issues. Claimant is also entitled to an assessed fee on review, payable by General Foods/LNW. In lieu of the Referee's attorney fee awards and for claimant's counsel's services on review, we award the following fee.

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 is $3,200, to be paid by General Foods/LNW. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated August 4, 1989 is reversed in part and affirmed in part. The denial issued by Liberty Northwest Insurance Corporation, as insurer for Agripac, Inc., is reinstated and upheld. The denial issued by Liberty Northwest, as insurer for General Foods Corporation, is set aside and the claim is remanded to Liberty Northwest for processing according to law. n lieu of the Referee's $2,600 attorney fee awards, for services at hearing and on review, claimant is awarded a reasonable attorney fee of $3,200, to be paid by Liberty Northwest, as insurer for General Foods. The remainder of the order is affirmed.

In the Matter of the Compensation of
WALTER E. MCCARTHY, Claimant
WCB Case No. 89-25548
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Crider and Brittingham.

The insurer requests review of those portions of Referee Bethlahmy's order that: (1) set aside its April 9, 1990 partial denial of claimant's compression fractures of the mid-back; and (2) awarded claimant an assessed attorney fee concerning the partial denial. Claimant cross-requests review of those portions of the Referee's order that: (1) declined to assess a penalty and attorney fee for the insurer's allegedly untimely and unreasonable December 15, 1989 denial of claimant's low back condition; and (2) declined to assess a penalty and attorney fee for the insurer's allegedly unreasonable partial denial of claimant's compression fractures. On review, the issues are claims processing, compensability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

Except for the last three paragraphs, we adopt the Referee's "FINDINGS OF FACT".

FINDINGS OF ULTIMATE FACT

The insurer's December 15, 1989 denial issued more than 60 days after notice or knowledge of the claim.

The December 15, 1989 denial was unreasonable.

The insurer resisted the payment of compensation by the timing and content of the December 15, 1989 denial.

A claim was filed on claimant's behalf for services related to compression fractures.

The insurer had legitimate doubt as to its liability for the compression fractures.

The compression fractures are not materially related to the compensable injury.

CONCLUSIONS OF LAW AND OPINION

Timeliness of the December 15, 1989 Denial

The Referee concluded that the claim was not made until the filing of the 801 form was accomplished on October 25, 1989, and, therefore, that the denial of December 15, 1989 was not untimely. We disagree.

Written notice of acceptance or denial of the claim shall be furnished to the claimant within 60 days after the employer has notice of knowledge of the claim. Former ORS 656.262(6). A claim includes any compensable injury of which an employer has notice or knowledge. Former ORS 656.005(6). For workers' compensation purposes, a compensable injury includes an accidental injury arising out of and in the course of employment requiring medical services or resulting in disability or death. Former ORS 656.005(7).

In this case, claimant told his immediate supervisor on October 9, 1989 that he had hurt his back while working and that he was going to the hospital for treatment. Additionally, the employer's portion of the 801 form signed on October 25, 1989 indicates that the employer first knew about the injury on October 9, 1989. Therefore, the employer had 60 days from October 9, 1989 to accept or deny. The 60-day period to accept or deny ended on December 9, 1989. The insurer issued its denial on December 15, 1989. The delay, albeit only six days, is not explained by the insurer and is therefore unreasonable. Claimant is entitled to a penalty and attorney fee for the untimely denial. Former ORS 656.262(10) and ORS 656.382(1).

Reasonableness of the December 15, 1989 Denial

The Referee was not persuaded that the December 15, 1989 denial was unreasonable. We disagree.

At the time of the denial the insurer was in possession of an 801 form indicating that claimant hurt his back while working. The insurer also had received Dr. Butler's November 30, 1989 report indicating that claimant hurt his back at work and diagnosing an acute right upper lumbar paraspinal muscle strain seven weeks prior. The insurer was aware that the hospital was not treating this injury as work related, but did not pursue getting the medical records. The insurer claims that the employer was not sure that this was a valid claim because it was not reported as a claim until October 25, 1989. This concern about the validity of the claim must be discounted because as already reported above, the 801 form filed on October 25, 1989 indicated the employer knew about the injury on October 9, 1989. Because all of the existing medical evidence at the time of the denial supported compensability, we conclude the the denial was unreasonable. Claimant is entitled to both a penalty and an attorney fee in this regard. Id.

Validity and Reasonableness of the April 9, 1990 Denial

The Referee concluded that the partial denial of April 9, 1990 was premature, set it aside and awarded claimant an assessed attorney fee. We disagree.

The Referee reasoned that the denial was premature because she found that no claim had been filed for compression fractures. We dispute the factual premise. When claimant was admitted to the emergency room on October 9, 1989, he was diagnosed with both a strain and compression fractures. Moreover, he was sent for evaluation of the compression fracture; the doctor's report was submitted to the insurer on January 8, 1990. By seeking services and submitting reports detailing the services, a claim was filed for the compression fractures. See e.g., Billy Eubanks, 35 Van Natta 131 (1983). The reports suggested that the compression fractures might be acute. The records could be interpreted as saying that claimant's back condition for which treatment was required might be the result of the compression fracture. Under these circumstances, we conclude that a denial of the compression fractures was not premature. See Jack Allen, 43 Van Natta 190 (1991).

Having found that the denial was not premature, we must determine whether the fractures were related to the compensable injury. We find that they are not.

Dr. Butler, M.D., claimant's treating physician, has opined that the compression fractures are old, long predating the injury. His opinion is unrebutted. Consequently, there is no evidence relating the compression fractures in any way to the compensable injury. Therefore, the denial must be upheld.

We adopt the final paragraph of the Referee's order which concludes that the April 9, 1990 denial was not unreasonable and, therefore, that no penalty or attorney fee may be assessed on the basis of the denial.

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 concerning the unreasonable and untimely December 15, 1989 denial is $1,200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 25, 1990 is affirmed in part and reversed in part. The insurer's April 9, 1990 partial denial is reinstated and upheld. The $1,200 assessed attorney fee on the partial denial issue is reversed. The insurer shall pay to claimant a penalty equal to 25 percent of the disability benefits due when it withdrew its December 15, 1989 denial of claimant's back strain on April 9, 1990. For services regarding the insurer's unreasonable conduct, claimant's attorney is awarded a $1,200 fee, payable by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
JAMES E. NEAL, Claimant
WCB Case No. 90-02120
ORDER ON REVIEW
David Hollander, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Bethlahmy's order that: (1) upheld the insurer's denial of his aggravation claim for his current right hand condition; (2) found that claimant was not entitled to interim compensation from September 27, 1989 to February 21, 1990; and (3) declined to assess penalties and attorney fees for an allegedly unreasonable failure to pay interim compensation. On review, the issues are aggravation, interim compensation and penalties and attorney fees. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Aggravation

The Board adopts the Referee's "Opinion" on the issue of aggravation.

Interim Compensation

Claimant contends that he is entitled to interim compensation from September 27, 1989 to the date of the denial. We disagree. With regard to an aggravation claim, interim compensation is payable from the date of medically verified inability to work resulting from the worsened condition. Former ORS 656.273(6).

Here, the medical opinions of claimant's treating doctor do not establish an inability to work due to worsened conditions. Although Dr. Anderson reported that claimant was not working due to his injury, he did not relate claimant's inability to work to a worsened condition related to the compensable injury. Accordingly, the insurer's duty to pay interim compensation was not triggered by Dr. Anderson's reports.

Penalties and attorney fees

The Board adopts the Referee's "Opinion" on the issue of penalties and attorney fees.

ORDER

The Referee's order dated July 10, 1990 is affirmed.

In the Matter of the Compensation of
KARLA H. RICHARDSON, Claimant
WCB Case No. 90-00832
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Galton's order that affirmed a Director's order finding claimant ineligible for vocational services. On review, the issue is vocational services. We affirm.

FINDINGS OF FACT

Claimant was compensably injured on May 7, 1986, when she fell from a chair which broke. She injured her left shoulder, neck, and lower back. At the time of injury, she worked for the self-insured employer as a word processor.

Claimant was released to work in January 1987. Her claim was closed with no award for permanent disability. Claimant did not succeed in returning to full time work. Her claim was reopened for aggravation. Her treating physician, Dr. Tilison, orthopedist, released her to full time work effective September 24, 1987. Claimant selected a new physician, Dr. Apple, chiropractor, who opined that she could not then return to full time work but would be able to do so eventually.

Claimant returned to part time work as a run card administrator. The employer assisted with worksite modifications. The claim was closed, and claimant was eventually awarded 15 percent unscheduled permanent disability.

On August 12, 1988, Dr. Apple approved claimant's return to full time work. Claimant worked full time from November 21, 1988 through March 30, 1989 as run card administrator. However, during this time claimant's work was deficient and she was repeatedly counselled. A corrective action plan was put in place on February 13, 1989. A written warning was given on March 10, 1989. On March 31, 1989, Dr. Apple notified the employer that claimant could work only if she could alternate sitting with standing and walking at 15 minute intervals. This restriction was greatly beyond any prior restriction Apple had imposed. It was not consistent with the requirements of the job which claimant had been performing to that time. It did not reflect any change in claimant's physical condition.

The employer terminated claimant because no work within the restrictions was available.

Claimant requested vocational services.

FINDINGS OF ULTIMATE FACT

We adopt the Referee's Findings of Ultimate Fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's order with the following comment. Claimant contends that although she performed the job of run card operator for more than 60 days, she is physically unable to do so and, consequently, should be allowed vocational services. We are not persuaded that claimant was unable to perform the job or that Dr. Apple's March 31, 1989 restrictions were necessary to

accomodate her physical condition. Consequently, we agree that there is no statutory basis for modification of the Director's order.

ORDER

The Referee's order dated June 26, 1990 is affirmed.

March 20, 1991 Cite as 43 Van Natta 598 (1991)

In the Matter of the Compensation of
JOHN W. AGAR, Claimant
WCB Case No. 89-22462
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Knapp's order that declined to assess an attorney fee under ORS 656.386(1). On review, the issue is attorney fees.

We affirm and adopt the Referee's order as supplemented. The self-insured employer contends that the Board lacked jurisdiction of the Referee's orders because the Opinion and Order became final before the request for review was filed.

On April 19, 1990, the Opinion and Order issued awarding claimant's counsel a penalty and penalty related attorney fee for the late payment of interim compensation, and an additional assessed attorney fee under ORS 656.386(1). On May 11, 1990, in response to a motion submitted by the employer, the Referee abated his order to consider the motion. On May 29, 1990, the Referee issued an Order on Reconsideration. The Referee modified his April 19, 1990 order by deleting claimant's assessed fee under ORS 656.386(1). Except for this modification, the Referee stated that "[t]he April 19, 1990 Opinion and Order remains in effect. . ." Claimant requested review of the Order on Reconsideration on June 8, 1990. The sole issue on appeal concerned the assessed attorney fee under ORS 656.386(1).

Inasmuch as the Referee's April 19, 1990 order was abated for reconsideration and since that order was expressly modified by eliminating the ORS 656.386(1) attorney fee, we conclude that claimant had 30 days from the issuance of the May 29, 1990 Order on Reconsideration to seek review. See ORS 656.289(3); Mary G. Chard, 39 Van Natta 786 (1987). The lack of appeal rights on the order does not defeat claimant's entitlement to appeal the Order on Reconsideration. Claimant's appeal rights are statutory. See ORS 656.289; 656.295; Larry Vigal, 41 Van Natta 1266 (1989). Claimant's appeal of this order was within 30 days as required by statute, and thus, was timely.

ORDER

The Referee's order dated April 19, 1990, as reconsidered May 29, 1990, is affirmed.

In the Matter of the Compensation of
HAROLD W. COMBS, Claimant
Own Motion Nos. 66-0250M & 83-0015M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted to the Board claimant's claim for medical benefits relating to his February 6, 1959, industrial injury. Claimant's aggravation rights have expired. SAIF recommends reopening of claimant's claim for the provision of office visits and prescription medications.

For conditions resulting from a compensable injury occurring before January 1, 1966, the Board may authorize the payment of medical benefits. ORS 656.278(1)(b). Here, we find that the office visits and prescription medications are reasonable and necessary medical services which are required to maintain claimant's medically stationary status. Therefore, we conclude that claimant's claim should be reopened for those medical services. See OAR 438-12-037(1)(c). Accordingly, claimant's claim is reopened for the provision of office visits and prescription medications in an amount not to exceed $435.37.

Additionally, the Board vacates that portion of its June 13, 1990, Own Motion Order that denied SAIF reimbursement from the Reopened Claims Reserve for medical benefits it paid claimant since January 1, 1988. Those medical benefits were paid in accordance with our September 3, 1986, Own Motion Order that reopened claimant's claim for the "payment of medical services recommended by Dr. Petterson." In denying reimbursement, we reasoned that, because the claim was reopened before 1988, we did not have the authority to allow reimbursement of any medical benefits paid under that claim reopening, even those provided after January 1, 1988. We note, however, that our September 3, 1986, order purported to authorize payment for medical services which had not yet been claimed when the order issued. We do not have the authority to authorize payment for, or reimbursement of, medical services not yet claimed. Therefore, to the extent that our September 3, 1986, order may be read as granting future, unclaimed medical services provided by Dr. Petterson on or after January 1, 1988, it is disavowed. By this order, Own Motion Claim No. 83-0015M is closed as of December 31, 1987.

Inasmuch as the claim is deemed closed as of December 31, 1987, we are authorized to allow reimbursement of medical benefits provided since January 1, 1988. Accordingly, claimant's claim is reopened for reimbursement to SAIF for injury-related office visits, health care and prescription medications it provided claimant from January 1, 1988 through December 3, 1989, in an approximate amount of $3,558.72. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. By this order, the claim is again closed.

IT IS SO ORDERED.

In the Matter of the Compensation of
DUANE L. JONES, Claimant
WCB Case No. 88-19841
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Tom Ewing (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Lipton's order that: (1) upheld the Inmate Injury Fund's (Fund) denial of his claim for medical services; and (2) declined to award permanent partial disability. On review, the issues are medical services and extent of unscheduled permanent partial disability.

We affirm and adopt the order of the Referee, with the following supplementation concerning the medical services issue.

Former ORS 655.515 provides, in relevant part:

> "(1) No benefits, except rehabilitation services, shall accrue to the inmate until the date of release from confinement * * * *.
>
> (2) Benefits shall be discontinued during any subsequent period of reconfinement in a penal institution."

Claimant contends that he was "released from confinement," within the meaning of the above-quoted statute, when he was on temporary leave. Therefore, he contends, the Fund should be required to pay for medical services which he received while on leave. We do not agree.

Pursuant to ORS Chapter 421.165, the policy of the Department of Corrections is "to allow inmates short term and/or long term temporary leaves * * * [when] in accordance with good correctional practices." OAR 291-116-005(3).

Under the Department's rules, an inmate is defined as: "Any person under the supervision of the Department of Corrections who is not on parole or probation status." OAR 291-116-010(5). Long-term temporary leave is defined as: "A temporary leave * * * preceding an established parole or discharge date." OAR 291-116-010(7), emphasis added.

We agree with the Referee that beginning a temporary leave is not the same as an inmate's "date of release from confinement." It is undisputed that claimant was on temporary leave when he received the chiropractic treatments in question. Inasmuch as there is no contention that claimant had an established parole or probation date or had been permanently released from confinement, we conclude that he has not proven that he was entitled to benefits while on leave. Therefore, his claim for benefits under former ORS 655.515 was properly denied by the Fund.

ORDER

The Referee's order dated May 10, 1990 is affirmed.

In the Matter of the Compensation of
CHARLENE F. ROUNSAVILLE, Claimant
WCB Case No. 89-23258
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Alan Ludwick (Saif), Defense Attorney

Reviewed by Board Members Cushing and Westerband.

Claimant requests review of Referee Michael Johnson's order that declined to award an assessed attorney fee when a denial had been rescinded prior to hearing. On review, claimant contends that she is entitled to an assessed attorney fee or, alternatively, an approved attorney fee. We affirm in part and modify in part.

We adopt the Referee's findings of fact, opinion and conclusion that held that claimant was not entitled to an assessed attorney fee. See Duane L. Jones, 42 Van Natta 875 (1990).

In the event that we adhered to the Jones holding, claimant seeks an out-of-compensation fee. We find that claimant's attorney's services have resulted in the rescission of SAIF's denial prior to the scheduled hearing. Under such circumstances, we conclude that claimant's attorney has been instrumental in obtaining compensation for claimant without a hearing. See former OAR 438-15-030(1). Consequently, claimant's attorney is entitled to an approved fee.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that claimant's attorney is entitled to a reasonable fee equal to 25 percent of the increased compensation resulting from the rescission of SAIF's denial, not to exceed $550. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issue, the value of the interest involved, and the nature of the proceeding.

ORDER

The Referee's order dated July 24, 1990, as amended August 9, 1990, is affirmed in part and modified in part. Claimant's attorney is awarded 25 percent of the increased compensation created by the SAIF Corporation's rescission of its denial, not to exceed $550, payable directly to claimant's attorney.

In the Matter of the Compensation of
MILTON L. WILSON, Claimant
WCB Case Nos. C1-00183 & C1-00184
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT
Emmons, et al., Claimant Attorneys
Gail M. Gage (Saif), Defense Attorney

Reviewed by Board Members Crider and Speer.

On February 8, 1991, 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 a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injuries. However, by order dated March 11, 1991, the Board withdrew its acknowledgment and refused to approve the agreement because there was no evidence that the alteration made to the agreement by the claims adjuster from SAIF Corporation were agreed to by the other signatories to the agreement.

Subsequently, claimant's counsel and SAIF's counsel have jointly requested reconsideration of our March 11, 1991 order. Specifically, the parties contend

that all of the signatories were in agreement with the modification, and therefore, request the Board to approve the agreement. In support of the motion, the parties attach an exhibit to that effect.

The Board may reconsider final orders under ORS 656.236, provided that the motion for reconsideration is filed in accordance with OAR 438-09-035(1), and states specifically the reasons reconsideration is requested. Reconsideration of a final order issued by the Board under ORS 656.236 and these rules shall be limited to the record before the Board at the time its final order was mailed and no additional information will be considered. See OAR 438-09-035(2) & (3).

We find that the record before the Board at the time of the March 11, 1991 order contained a copy of the January 8, 1991 letter directed to the Department of Insurance and Finance, which the parties have submitted as exhibit A to their motion. We note that the letter was drafted by SAIF Corporation, addressed to the Department, and that claimant's counsel was copied. We also note that the letter specifically discussed the deletion of the altered sections of the agreement. We therefore find the signatories were apprised of the change. If the parties had objected to the deletion they had ample time in which to voice their objections.

The Board is persuaded that its sole objection to the agreement has been met and that the terms of the agreement are in accordance with all statutory and administrative prerequisites. Therefore, the Board shall not require the parties to submit a revised agreement pursuant to the standard procedures.

On reconsideration, as modified herein, the parties' claim disposition agreement is approved, hereby fully and finally resolving this matter.

IT IS SO ORDERED.

March 21, 1991 Cite as 43 Van Natta 602 (1991)

In the Matter of the Compensation of
PAUL D. CAIN, Claimant
WCB Case No. 90-10378
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Kathryn Wilske (Saif), Defense Attorney

Reviewed by Board Members Myers and Cushing.

The SAIF Corporation requests review of Referee Galton's order that: (1) increased claimant's unscheduled permanent disability award for a closed head injury from 15 percent (48 degrees), as awarded by Determination Order, to 38 percent (121.6 degrees); and (2) awarded 9 percent (17.28 degrees) scheduled permanent disability for the loss of use or function of his right arm (elbow), whereas a Determination Order awarded no scheduled permanent disability. Claimant cross-requests review seeking an increase in his unscheduled permanent disability award. On review, the issue is extent of permanent disability, both scheduled and unscheduled. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable closed head injury and a minor back injury on July 18, 1987 resulting from an auto accident. He underwent maxillofacial, reconstructive and plastic surgeries on his face to repair lacerations and fractures and to reduce scarring.

Claimant was treated or evaluated by Dr. Nolan, plastic surgeon; Dr. Krump, D.D.S.; Dr. Eschtruth, D.O.; Dr. Takacs, D.O.; Dr. Rosenbaum, neurologist; Dr. Labs, neurolopsychologist; Dr. Vranizan, D.M.D.; Dr. Lipman, M.D.; and Dr. Anderson, D.M.D.

A May 2, 1990 Determination Order closed claimant's claim and awarded 15 percent unscheduled permanent disability. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee awarded claimant an additional 23 percent unscheduled disability, for a total of 38 percent unscheduled permanent disability. He also awarded 9 percent scheduled permanent disability. SAIF contends that the May 2, 1990 Determination Order, which awarded claimant 15 percent unscheduled permanent disability, should be affirmed. We agree.

For claims in which the claimant was medically stationary on or before July 1, 1990, the disability rating standards in effect at the time the claim is closed and evaluated shall be applied at hearing and on review of the Determination Order or Notice of Closure. OAR 438-10-010(1). For claims in which the claimant was medically stationary after July 1, 1990, the disability rating standards in effect on the date of the issuance of the reconsideration order shall be applied at hearing and on review of the reconsideration order. OAR 438-01-010(2).

Claimant's condition was medically stationary on March 30, 1990. The claim was closed by Determination Order on May 2, 1990. Therefore, pursuant to the applicable rules, the evaluation of claimant's disability shall be based on the standards in effect at the time claimant's claim was closed by the May 2, 1990 Determination Order. Consequently, former OAR 436-35-001 et seq. applies to a rating of claimant's permanent disability. Former OAR 436-35-010 through 436-35-260 apply to a rating of scheduled permanent disability and former OAR 436-35-270 through 436-35-440 apply to a rating of unscheduled permanent disability.

Scheduled permanent disability is rated on permanent loss of use or function of a body part due to an on-the-job injury. Former OAR 436-35-010(2)(a). Unscheduled permanent disability is rated on permanent loss of earning capacity. Former OAR 436-35-270(2). If there is no measurable impairment, no award of unscheduled or scheduled permanent disability shall be allowed. Former OAR 436-35-010(2)(b); 436-35-270(2).

Scheduled Permanent Disability

Claimant contends that he sustained permanent loss of use or function of his right arm as a result of an intravenous infection caused while he was hospitalized due to his compensable head injury. SAIF argues that the record is devoid of medical evidence to establish such a loss of use of function. We agree.

"Impairment" means a decrease in the function of a body part or system as measured by a physician. Former OAR 436-35-005(1). The only evidence of loss of use or function in claimant's right arm (elbow) is claimant's testimony. While that evidence is probative, it does not establish ratable impairment under the "standards." Therefore, as none of claimant's physicians noted impairment to claimant's right arm, let alone an arm condition itself, we find that claimant has failed to establish entitlement to an award of scheduled permanent disability.

Furthermore, we find that the record does not establish permanent right arm impairment. While claimant has complained of a right arm ache, there is no evidence to establish that such an ache restricts claimant's use of function of

his right arm, especially in light of the fact that claimant has successfully returned to heavy duty work. Claimant has not sought medical treatment for his arm since he was released from the hospital in 1987. Under such circumstances, we also do not find the evidence clear and convincing that claimant sustained permanent right arm disability in excess of that to which he is entitled under the "standards." Consequently, we award no scheduled permanent disability.

Unscheduled Permanent Disability

Claimant seeks entitlement to an increased unscheduled permanent disability award for loss of earning capacity due to back impairment, tinnitus, organic brain damage, including anergia and memory loss, hearing loss, a vestibular condition and a depressive reaction, including sleep disturbance. SAIF contends that the May 2, 1990 Determination Order should be affirmed. We agree.

Claimant suffered back pain resulting from his injury. However, claimant's back condition was medically stationary as early as February 8, 1989, and claimant was found to have full range of motion in both his cervical and lumbar spine. (Exs. 14, 16 and 29). Therefore, we conclude that claimant suffered no permanent back impairment resulting from his compensable injury.

With respect to claimant's argument that he is entitled to permanent disability resulting from organic brain damage, we find that the record fails to establish that such a condition exists. (Ex. 29). Therefore, we do not award any disability for that condition.

With respect to claimant's tinnitus, hearing loss and vestibular problems, we likewise find insufficient evidence to award permanent disability for these conditions. Specifically, the only report addressing claimant's alleged hearing loss convinces us that claimant does not suffer from hearing loss due to his injury. (Ex. 30). While claimant has complained of tinnitus and vestibular problems, there is no medical evidence in the record with which to rate impairment due to these conditions. Consequently, we do not award disability for these conditions, as well.

Finally, with respect to claimant's contention that he suffers permanent impairment resulting from his psychological condition, we find that the record establishes otherwise. Specifically, Dr. Labs, neuropsychologist, opined that claimant sustained no permanent psychological impairment, either physiological or neuropsychological, resulting from his compensable injury. (Ex. 21). There is no evidence to the contrary. Therefore, we do not find that claimant has established permanent psychological impairment resulting from his compensable injury.

As no physician has measured impairment resulting from claimant's compensable injury, we conclude that claimant is not entitled to an award of unscheduled permanent disability. Former OAR 436-35-005(1); former 436-35-270(2). Furthermore, we do not find clear and convincing evidence that claimant sustained permanent disability outside the standards.

However, inasmuch as SAIF does not seek a reduction in claimant's unscheduled permanent disability awarded by the May 2, 1990 Determination Order, we affirm the May 2, 1990 Determination Order in its entirety.

ORDER

The Referee's order dated August 29, 1990 is reversed. The May 2, 1990 Determination Order is reinstated and affirmed.

In the Matter of the Compensation of
RUBEN D. CARLOS, Claimant
WCB Case No. 89-21890
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Darryl Nelson, Defense Attorney

Reviewed by Board Members Westerband and Cushing.

The insurer requests review of those portions of Referee Livesley's order that: (1) set aside its denial of claimant's aggravation claim for a back condition; and (2) awarded 66 percent (211.2 degrees) unscheduled permanent disability for a back injury, whereas a Determination Order awarded no permanent disability. On review, the issues are aggravation and extent of unscheduled permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant sustained a compensable lumbar strain on February 16, 1989. He treated with Dr. Hebert, D.C., through October 1989, at which time he moved to Drain, Oregon. In November 1989, claimant began treating with Dr. Tutak, D.C.

Claimant does not speak or write English. He has not worked since the injury.

Claimant was evaluated by Dr. Myers, neurological consultant, in April, October and November 1989; by BBV Medical Services in June 1989 and January 1990; by Dr. Golden, M.D. in November 1989; and by the Western Medical Consultants in January 1990.

Dr. Hebert found claimant medically stationary on September 9, 1989, and, at that time, released claimant to return to full-time employment. A September 14, 1989 Determination Order closed claimant's claim without an award of permanent disability.

In October, 1989, a CT scan showed a possible disc herniation. An MRI was recommended, but was never performed.

On November 6, 1989, claimant sought treatment from Dr. Tutak for worsened back symptoms. Tutak authorized time loss starting on November 6, 1989. Claimant was again medically stationary on January 18, 1990.

The insurer denied claimant's aggravation claim on January 25, 1990. Claimant requested a hearing on the Determination Order and on the aggravation denial.

Claimant suffered a symptomatic exacerbation of his compensable back condition in November 1989 which resulted in diminished earning capacity beyond the level fixed at the time of the September 14, 1989 Determination Order.

CONCLUSIONS OF LAW AND OPINION

Aggravation

We adopt the Referee's "Conclusion of Law and Opinion" regarding claimant's aggravation claim, except for the first full paragraph as set forth on page 7 of the Referee's Opinion and Order. We make the following supplementation.

Claimant's claim was closed by a September 14, 1989 Determination Order. He was awarded no permanent disability by that order. Claimant had been

released to return to full-time employment prior to the September 14, 1989 Determination Order.

On November 6, 1989, Dr. Tutak authorized time loss due to an exacerbation of claimant's back condition.

Because claimant was not awarded permanent disability by the September 14, 1989 Determination Order, we find that claimant's last arrangement of compensation did not contemplate any future exacerbation resulting in diminished earning capacity. See John A. Calder, 42 Van Natta 977, 979 (1990); Louis A. Duchene, 41 Van Natta 2399, 2400 (1989); Lorna A. Baker, 41 Van Natta 1844, 1846 (1989). Consequently, we find that claimant proved a compensable aggravation.

The remaining issue is whether, and to what extent, claimant sustained permanent disability. Where an aggravation claim has been found to be compensable, and where the record establishes that the claimant is medically stationary at the time of hearing, the Referee has jurisdiction to rate the extent of permanent disability. Former OAR 438-08-020; See John A. Calder, supra.

Here, claimant's treating physician, Dr. Tutak, found claimant's condition medically stationary on January 18, 1990. There is no evidence to the contrary. The hearing was held on March 5, 1990. Therefore, we proceed to rate the extent of permanent disability.

Extent of Unscheduled Permanent Disability

The Referee awarded claimant 66 percent unscheduled permanent disability. In making his determination, the Referee found claimant credible, and found that claimant proved a permanent loss of lumbar range of motion, a disc derangement resulting from the compensable injury and found that claimant suffered from a chronic condition limiting repetitive use of his back. We are not so persuaded. We reverse.

Because claimant's condition was medically stationary on January 18, 1989, we apply the standards which became effective on January 1, 1989. Therefore, we apply former OAR 436-35-270 through 436-35-440 in rating claimant's unscheduled permanent disability.

The insurer contends that claimant has failed to prove that he has permanent impairment resulting from his compensable injury. We agree.

Claimant relies primarily on claimant's positive demeanor credibility finding. We find, however, that the issue at hand, extent of permanent disability, turns, not on claimant's credibility, but on the persuasive medical evidence in the record. Therefore, we go directly to the medical evidence in determining the issue of extent of permanent disability.

Impairment, for purposes of the "standards," is determined at the date of hearing. Ronald G. Boehm, 42 Van Natta 1059 (1990). There are two medical reports dated near the hearing date which rate the extent of claimant's disability. We generally rely on impairment findings which are most recent and nearest to the medically stationary date. See Darlene J. Byrd, 42 Van Natta 1029 (1990). Here, however, as there are two medical reports dated near the medically stationary date which come to the same conclusion regarding claimant's impairment, we rely on them both.

On January 18, 1989, BBV Medical Services rated claimant's loss of lumbar range of motion to be minimal. After making range of motion findings, BBV noted that claimant demonstrated the presence of nonorganic physical findings, "which

could not be based on structural damage of claimant's body," and noted that there were other inconsistent physical findings in straight-leg raising and in passive flexion. (Ex. 33). BBV, after considering the above, concluded, despite minimal findings, that claimant sustained no permanent impairment resulting from his compensable injury. However, it is unclear whether the BBV examination was conducted with the assistance of an interpreter. Further, BBV's opinion does not indicate whether or not a language barrier affected their opinion.

Unlike the BBV report, the January 2, 1990 report, authored by the Western Medical Consultants, was made with the assistance of an interpretor. The Consultants also noted significant functional overlay and inconsistent physical findings.

The Consultants rated claimant's lost lumbar range of motion as mild. In addition to lost range of motion, the Consultants noted that muscle strength could not be determined because of inconsistent and poor effort on the part of claimant and that claimant complained of pain with little provocation. As a result, the Consultants opined that there was no basis upon which to rate permanent impairment. Id.

Claimant also contends entitlement to 4 percent impairment for a disc herniation at L5-S1 resulting from his compensable injury. There is no evidence, however, that claimant's disc bulge was caused by his compensable back injury. Therefore, no value may be given for his disc bulge. See Daniel G. Huff, 42 Van Natta 2805 (1990).

Claimant contends, as the Referee found, that he suffers from a chronic condition limiting repetitive use of his back. Again, we find that there is no medical evidence to support a finding that claimant suffers from a chronic condition. Further, while claimant's testimony may be probative, it, alone, does not establish the existence of a "chronic" condition. Therefore, we do not award claimant permanent disability for a chronic condition limiting repetitive use of his back.

Where the claimant fails to establish any measurable impairment resulting from his or her compensable injury/condition, no award of disability is allowed. Former OAR 436-35-010(2)(b), OAR 436-35-280(1).

Here, neither of the two persuasive medical opinions is based upon the existence or nonexistence of a language barrier. Yet, both made explicit findings of inconsistencies and functional overlay. Further, both concluded that there was no reliable data upon which to rate permanent impairment.

Consequently, we conclude that, under the "standards," claimant is not entitled to any permanent disability resulting from his compensable injury.

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).

Unscheduled permanent disability is based on a permanent loss of earning capacity. We do not find the evidence highly probable that claimant has suffered permanent loss of earning capacity resulting from his compensable injury. See Riley Hill General Contractor, Inc., supra. Accordingly, we conclude that claimant has failed to prove by clear and convincing evidence that he suffers unscheduled permanent disability.

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 aggravation 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.

ORDER

The Referee's order dated May 1, 1990 is affirmed in part and reversed in part. Those portions of the Referee's order that awarded claimant 66 percent (211.2 degrees) unscheduled permanent disability and awarded claimant's attorney 25 percent of the increased compensation created by the Referee's order are reversed. The Determination Order is reinstated and affirmed. The aggravation claim is closed without an award of permanent disability. The remainder of the order is affirmed. For services on Board review concerning the aggravation issue, claimant is awarded a reasonable assessed fee of $750, payable by the insurer.

March 21, 1991 Cite as 43 Van Natta 608 (1991)

In the Matter of the Compensation of
BRAD R. CHRISTIE, Claimant
WCB Case No. 90-03496
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Darryl Nelson, Defense Attorney

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Garaventa's order which: (1) upheld the insurer's partial denial of a psychological condition and of alcoholism; (2) found that a Determination Order had not prematurely closed the claim; and (3) awarded claimant 1 percent (3.2 degrees) unscheduled permanent disability in addition to the 40 percent (128 degrees) unscheduled permanent disability awarded by the Determination Order. In its brief, the insurer contends that the Referee erred by applying the wrong law to uphold the partial denial. On review the issues are compensability, premature claim closure, extent of unscheduled disability and the applicability of Oregon Laws 1990 Chapter 2 to the compensability question.

We affirm and adopt the Referee's order with the following supplementation on the applicability of Oregon Laws 1990 Chapter 2 to this case.

Claimant requested a hearing to protest the Determination Order on February 13, 1990. Hearing was scheduled for June 21, 1990 by Notice of Hearing dated February 20, 1990. On May 4, 1990 the insurer issued its partial denial. The Oregon Legislature met in Special Session on May 7, 1990 and passed significant amendments to the Workers' Compensation Act in Oregon Laws Chapter 2 (commonly referred to as SB 1197). On May 15, 1990 claimant amended his request for hearing to include a challenge to the partial denial of May 4, 1990. All issues were heard by Referee Garaventa on June 21, 1990.

The insurer argues that the amendments to ORS 656.005(7) contained in Section 3 of Oregon Laws 1990 Chapter 2 should be applied to the compensability question. We disagree. Section 54 of Oregon Laws 1990 Chapter 2 provides that except for amendments to certain statutes (not including ORS 656.005), the act becomes operative on July 1, 1990. Thus, on the date of hearing the law which

the insurer would have us apply was not operative. The Referee correctly applied the law which was operative on the date of hearing.

ORDER

The Referee's order dated July 18, 1990 is affirmed.

March 21, 1991 Cite as 43 Van Natta 609 (1991)

In the Matter of the Compensation of
DAVID R. HIEBERT, Claimant
Own Motion No. 66-0205M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted to the Board claimant's claim for medical benefits relating to his June 20, 1955, industrial injury. Claimant's aggravation rights have expired. SAIF recommends reopening of claimant's claim for the provision of office visits, x-rays and physical therapy. SAIF also requests Board authorization of reimbursement from the Reopened Claims Reserve for its payment of medical benefits.

For conditions resulting from a compensable injury occurring before January 1, 1966, the Board may authorize the payment of medical benefits. ORS 656.278(1)(b). Here, claimant seeks payment for office visits, x-rays and physical therapy provided from March 23 through June 1, 1988. However, those services have already been authorized by the Board. In August, 1987, claimant's doctor requested claim reopening for recommended total left knee replacement surgery. By Own Motion Order dated November 13, 1987, the Board reopened claimant's claim for the payment of medical benefits from the date of the proposed surgery until claimant becomes medically stationary. Claimant underwent surgery in November, 1987, and his claim was closed by Notice of Closure on January 8, 1991, which declared him medically stationary as of October 20, 1988. Inasmuch as claimant's claim was open for left knee treatment when the claimed medical services were provided, we find those services were already authorized by our November 13, 1987, order. Therefore, it is unnecessary to authorize additional medical benefits.

Finally, we decline to authorize reimbursement from the Reopened Claims Reserve for SAIF's payment of the above medical benefits. ORS 656.625(1) provides that the Director "shall establish a Reopened Claims Reserve within the Insurance and Finance Fund for the purpose of reimbursing the additional amounts of compensation payable to injured workers that results from any award made by the board pursuant to ORS 656.278 after January 1, 1988." Generally, we have declined to authorize reimbursement to a carrier which voluntarily reopened a claim before January 1, 1988. See, e.g., Raymun B. Savalas, 43 Van Natta 38 (1991). In Savalas, we reasoned that a claim reopening before January 1, 1988, does not qualify as an award made "pursuant to ORS 656.278 after January 1, 1988," as provided in ORS 656.625. We concluded, therefore, that ORS 656.625 does not permit reimbursement of benefits paid pursuant to a pre-1988 reopening. See id.

We have fashioned an exception to the above rule in certain claims involving compensable injuries occurring before January 1, 1966. E.g., Harold W. Combs, 43 Van Natta 599 (1991); James H. Powell, Own Motion No. 66-0186M, Unpublished (October 24, 1990). In Combs and Powell, we ordered the claims reopened before 1988 for the payment of injury-related medical services, including medical services that had not yet been claimed. The carriers subsequently

requested reimbursement for those medical benefits provided after January 1, 1988. Reasoning that we are not authorized to grant payment of medical services that were not claimed, we disavowed our previous orders of reopening insofar as they authorized medical services provided after January 1, 1988. We then authorized those medical services provided after January 1, 1988, and allowed reimbursement for those benefits.

Here, unlike Combs and Powell, there was a claimed need for left knee surgery when the Board reopened claimant's claim in 1987. Thus, we were authorized to grant payment for the surgery and surgery-related services until claimant's condition became medically stationary. Inasmuch as that reopening occurred before January 1, 1988, and claimant was not yet medically stationary when the claimed medical services were provided, those medical benefits are not eligible for reimbursement from the Reopened Claims Reserve. See ORS 656.625(1); Raymun B. Savalas, supra. Accordingly, SAIF's request for authorization of reimbursement is denied.

IT IS SO ORDERED.

March 21, 1991 Cite as 43 Van Natta 610 (1991)

In the Matter of the Compensation of
JOHN W. KUYKENDALL, Claimant
WCB Case No. TP-90056
ORDER OF ABATEMENT
Smith & Smith, Claimant Attorneys
J. David Thurber (Saif), Defense Attorney

Claimant has requested reconsideration of our March 8, 1991 Third Party Distribution Order which held that the SAIF Corporation was entitled to $33,167.50 of the $37,248.53 balance remaining from a third party recovery. Noting that the third party recovery was by means of judgment and contending that SAIF currently retains the $4,081.03 difference between the remaining balance from the recovery and its third party lien as found by our order, claimant seeks modification of our order.

Before addressing claimant's motion, SAIF is granted an opportunity to respond. To be considered, SAIF's response must be submitted within 10 days from the date of this order. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

March 21, 1991 Cite as 43 Van Natta 610 (1991)

In the Matter of the Compensation of
EMMA G. MOSLEY, Claimant
WCB Case Nos. 90-12032, 89-25360 & 90-08108
SECOND ORDER OF DISMISSAL
Karen M. Werner, Claimant Attorney
Beers, et al., Defense Attorneys
Dennis Ulsted (Saif), Defense Attorney
Miller, et al., Defense Attorneys

Claimant has requested reconsideration of our February 20, 1991 order that dismissed her request for Board review because all parties to the proceeding had not received timely notice of her request. Contending that she only sought review of one WCB case number involving one party (Sacred Heart Hospital/SAIF

Corporation), claimant argues that she was not required to serve the other parties to the proceeding (Oregon Med Labs/Connecticut Indemnity) with a copy of her request for Board review. We disagree.

A party requesting Board review cannot attempt to limit the scope of the Board's review by seeking review of only select case numbers which are included with other case numbers in the same Referee's order. William E. Wood, 40 Van Natta 999, 1001 (1988). If an insurer was a party to the Referee's order, it remains a party on review. See Zurich Ins. Co. v. Diversified Risk Management, 300 Or 47 (1985); Riley E. Lott, 42 Van Natta 239, 240 (1990).

Here, Oregon Medical Labs and its insurer, Connecticut Indemnity, were parties to the proceeding before the Referee. They retain this status on Board review, regardless of claimant's intentions in appealing the Referee's order. As we reasoned in Wood, an appealing party requests Board review of a Referee's order, not particular case numbers.

Consequently, after further consideration, we continue to find that Oregon Medical Labs and Connecticut Indemnity are parties. Because neither party received notice of claimant's request for Board review within 30 days of the Referee's order, we lack authority to review the Referee's order. See ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

Accordingly, our February 20, 1991 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our February 20, 1991 order. The parties' rights of appeal shall commence from the date of this order.

IT IS SO ORDERED.

March 21, 1991 Cite as 43 Van Natta 611 (1991)

In the Matter of the Compensation of
LEE ROY PARKER, Claimant
Own Motion No. 87-0065M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his February 26, 1968, industrial injury. Claimant's aggravation rights have expired. SAIF accepts responsibility for the proposed right knee surgery but opposes reopening of his claim for temporary disability benefits on the ground that claimant has withdrawn from the work force.

Our review of this claim reveals that this claim has been open since 1987. By Own Motion Order dated March 17, 1987, the Board reopened claimant's claim with temporary disability benefits beginning July 11, 1986, and continuing, less any time worked, until claim closure pursuant to ORS 656.278. SAIF began paying temporary disability benefits but terminated benefits as of December 27, 1989. The claim has not been closed and remains in open status.

Our March 17, 1987, order of reopening directed SAIF to pay temporary disability benefits until claim closure. Inasmuch as claimant's claim remains open, SAIF is obligated to continue payment of temporary disability benefits until termination of benefits is permitted by law. By disputed claim settlement dated April 10, 1990, the parties stipulated that claimant was medically stationary as of February 15, 1990. However, there is no persuasive evidence that claimant has returned to or been released for any type of work. Therefore, SAIF

was obligated to continue the payment of temporary disability benefits until claim closure.

Furthermore, we find that claimant's compensable injury has again worsened requiring right knee surgery. SAIF nevertheless contends that claimant is not entitled to temporary disability benefits because he voluntarily retired from the work force as stipulated in the disputed claim settlement of April 10, 1990. However, claimant's retirement during the processing, and before closure, of his claim does not affect his entitlement to temporary disability benefits. See Weyerhaeuser Co. v. Kepford, 100 Or App 410 (1990). Because claimant was in the work force when his claim was reopened in 1987, he is entitled to temporary disability benefits throughout the processing of the claim. See id.

Accordingly, SAIF is directed to resume the payment of tempoary disability benefits from December 28, 1990, through the date of the proposed right knee surgery. Thereafter, SAIF shall continue paying temporary total disability benefits until one of the following events 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. Because this claim was reopened before 1988, temporary disability benefits paid during this open period are not reimbursable from the Reopened Claims Reserve. See Raymun B. Savalas, 43 Van Natta 38 (1991). When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-12-055.

IT IS SO ORDERED.

In the Matter of the Compensation of
J. R. RICHARDSON, Claimant
WCB Case No. 89-20342
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Westerband and Myers.

Claimant requests review of those portions of Referee Galton's order that: (1) upheld the self-insured employer's denial of surgery; and (2) declined to assess penalties and related attorney fees for an allegedly unreasonable limitation on claimant's right to medical care. In its respondent's brief, the employer objects to that portion of the Referee's order that set aside its denial of claimant's medical care provided by four out-of-state physicians and by one in-state physician. On review, the issues are medical services, compensability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and "Findings of Ultimate Fact" as our own.

CONCLUSIONS OF LAW AND OPINION

Medical Services

We adopt that portion of the Referee's "Conclusions of Law and Opinion," concluding that the proposed surgeries are neither reasonable nor necessary.

Compensability

The Referee set aside the employer's denial of medical care by five physicians: four out-of-state physicians and one in-state physician, expected to perform surgery out-of-state. We adopt that portion of the Referee's "Conclusions of Law and Opinion," concluding that medical care provided by the five physicians is compensable, except for the last two full paragraphs of the "Conclusion of Law and Opinion" section, as set forth on page 8 of the Opinion and Order. We make the following supplementation.

In Safeway Stores, Inc. v. Dupape, 106 Or App 126 (1991), the Court of Appeals affirmed the Board's order in Phyllis I. Dupape, 41 Van Natta 2427 (1989). In Phyllis I. Dupape, the Board held that employers have only a limited right to veto a claimant's choice of out-of-state physicians, and that the only adequate basis for a veto is when the out-of-state physician would be unlikely to comply with the workers' compensation reporting requirements. Phyllis I. Dupape, supra.

The Court of Appeals, in affirming the Board's Dupape decision, found that the Board's conclusion was not inconsistent with the wording or purpose of ORS 656.245(3) or with OAR 436-60-050(5). OAR 436-60-050(5) was interpreted by the Supreme Court as giving an employer only a limited right to object to a claimant's choice of physician. See Reynaga v. Northwest Farm Bureau, 300 Or 255 (1985). The Dupape court concluded that the Board is entitled to require that the employer state a reason for its objection and to require that the reason be related to a concern that the out-of-state doctor will not comply with Oregon's reporting requirements or other cognizable purposes of the statute or rules. Safeway Stores, Inc. v. Dupape, supra. Inasmuch as the employer's denial of treatment for the out-of-state physicians failed to provide such a reason, it is set aside.

Penalties and Related Attorney Fees

We adopt that portion of the Referee's "Conclusions of Law and Opinion," finding that the employer's denial of out-of-state medical care was not unreasonable.

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 employer's contentions on review concerning the compensability of out-of-state medical treatment is $750, to be paid by the employer. 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 March 13, 1990 is affirmed. For services on Board review concerning the compensability of medical care provided by out-of-state physicians, claimant's attorney is awarded a reasonable assessed fee of $750, payable by the employer.

In the Matter of the Compensation of
JOHN T. SEIBER, Claimant
WCB Case No. 89-14515
SECOND ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
Roberts, et al., Defense Attorneys

The self-insured employer requests reconsideration of our February 22, 1991 Order on Reconsideration which directed the employer to pay temporary disability to which claimant was procedurally entitled between November 24, 1988 and June 2, 1989. Noting that we have also found claimant medically stationary as of November 23, 1988, the employer seeks permission to immediately offset this overpayment against the procedural temporary disability benefits granted by our order rather than against claimant's future permanent disability awards as provided in our order.

In our Order on Reconsideration, we found that claimant was substantively entitled to temporary disability compensation only until November 23, 1988, the date he became medically stationary. However, because he was never released to regular work, we held that he was procedurally entitled to such benefits through June 2, 1989, the date of his claim was closed. See ORS 656. 268; Betty J. McKiernan, 43 Van Natta 213 (1991).

In reaching that decision, we recognized that the award resulted in an overpayment of temporary disability compensation beyond claimant's medically stationary date. Therefore, we authorized the employer to offset the overpayment of temporary disability compensation between November 24, 1988 and June 2, 1989, against any future awards of permanent disability.

On reconsideration, the employer notes that the June 2, 1989 Determination Order awarded claimant 5 percent scheduled disability for the right forearm. Assuming that it had properly processed the claim and paid claimant the temporary disability up to that point, the employer contends that it would have been entitled to recover the overpayment at that time by offsetting the overpaid temporary disability against the 5 percent permanent disability award. Therefore, the employer requests that this overpayment be recognized and allowed as an immediate, retrospective offset credit against the retrospective benefits we awarded claimant.

The employer argues that there is no "equitable basis" to place claimant in the position that he would have been in had the benefits been properly paid, while denying the employer the same treatment. We adhere to our prior order.

The relief obtained by claimant was based, in part, on the fact that the employer did not provide temporary disability benefits to which claimant was statutorily entitled. Although we did not consider the employer's conduct to be unreasonable, it was nonetheless improper. Had the employer properly processed the claim and paid temporary disability benefits until closure, it could have recovered the resulting overpayment from claimant's permanent disability award. However, because of the employer's failure to comply with its claim processing duties, such an offset was not possible. Were we to now accede to the employer's request for an immediate retrospective offset, we would be ignoring the fact that the overpayment created by our order was prompted by the employer's own processing omissions. Under such circumstances, we decline to grant the request for an immediate offset and adhere to our prior authorization for recovery of the overpaid temporary disability from claimant's future permanent disability awards.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DONALD W. YEDLOUTSCHNIG, Claimant
WCB Case No. TP-90019
THIRD PARTY ORDER
Doblie & Associates, Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

Claimant has petitioned the Board requesting a determination as to whether the Board has jurisdiction over a dispute arising out of a third party settlement. We conclude that we lack jurisdiction over this matter.

FINDINGS OF FACT

Claimant suffered a compensable injury on January 14, 1986, while working for the SAIF Corporation's insured. SAIF accepted the claim and paid claimant benefits pursuant to law.

The compensable injury gave rise to a cause of action against a third party. By letter dated March 19, 1986, SAIF advised claimant that, pursuant to law, he had three alternatives with regard to an action against the potential third party defendants. Claimant was advised that he could: (1) elect to recover damages against the third party himself; (2) elect to assign his rights against the third party to SAIF to pursue; or (3) take no action on the election, in which event his cause of action against the third party would be deemed assigned to SAIF by operation of law. On March 24, 1986, claimant signed an election form assigning his third party rights to SAIF.

SAIF brought suit against several third party defendants in Marion County Circuit Court. In December 1988, the action between SAIF and the third party defendants was settled before trial for $37,500. After deducting litigation costs, the paying agency's current and future claim costs exceed the remaining balance of the third party settlement. Claimant received no part of the settlement proceeds.

Subsequently, in November 1989, claimant brought suit against SAIF in Multnomah County Circuit Court. In that lawsuit, claimant seeks general and special damages resulting from SAIF's alleged failure to vigorously pursue the third party action. Claimant alleges causes of action based upon breach of fiduciary duty, breach of contract, fraud, and legal malpractice. Claimant does not allege entitlement to any of the settlement proceeds through redistribution of the proceeds.

SAIF filed a Motion to Dismiss claimant's suit based upon an allegation that the Circuit Court lacks jurisdiction to address the dispute and that exclusive jurisdiction rests with the Board. Claimant filed a response opposing dismissal of the suit and arguing that the Court has primary or concurrent jurisdiction of this matter. The Court subsequently abated the matter in order to allow claimant to petition the Board for a decision on the jurisdictional question.

CONTENTIONS

SAIF characterizes this dispute as one concerning claimant's election to assign his third party rights to SAIF. Citing EBI Companies v. Cooper, 100 Or App 246 (1990), SAIF argues that jurisdiction over the subject matter of an election by a worker to assign his third party claim rests with the Board. In addition, SAIF requests that the Board approve the settlement between SAIF and the third party defendants.

Claimant frames this dispute differently. Claimant characterizes the issue as requiring the Board to determine whether it has jurisdiction to award the damages sought by claimant in his suit against SAIF, i.e., both special and general damages for the various causes of action asserted in his suit against SAIF.

CONCLUSIONS OF LAW AND OPINION

If a worker receives a compensable injury due to the negligence or wrong of a third person not in the same employ, the worker shall elect whether to recover damages from such third person. ORS 656.578. Assuming the worker elects to pursue a third party action, 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.

The paying agency may require the worker to exercise the right of election provided in ORS 656.578 by serving a written demand upon such worker. ORS 656.583(1). Pursuant to ORS 656.591, an election not to proceed against the employer or third person operates as an assignment to the paying agency of the cause of action, if any, of the worker against the third person, and the paying agency may bring an action against such third person in the name of the injured worker. SAIF v. Meredith, 104 Or App 570 (1990).

Our authority in matters concerning settlement of a third-party action is defined by statute. SAIF v. Wright, 102 Or 598 (1990). Generally, we are authorized to order written approval of the settlement by the paying agency and, if the settlement is approved, we are authorized to determine a "just and proper" distribution of settlement proceeds. Id. at 601. Here, because claimant assigned his third party rights to SAIF as paying agency, we are not asked to order SAIF's approval of a settlement negotiated by claimant. To the contrary, SAIF has itself reached a settlement of the third party action. SAIF has requested that we approve that third party settlement. ORS 656.587 authorizes us to order approval of a settlement only where "the worker or other beneficiaries or the legal representative of the deceased worker" has reached a compromise. Because SAIF, rather than claimant, negotiated the settlement of the third party action, we lack jurisdiction, under ORS 656.587, to order approval of that settlement. See Harvey v. Lou Surcamp Logging, 100 Or App 227 (1990).

Similarly, there is no dispute concerning a "just and proper" distribution of the third party settlement proceeds. Claimant does not contend that SAIF is entitled to less than the full amount of the third party settlement after deduction of litigation costs. Indeed, pursuant to his counsel's March 4, 1991 letter to the Board, claimant has affirmatively stated that he does not seek a redistribution of the $37,500 third party settlement.

Therefore, the posture of this case is different from that presented to the Board in EBI Companies v. Cooper, supra. In Cooper, the worker elected to assign his third party rights to the paying agency. The paying agency settled that action, and the proceeds were distributed pursuant to ORS 656.591(2). The claimant received no portion of the distribution. The claimant subsequently petitioned the Board for a third party order pursuant to ORS 656.593 to redistribute the recovery in the third party action. The claimant contended that the paying agency had induced him to assign his claim by fraud or misrepresentation. We concluded that the assignment was fraudulently obtained and we ordered redistribution of the proceeds.

The Court of Appeals affirmed. In the process, the court addressed the question of our jurisdiction. The court first concluded that the dispute involved "matters concerning a claim under ORS 656.001 to 656.794" because the worker's right to receive compensation was directly in issue. See ORS

656.704(1), (3). The court next concluded that ORS 656.591 gives the Board jurisdiction over the parties and the subject matter of an election by a worker to assign his third party claim to a paying agency. The court then concluded that our authority to order rescission of an election fraudulently obtained flows from the exercise of that jurisdiction, "because an election that was induced by fraud is, in fact, no election." The court's reasoning in Cooper does not apply here because claimant does not seek rescission of his assignment election.

In sum, pursuant to our limited jurisdiction, we may decide whether an election by a worker to assign his rights to pursue a third party action was fraudulently obtained where the relief sought for such conduct is an order distributing the proceeds of the third party action under ORS 656.593, as if claimant had elected to prosecute the action himself, rather than under ORS 656.591. See EBI Companies v. Cooper, supra; Harvey v. Lou Surcamp Logging, supra. Inasmuch as claimant is not contending that he should not be held to his assignment and he does not seek a different distribution of the proceeds, we have no jurisdiction of the matter.

IT IS SO ORDERED.

March 22, 1991 Cite as 43 Van Natta 617 (1991)

In the Matter of the Compensation of
MOLLIE E. BARROW, Claimant
WCB Case No. 89-17353
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Speer and Howell.

The SAIF Corporation requests review of those portions of Referee Peterson's order that: (1) set aside its partial denial of claimant's psychological condition; and (2) assessed penalties and related attorney fees for claims processing and discovery violations. The issues on review are compensability 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."

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Conclusions of Law" with the following modifications.

Compensability of Psychological Treatments

SAIF argues that claimant's psychological condition is not compensable because a masters degree counselor made the diagnoses of depression and anxiety, rather than a psychiatrist or clinical psychologist. We find this analysis without merit. Claimant asserts that she has a significant emotional sequela secondary to her compensable knee injury. The record as a whole substantiates this claim. A masters level counselor, as well as a treating medical doctor, relate claimant's depression to her inactivity following a disabling knee injury. This is adequate evidence for finding the psychological condition

compensable and we accordingly affirm the Referee. See Thomas v. Liberty Mutual Insurance, 73 Or App 128, 131 (1985).

Penalties for Claims Violations

The Referee assessed a penalty of 25 percent of all unpaid medical bills for a late denial and another penalty of 25 percent of unpaid medical bills for SAIF's failure to process a claim for a stationary bike and health club membership. We agree with the Referee's conclusion that these claims processing violations warranted assessment of penalties. Nevertheless, although claimant is entitled to a penalty for SAIF's failure to comply with a number of regulations and administrative rules, there is no legal authority to assess penalties totalling more than 25 percent of the compensation then due. Former ORS 656.262(10); see Kim L. Haragan, 42 Van Natta 311, 313 (1990).

We modify the Referee's order to the extent that he assessed three separate 25 percent penalties. Rather, claimant is entitled to a single 25 percent penalty based on all compensation due at the time of hearing. The compensation then due should be determined based on the unpaid billings for medical services associated with the denials of claims for the compensable psychological and right leg conditions. See ORS 656.262(10).

Attorney Fees for Claims Violations

Although a 25 percent penalty may not be assessed for each of the claims processing violations, there is authority for awarding an attorney fee for each unreasonable claims processing violation regardless of whether any penalty may be assessed. See e.g., Haragan, supra; Maria Martinez, 40 Van Natta 59, 61 (1988); Paul Jackson, 40 Van Natta 558, 561 (1988). Thus, we affirm the Referee's attorney fee awards made in association with the assessment of penalties for unreasonable delays in accepting or denying claims. See Ellis v. McCall Insulation, 308 Or 74 (1989).

Discovery Violations

The Referee also concluded that a penalty was warranted for SAIF's late discovery and complete failure to provide discovery for two medical documents. We agree that SAIF violated former OAR 438-07-015(2). However, there was no showing here that SAIF's discovery violations unreasonably delayed acceptance of the claim or resulted in a delay or refusal to pay compensation. See ORS 656.262(10). Accordingly, the discovery violations do not warrant assessment of a penalty. See Ellis v. McCall Insulation, supra; Buck E. Johnson, 43 Van Natta 423 (1991).

The Referee also assessed an attorney fee of $100 due to SAIF's failure to provide timely discovery. We disagree. Pursuant to ORS 656.382(1), an attorney fee is allowed if an insurer "unreasonably resists the payment of compensation." Absent a showing that SAIF's "inaction affected some obligation to pay compensation due in the past, present or future, it cannot be said that there was any resistance to such payment." Buck E. Johnson, supra.

Attorney Fees on Board Review

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 of claimant's psychological condition is $750, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 19, 1990 is modified in part, reversed in part and affirmed in part. For late denials of unpaid medical bills and for failure to process claims for a stationary bike and health club membership, the SAIF Corporation shall pay claimant one 25 percent penalty based on all compensation due at the time of hearing. The compensation then due shall be determined based on the unpaid billings for medical services associated with the denials of claims for the psychological and right leg conditions. The attorney fee for SAIF's discovery violations is reversed. The remainder of the Referee's order is affirmed. For services on Board review concerning the compensability of claimant's psychological condition, claimant's attorney is awarded an assessed fee of $750 to be paid by SAIF.

March 22, 1991 Cite as 43 Van Natta 619 (1991)

In the Matter of the Compensation of
MARY E. BIGLER, Claimant
WCB Case No. TP-90064
THIRD PARTY ORDER OF DISMISSAL
Burt, et al., Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

The SAIF Corporation, as a paying agency, petitions the Board to resolve a dispute concerning SAIF's entitlement to a share of any recovery stemming from claimant's June 26, 1988 motor vehicle accident. Contending that the accident resulted in the reopening of claimant's January 1988 back injury claim, SAIF seeks a Board order granting it a share of any eventual recovery from the June 1988 motor vehicle accident. We dismiss the petition as premature.

FINDINGS OF FACT

In January 1988 claimant sustained a compensable back injury while working as a registered nurse. She continued to work, but was placed under a 35 pound lifting restriction. For the first week after her injury, claimant received chiropractic treatment on a daily basis. Within a month, she had reduced her treatments to one per week.

In March 1988 SAIF accepted the claim as nondisabling. SAIF identified the accepted conditions as "disorder of sacroiliac joint; sprain left hip."

In June 1988 claimant was involved in an off-the-job motor vehicle accident with another vehicle. She suffered injuries to several areas of her body, including her low back. Thereafter, claimant was taken off work and began receiving chiropractic treatments more frequently.

In August 1988 claimant returned to her nursing duties on a part-time, modified basis. However, by October 1988, she was taken off work because of her inability to fully resume her duties.

As a result of the June 1988 motor vehicle accident, claimant filed an aggravation claim with SAIF for her worsened back condition. In addition, she retained counsel to seek damages from the operator of the motor vehicle involved in the June 1988 accident. A cause of action has been filed.

SAIF denied claimant's aggravation claim. In September 1989 a Referee set aside the denial and remanded the aggravation claim to SAIF for processing. In so doing, the Referee found that:

> ". . . although claimant was doing fairly well regarding her low back prior to the June 1988 motor vehicle accident, she had not fully recovered from her January 1988 injury and although the June 1988 motor vehicle accident was the cause of her worsening at that time, the January 1988 work injury was a material contributing cause of claimant's worsened condition regarding her low back subsequent to the June 1988 motor vehicle accident."

A March 22, 1990 Determination Order closed the claim. Claimant was awarded: (1) temporary partial disability benefits between January 1988 and the June 1988 motor vehicle accident; (2) temporary total disability benefits commencing after the accident and continuing until her August 1988 return to work; (3) two months of temporary partial disability during her attempted return to work; and (4) approximately 15 1/2 months of temporary total disability benefits following her unsuccessful return to work and her February 1990 medically stationary date. Claimant was also awarded 31 percent unscheduled permanent disability.

On March 23, 1990, SAIF submitted a third party election form to claimant's counsel. Claimant was requested to indicate whether she intended to proceed against the driver of the other motor vehicle involved in the June 1988 accident on her own behalf or whether she wished to assign her cause of action to SAIF.

On March 28, 1990, claimant's counsel responded to SAIF's request for an election. After reviewing the Referee's September 1989 order, claimant's counsel stated that the June 1988 motor vehicle accident was a separate and distinct injury that was unrelated to the compensable injury. Under such circumstances, it was claimant's position that there was no need to complete the third party election form.

No recovery by means of settlement or judgment has been obtained against the alleged third party. Moreover, no compromise between claimant and the alleged third party has been achieved.

CONCLUSIONS OF LAW

Pursuant to ORS 656.587, the Board is authorized to resolve disputes concerning the approval of any compromise of a third party action. In exercising this authority, we employ our independent judgment to determine whether the compromise is reasonable. Natasha D. Lenhart, 38 Van Natta 1496 (1986).

Generally, we will approve settlements negotiated between a claimant/plaintiff and a third party defendant, unless the settlement appears to be grossly unreasonable. Dorotha M. Clarke, 40 Van Natta 1125 (1988), Kathryn I. Looney, 39 Van Natta 1400 (1987). However, where a claimant has not accepted the settlement offer, no third party compromise exists for us to consider. Delores M. Shute, 41 Van Natta 1028 (1989).

Here, not only has claimant not accepted a settlement offer, there is no indication that such an offer has even been made. Inasmuch as the record does not establish that a compromise between the worker and the purported third party currently exists, we are without authority to proceed under ORS 656.587. Shute, supra.

Furthermore, pursuant to ORS 656.593(3), we are authorized to resolve any conflict concerning the "just and proper distribution" of the remaining proceeds from a third party settlement. Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). Yet, where no third party settlement has been reached, there are

no proceeds from which we can determine a "just and proper" distribution. See ORS 656.593(3); Shute, supra. Thus, in the absence of a settlement, any petition for resolution of such a "dispute" is considered to be a request for an advisory opinion which we are not empowered to issue. Shute, supra.

Finally, there is likewise no evidence that a judgment has been recovered. Without such a recovery, we also lack the authority to resolve any conflict as to the amount of the remaining balance which may be retained by the purported paying agency under ORS 656.593(1)(d).

SAIF argues that, should we decline to consider the parties' present dispute, it will be either required to attempt to unravel a void settlement or to prevent claimant from collecting upon a judgment without sharing a portion with SAIF. We do not agree that SAIF's alternatives are as dire as it describes. Inasmuch as it is aware that claimant has instituted a cause of action against the purported third party, SAIF would be under no prohibition from notifying that party and its insured of the existence of its claim. Similarly, considering claimant's refusal to acknowledge its claim as a paying agency, SAIF could also consider providing the notice of its purported lien to the clerk of the court pursuant to ORS 656.593(1). Such notice would provide the clerk of the court with knowledge of SAIF's alleged lien without making the notice a part of the court record. These measures would not only minimize the likelihood of a "retroactive" dispute as SAIF fears, but would greatly enhance the opportunity to present a ripe dispute for timely resolution should the need for Board intervention subsequently arise.

In conclusion, a dispute between claimant and SAIF currently exists. Yet, for the reasons discussed above, this is not a dispute which we are authorized to resolve. Accordingly, SAIF's petition for third party relief is dismissed.

IT IS SO ORDERED.

March 22, 1991 Cite as 43 Van Natta 621 (1991)

In the Matter of the Compensation of
CYNTHIA J. MELVIN, Claimant
WCB Case No. 89-20436
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Nelson, et al., Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

The insurer requests review of Referee Brown's order that set aside its denial of compensability of a cervico-dorsal strain. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant had a neck strain (whiplash) as a result of an automobile accident in 1979, and a concussion in 1987.

Claimant first worked for the employer from 1981 to 1984, and again from March 1989 until September 14, 1989.

Claimant's regular job was to check in dirty laundry and check out clean. On September 14, 1989, she was transferred to a different job folding and checking clean laundry for holes. That morning she was trained by Terri Miller, a

co-worker, on how to fill baskets, and how to fold and check for holes. After she had done a number of garments she was told by Trish Boone (the owner's wife) that she had done them wrong and to hold them up high to look for holes. Claimant did so. She folded several hundred garments. When she finished she was told that she had done them wrong and to do them over. At 12:45 p. m. claimant walked off the job.

When claimant came in to pick up her check on September 19, 1989 she filled out an 801 form for an injury to her left neck and upper back (Ex. 2). She reported on the 801 form that her injury occurred when she "was told to check coveralls for holes, holding garment up in air with right hand, push pockets back with left hand while in air. I did this from 9 a. m. till 1 p. m. I finished 360 coveralls. When I was done I was told to do them over again as I was told not to be nitpicky." (Ex. 2).

On September 20, 1989, Dr. Schroeder, chiropractor, diagnosed claimant with a cervico-dorsal strain on an 827 form (Ex. 3), which Dr. Schroeder corrected to include a lumbosacral strain as well (Ex. 6-1). Dr. Schroeder made no findings connecting her diagnosis of claimant's current back condition with either of claimant's previous injuries.

On September 22, the employer had two employees, Terri Miller and Marcie Spencer, write notarized statements regarding the correct way to fold coveralls, which was not to hold them up in the air. On the same date the insurer denied claimant's claim on the 801 form.

On September 29, 1989, the insurer formally denied claimant's claim for cervico-dorsal strain on the basis that it did not arise out of and in the course and scope of her employment at the employer.

FINDINGS OF ULTIMATE FACT

Claimant suffered a cervico-dorsal strain and a lumbosacral strain in the course of her employment on September 14, 1989.

CONCLUSIONS OF LAW AND OPINION

We adopt the opinion and conclusions of the Referee, including sections (3) and (4) of his "FINDINGS" on credibility.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $350 is a reasonable fee for services on review rendered by claimant's counsels, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case as represented by claimant's respondent's brief and their statement of services, the average complexity of the issue, and the value of the interest involved. The manner in which this fee shall be apportioned is a matter to be decided by claimant's co-counsels, not this forum. See Fred L. Snider, 43 Van Natta 577 (1991).

ORDER

The Referee's order dated March 8, 1990 is affirmed. For services on review, claimant's counsels are awarded $350, payable by the insurer.

In the Matter of the Compensation of
BRIAN S. MODE, Claimant
WCB Case No. 89-24394
ORDER ON REVIEW
Svodoba & Associates, Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of those portions of Referee Gruber's order which: (1) affirmed a Determination Order awarding 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the right forearm/wrist and 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the left forearm/wrist; and (2) declined to adjust claimant's temporary total disability compensation rate. On review, the issues are extent of scheduled permanent disability and rate of temporary total disability compensation. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact." In addition, we supplement with the following findings.

Claimant began working for the insured as a core layer in February 1988. He was scheduled to work from 11 p.m. to 7 a.m., Monday through Friday. Claimant was paid by the piece, based on the square footage of plywood produced.

Claimant's employment agreement did not contemplate that he would be paid for time that he did not work such as holidays or any time that the plant was shut down for repairs.

Dr. Macha, claimant's treating physician, has recommended that claimant not return to repetitive manual labor.

FINDINGS OF ULTIMATE FACT

Claimant has sustained a 5 percent loss of use or function of his right forearm/wrist as a result of his compensable condition. Claimant has sustained a 5 percent loss of use or function of his left forearm/wrist as a result of his compensable condition.

Claimant was regularly employed by the employer. Claimant's renumeration was not based solely upon a daily or weekly wage but upon production.

There were no extended gaps in employment during the last 26 weeks that claimant worked for the insured.

CONCLUSIONS OF LAW AND OPINION

Extent of Scheduled Permanent Disability

The Referee affirmed the Determination Order awarding claimant 5 percent scheduled permanent disability for loss of use or function for each forearm/wrist. Claimant's condition became medically stationary on September 21, 1989, and his claim was closed by Determination Order on November 9, 1989. Although the Referee did not specify which standards he applied, he apparently applied the standards in effect January 1, 1989, former OAR 436-35-001 et seq. These are the rules which we apply as well. Former ORS 656.283(7) and 656.295(5);

OAR 438-10-010. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent disability. Former 436-35-010(1).

In addition to the award of 5 percent for loss of repetitive use of each forearm/wrist, claimant contends that he is entitled to additional awards for pain, loss of sensation, decreased grip strength, and carpal bone resections.

Pain

Claimant asserts that he has suffered the total loss of use of the fourth and fifth fingers of both hands due to pain. However, pain is considered in the rules "to the extent it results in measurable impairment. If there is no measurable impairment, no award of scheduled permanent partial disability is allowed." Former OAR 436-35-010(2)(b). Therefore, we award no separate value for pain alone.

Loss of Sensation

We adopt the Referee's discussion on this value.

Decreased Grip Strength

We adopt the Referee's discussion on this value with the following comment. A value is assigned for decreased grip strength due to nerve damage or atrophy. Former OAR 436-35-110(3)(a) and former OAR 436-35-110(3)(d). Claimant has neither documented nerve damage nor atrophy.

Carpal Bone Resection

Finally, claimant argues that he should be awarded 5 percent scheduled disability for each carpal bone resection under former OAR 436-35-110(4)(f). The employer notes that claimant underwent bilateral carpal tunnel releases rather than carpal bone resections. The employer is correct; there is no evidence that carpal bone resections were performed. The standards provide no value for carpal tunnel releases. Thus, no value can be awarded for claimant's surgeries. Carol A. Ray, 42 Van Natta 1008, 1010 (1990).

Accordingly, claimant's only rateable impairment under the standards is 5 percent for loss of repetitive use of the right forearm/wrist and 5 percent for loss of repetitive use of the left forearm/wrist. Former OAR 436-35-110(7). Consequently, claimant's total scheduled disability award is 5 percent for loss of use or function of the right forearm/wrist and 5 percent for loss of use or function of the left forearm/wrist.

Rate of Temporary Total Disability Compensation

We affirm and adopt the Referee's reasoning and conclusion on this issue with the following comment. "Extended gaps" in employment are those which alter the employment relationship between the worker and the employer. Craig E. Hobbs, 39 Van Natta 90 (1987). Here, the brief gaps in claimant's employment caused by holidays and equipment breakdowns did not cause a change in the work relationship between the employer and claimant. Therefore, the Referee properly calculated claimant's rate of temporary total disability based on his average weekly earnings during the last 26 weeks of his employment. Former OAR 436-60-020(7)(b); former OAR 436-60-020(7)(a).

ORDER

The Referee's order dated June 22, 1990 is affirmed.

In the Matter of the Compensation of
JAMES E. PEACOCK, Claimant
WCB Case No. 88-02788
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Nichols, Brittingham, and Crider.

The SAIF Corporation requests review of Referee Mirassou's order that set aside a Director's Review and Order, dated November 19, 1987, which found claimant ineligible for vocational assistance. On review, the issue is eligibility for vocational assistance. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Review of a Director's order is limited under ORS 656.283(2) and may be modified only if it: (a) violates a statute or rule; (b) exceeds the statutory authority of the agency; (c) was made upon unlawful procedure; or (d) was characterized by abuse of discretion or clearly unwarranted exercise of discretion.

Here, the Director declined to authorize vocational services for claimant because he resides outside the state of Oregon and was not available for services in Oregon. The Director relied on former OAR 436-120-040(3), effective when claimant requested services in August 1987. This rule gives the Director discretion to authorize vocational rehabilitation services outside Oregon if the insurer finds them more effective in the particular circumstances. The Director's decision was an exercise of his discretionary authority under that rule.

The Referee found that the Director's decision was a violation of ORS 656.283(2)(d) in that it was an abuse of discretion and a clearly unwarranted exercise of discretion. In reaching that decision, the Referee, like the Director, applied the law in effect at the time services were requested.

SAIF argues that the Director did not abuse his discretion in refusing to authorize services. SAIF further argues that the Referee improperly substituted her opinion for that of the Director.

Claimant agrees with the Referee's ultimate ruling that the Director abused his discretion, but contends that the Referee erred in applying the law in effect when the services were requested. Claimant argues that his eligibility for vocational services should be determined under former ORS 656.728(3), the law in effect at the time of claimant's 1977 injury, and that he is entitled to services under that law. Alternatively, claimant argues that the Director's decision was beyond the statutory authority of the agency.

We begin by addressing claimant's arguments. Assuming the law at injury were applicable, claimant has not proven that he is entitled to services under former ORS 656.728(3). That provision provided in pertinent part:

> "(3) The board shall by rule provide for reimbursement . . . from the Rehabilitation Reserve any sums paid as temporary disability compensation after the date the workman is determined to be medically stationary until a program of rehabilitation has been terminated as provided by ORS 656.268."

Claimant relies on the fact that the court in Argonaut Ins. Co. v. Workers' Compensation Dept., 89 Or App 591 (1988), determined whether reimbursement for compensation paid during an out-of-state program was appropriate under former

ORS 656.728(3). Claimant's reliance on former ORS 656.728(3) and the Argonaut decision is misplaced. The rule and the decision are addressed solely to reimbursement of temporary disability compensation; neither is relevant in determining claimant's entitlement to out-of-state services in the first instance.

Moreover, even if claimant would have been entitled to services under former ORS 656.728(3), that law is not applicable here; rather, the law at the time services were requested controls the present case. We recently took a contrary position in Warren C. Rock, 41 Van Natta 2176 (1989), concluding that the law at the time of injury controls. However, after reconsidering this issue, we conclude that the present case is controlled by the law at the time services were requested.

Pursuant to ORS 656.202(2), payment of benefits shall be continued as authorized by the law in force at the time of injury, except as otherwise provided by law. However, in 1985 the legislature amended ORS 656.202 to expressly except vocational assistance benefits from the provisions of that rule. ORS 656.202(5) (effective January 1, 1986, Oregon Laws 1985, section 6, chapter 600). We are, therefore, not required by ORS 656.202 to apply the law at the time of injury.

Furthermore, determining eligibility under the law in effect when services are requested is consistent with the Department's rules. In 1987, when claimant requested the services at issue in this case, former OAR 436-120-003 read in pertinent part:

> "(1) These rules govern vocational assistance pursuant to the Workers' Compensation Law on and after January 1, 1986, under each claim of a worker without regard to the date of injury except as these rules provide otherwise. . . ."
>
> "(4) The Director may modify or waive provisions of these rules if the Director finds that necessary to prevent manifest injustice or exceptional hardship to a worker from a strict construction of those provisions or from an error by an insurer, a vocational rehabilitation organization or the Department."

Here, the Director did not waive application of former OAR 436-120-003(1), and claimant has not established that his failure to do so was an abuse of discretion. The rules do not otherwise provide for determination of eligibility for vocational services under rules other than those effective at the time the service is requested. Deference to the Department's rules is appropriate, given the Director's broad discretion under the statute to establish eligibility requirements for vocational assistance. See former ORS 656.340(6), now ORS 656.340(7). Cf. Forrest A. Laffin, 40 Van Natta 1027 (1988).

Accordingly, we conclude that, in the present case, the Director correctly applied the rules in effect when claimant requested services in August 1987. To the extent our decision in Warren C. Rock, supra, is inconsistent with this ruling, it is disavowed.

We turn to claimant's second argument that the Director's decision was beyond the statutory authority of the agency. More specifically, claimant argues that former OAR 436-120-040(3), the rule relied on by the Director, is beyond the statutory authority of the agency. As discussed above, that rule gives the Director discretion to authorize vocational rehabilitation services outside Oregon if the insurer finds them more effective in the particular circumstances.

Claimant argues that limiting vocational services to workers living in Oregon is inconsistent with the stated legislative policy of returning injured workers to the work force.

We previously applied an earlier version of former OAR 436-120-040(3) in our decision in Forrest A. Laffin, supra. In Laffin, we noted that the pre-1985 Workers' Compensation statutes applicable in that case created no entitlement to vocational assistance, and that entitlement to such services existed entirely within the Director's rules. See former ORS 656.340(3); and 656.616. Under the rule applicable in Laffin, the Director had no discretion to authorize out-of-state vocational services. Former OAR 436-61-100(1) (incorrectly cited in Laffin as OAR 436-61-004). Thus, we concluded that the claimant was not entitled to out-of-state services.

Unlike the situation in Laffin, the post-1985 Workers' Compensation statutes applicable in the present case do create an entitlement to vocational assistance. Former ORS 656.340(6), now ORS 656.340(7). Nevertheless, vocational assistance continues to be available under conditions prescribed by the Director, including conditions relating to the worker's availability for assistance and the extent of assistance that may be provided. Id. Thus, the Director continues to have broad discretion to establish eligibility for vocational assistance.

We conclude that the rule at issue in the present case, former OAR 436-120-040(3), was within the Director's broad discretionary authority. The statute contains no express restrictions on the Director's authority to deny out-of-state vocational services. Moreover, former OAR 436-120-040(3) is less restrictive than the rule applicable in Laffin, in that it does give the Director some discretion in this matter to authorize out-of-state services. Accordingly, we reject claimant's argument that the Director's decision was based on a rule that was beyond the statutory authority of the agency.

We turn to SAIF's argument that the Director did not abuse his discretion and that the Referee improperly substituted her opinion for that of the Director. We recently held in Richard A. Colclasure, 42 Van Natta 2454, on recon 2574 (1990), that the Referee makes the evidentiary record and then determines if the Director abused his discretion in light of the hearing record. The Referee may only modify the Director's order pursuant to ORS 656.283(2)(d) if the hearing record "as a whole" indicates that the Director acted to an end or purpose not justified by, and clearly against, reason and evidence.

In this matter, the Director determined that claimant was ineligible for vocational services because he is no longer available in Oregon for vocational assistance. The evidentiary record created by the Referee supports such a finding. Thus, we conclude the Director did not abuse his discretion in making such a finding.

Inasmuch as we have found that the Director's decision was properly within his authority, as derived from former ORS 656.340(6), we find that the Director's Review and Order should be affirmed.

ORDER

The Referee's order dated September 14, 1988 is reversed. The Director's Review and Order, dated November 19, 1987, is reinstated and affirmed.

In the Matter of the Compensation of
LAUREL M. PRESTON, Claimant
WCB Case No. 89-09263
ORDER ON REVIEW
Brothers, et al., Claimant Attorneys
Lester R. Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of that portion of Referee Michael Johnson's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for a mental disorder. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

ULTIMATE FINDINGS OF FACT

The Board adopts the Referee's "Ultimate Findings of Fact," with the exception of the last sentence of the first paragraph.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Opinion" with the following modifications.

The SAIF Corporation concedes that claimant suffers from a mental or emotional disorder which is generally recognized in the medical community, and that there is clear and convincing evidence that the mental disorder arose out of the employment conditions of progressive discipline due to unsatisfactory work performance. We agree with the Referee that the employer's actions relative to claimant's performance evaluation and the disciplinary actions taken by management were reasonable. Consequently, even though SAIF concedes that such stressors caused claimant's mental disorder, we exclude those actions, and their effect upon claimant, from our compensability determination. ORS 656.802(2)(b).

Claimant testified that nondisciplinary stressors of ostracism and friction with her co-workers contributed to her disability. Claimant must prove by clear and convincing evidence that her exposure to such stressors was a material contributing cause of her mental disorder. ORS 656.802(2)(d); Deborah Andersen, 42 Van Natta 513 (1990). "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).

We conclude that the causal connection between claimant's mental disorder and social ostracism and friction is a complex medical question that requires expert medical evidence to resolve the issue. Uris v. Compensation Department, 247 Or 420, 424-26 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Although lay testimony may be probative, it is not persuasive when the claim involves a complex medical question. After conducting a de novo review of the medical and lay evidence, we conclude that there is a failure of proof that the nondisciplinary factors were a material contributing cause of claimant's mental disorder.

There are no medical findings that social friction and ostracism of claimant by her fellow workers was a material cause of claimant's mental disorder. In making her diagnosis, Dr. Hebert, claimant's attending clinical psychologist, refers only to the severe stressors of intensive supervision at work.

(Exs. 1A, 4). There are occasional references in chart notes to claimant's feelings of betrayal by fellow workers for their complaints to management about her work performance and their cooperation with supervisors in documenting her performance problems. However, there is no basis in the medical record to support the contention that social ostracism was a factor in contributing to claimant's mental disorder.

Similarly, Dr. Hyde, psychiatrist, refers only to the employer's discipline for alleged performance problems as the cause of claimant's work-related stress condition. (Ex. 8).

Because we conclude that claimant has not established that factors other than reasonable disciplinary, corrective or job performance evaluation actions were a material contributing cause of her mental disorder, we do not reach the question whether the nondisciplinary conditions of social ostracism and friction are generally inherent in every working situation. ORS 656.802(2)(b).

ORDER

The Referee's order dated March 13, 1990 is affirmed.

March 22, 1991 Cite as 43 Van Natta 629 (1991)

In the Matter of the Compensation of
ERVEN SIMRIL, Claimant
WCB Case No. 90-06807
ORDER ON REVIEW
Cournoyer & Sussman, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

The self-insured employer requests review of Referee Peterson's order that awarded claimant 9 percent (28.8 degrees) unscheduled permanent disability for a low back condition in addition to the 28 percent (89.6 degrees) that was granted by the Determination Order that was issued on January 31, 1990. The employer further contests the Referee's failure to dismiss the request for hearing because claimant applied for and received a lump sum payment of the Determination order award. The issues on review are waiver and extent of unscheduled permanent partial disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Waiver

The employer contends that since claimant applied for and received a lump sum payment of the Determination Order award of 28 percent unscheduled disability, he cannot now request a hearing on the issue of extent of disability. The employer further argues that claimant intentionally waived his right to request a hearing when he signed the application for the lump sum payment, notwithstanding the fact the Director did not approve the payment. We disagree.

Claimant completed an application for approval of a lump sum payment of his permanent disability award. The application contained the standard wording "I understand that by applying for and accepting a lump sum payment of any part

of my permanent partial disability award, I waive the right to appeal the adequacy of the award." The employer made a lump sum payment of the award without the Director's approval.

The Referee held that a lump sum payment can only be made upon approval of the Department of Insurance and Finance. He further found that the claimant did not make an intentional or voluntary relinquishment of his appeal rights, as he did not understand he would lose his appeal rights by signing the lump sum application.

We agree with the Referee that approval of a lump sum payment can only be given by the Director where application has been made by claimant as he did in this matter. ORS 656.230(1), 656.304, OAR 436-60-060(1)-(13). The actions of the employer indicate that this is its understanding also as it characterized the payment as one made in error.

ORS 656.230(1) gives the Director discretion to order all or any part of the award to be paid in a lump sum. In this matter, the Director refused to approve the application. There was no order upon which to make a lump sum payment of the award. The employer's premature payment of the award does not obviate the need to obtain approval from the Director. Until that approval is received and an order issued by the Director, the terms of the lump sum payment agreement, including the waiver of appeal rights, have no binding effect. Thus, the employer's payment does not preclude the claimant from requesting a hearing on the extent of his disability. Because we believe the terms of the agreement are not binding absent the Director's approval, it is not necessary for us to determine whether or not claimant intentionally and voluntarily waived his right to request a hearing to contest the award of permanent disability.

Extent of Disability

We affirm and adopt the Referee on the issue of extent of disability.

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 waiver and extent of disability issues is $800, 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 respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated August 3, 1990 is affirmed. Claimant's attorney is awarded an assessed fee of $800, to be paid by the employer.

In the Matter of the Compensation of
ROGER F. SLADE, Claimant
WCB Case No. 89-11879
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Terrall & Miller, Defense Attorneys

Reviewed by Board Members Nichols, Brittingham and Westerband.

The self-insured employer requests review of those portions of Referee Galton's order that: (1) increased claimant's unscheduled permanent partial disability for a low back injury from 39 percent (124.8 degrees), as awarded by a Determination Order, to 48 percent (153.6 degrees); (2) set aside the employer's denial of claimant's medical services claim for chiropractic treatment in excess of the Director's guidelines; (3) awarded claimant an assessed fee for prevailing on the denial; (4) assessed a penalty and related attorney fee for the employer's allegedly unreasonable denial of medical services; and (5) awarded claimant an assessed fee for prevailing against the employer's cross-request for a reduction in claimant's unscheduled permanent partial disability. On review, the issues are extent of unscheduled permanent partial disability, medical services, penalties and attorney fees. We modify in part, and reverse in part.

FINDINGS OF FACT

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

We delete paragraph 13 and replace it with the following. Claimant continued to treat with Dr. Berardi. On behalf of Tri-Met, Fred S. James & Co. entered its partial denial on September 11, 1989, relying on OAR 436-10-040, rejecting treatments in excess of two per month under the guidelines. At that time, there were approximately $1,700 in unpaid bills from Dr. Berardi.

We delete the first sentence in paragraph 15 and replace it with the following. Dr. Berardi's palliative chiropractic treatments provided only transient pain relief lasting from a few hours to a day. (Tr. 25, 38, 44, 45, Ex. 26-2).

On August 29, 1989, claimant stopped treating with Dr. Berardi because he felt better and wanted to see how his condition would fare without chiropractic treatments. (Tr. 22, 23, 34, 35). On October 3, 1989, claimant returned to Dr. Berardi who opined that claimant was medically stationary as of that date. (Ex. 45).

At hearing, the employer cross-requested a reduction in the permanent partial disability compensation awarded by the Determination Order.

FINDINGS OF ULTIMATE FACT

Claimant has sustained a 41 percent loss of earning capacity as a result of the compensable injury. The palliative chiropractic treatments provided by Dr. Berardi in excess of two treatments per month were not reasonable and necessary. The September 11, 1989 denial referred to outstanding unpaid chiropractic bills and not to possible future chiropractic treatments. There are no amounts due under claimant's medical services claim. The employer's failure to refer Dr. Berardi's bills to the Medical Director was not a resistance to the payment of compensation.

CONCLUSIONS OF LAW AND OPINION

Unscheduled Permanent Partial Disability

The Referee applied the "standards" in effect at the date of the Determination Order and found that claimant had sustained 48 percent unscheduled permanent disability. We modify.

For purposes of determining injury-related permanent partial disability, former ORS 656.283(7) and former 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.

Because claimant's condition became medically stationary on April 25, 1989, and his claim was closed by Determination Order on June 2, 1989, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled 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. Former OAR 436-35-280.

The Referee adopted the values on claimant's permanent partial disability evaluation sheet. We cannot determine those values because the evaluation sheet is not in the record. Therefore, we apply the "standards" based on the record before us, under our de novo review authority.

Age

The appropriate value for claimant's age of 38 years is 0. Former OAR 436-35-290.

Formal education

The appropriate value for claimant's 13 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 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 6 as a bus driver (DOT # 913-463-010). Therefore, the appropriate value for skills is 2. Former OAR 436-35-300(4).

The employer argues that claimant's highest SVP is 7, which converts to a skills value of 1, because claimant received training as a diesel mechanic. However, because we find that claimant's training and two months work experience as a diesel mechanic were insufficient to meet the specific vocational

preparation time required for that job, we find that he did not successfully perform that job. See former OAR 436-35-300(4); Michael W. Davison, 42 Van Natta 1820, 1821 (1990). Accordingly, we do not use 7 as claimant's highest SVP.

Training

Whether claimant is entitled to a value for training under former OAR 436-35-300(5) is dependent upon whether or not claimant has demonstrated competence in some specific vocational pursuit. Competence in some "specific vocational pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off the job to perform other than an entry level position. Larry L. McDougal, 42 Van Natta 1544 (1990).

The Referee found that claimant had no training and assigned a value of 1. We disagree. We find that claimant has not acquired sufficient training to perform work as a diesel mechanic other than at an entry level. On the other hand, we find that claimant's work as a bus driver since May 1981 provides him with such training. In assigning a value for training, claimant's physical capabilities to do the job in question are not taken into account. Jimmie L. Wilson, 42 Van Natta 2526, 2528 (1990). Therefore, claimant's training value is 0. Former OAR 436-35-300(5).

Adaptability

The adaptability value for a claimant who is not working as a result of his or her compensable injury/condition 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).

Here, claimant is not working as a result of his compensable injury and no offer of employment has been made. Claimant's physical capacity is in the sedentary category. Therefore, the appropriate adaptability value is 8. Former OAR 436-35-310(4)(d).

The employer argues that claimant should have an adaptability value of 4 based on the 35 pound lifting limitation assigned by Dr. Brett, consulting neurologist. However, Dr. Brett last examined claimant on September 16, 1988, which was before claimant's January 1989 attempt to return to modified work which Dr. Berardi, treating chiropractor, testified exacerbated claimant's condition. (Ex. 45A-36). Therefore, we do not find Dr. Brett's limitation persuasive.

Alternatively, the employer argues that claimant should have an adaptability value of 6 (the average of the light and sedentary values) based on Dr. Berardi's statement that claimant has approximately a 10 to 15 pound lifting restriction. (Ex. 45A-53). However, Dr. Berardi consistently limited claimant to sedentary work, and he expressly limited claimant to lifting 10 pounds in a subsequent report. (Exs. 31A-1, 46-1). Therefore, we find that claimant is limited to sedentary work.

Impairment

The employer argues that the Referee should have used the range of motion findings of Dr. Wilson, neurologist, instead of those of Dr. Berardi. We disagree.

The Board generally gives greater weight to the conclusions of a treating physician; however, it will not so defer when there are persuasive reasons to do

otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds, 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986). Here, there are no persuasive reasons not to defer to Dr. Berardi. Furthermore, Dr. Berardi's October 1989 report provides the most current range of motion measurements, whereas Dr. Wilson's measurements date back to April 6, 1989.

Based on Dr. Berardi's October 3, 1989 examination, claimant's thoracolumbar range of motion findings are 45 degrees retained flexion, 5 degrees retained extension, 10 degrees retained right flexion, and 15 degrees retained left flexion. (Ex. 45-1). These losses are rated at 4.5 percent, 2.5 percent, 4 percent, and 3 percent respectively, and are added for a total loss of range of motion of 14 percent. Former OAR 436-35-350 (6), (7), (8), and (10).

Both Drs. Berardi and Brett limit claimant's repetitive use of his back. (Exs. 33-1, 31A, 46-2). Former OAR 436-35-320(4) values this loss at 5 percent.

In addition, claimant has unoperated disc derangements at L4-5 and L5-S1 as a result of his low back injury. (Exs. 10, 17, 11-2, 31). Claimant is entitled to an impairment value of 4 percent each for those disc derangements. Former OAR 436-35-350(2).

When applying the version of OAR 436-35-001 et seq in force from January 1, 1989 through October 1, 1990, we have previously held that multiple spinal surgeries and/or disc derangements are added, not combined. Mark S. Clancy, 43 Van Natta 578 (1991); Robert W. McDonald, 42 Van Natta 2500 (1990). Such a conclusion is not in accordance with former OAR 436-35-005(4), which provides that:

> "'Combine' describes the way any two percentages of impairment are put together unless the standard specifically calls for them to be added . . ."

We recently held that, in accordance with former OAR 436-35-005(4), multiple spinal surgeries are to be combined. See Jesse D. Starr, 43 Van Natta 474 (1991).

After further consideration of this issue, we conclude that the McDonald and Clancy holdings are inconsistent with former OAR 436-35-005(4). Consequently, we adhere to the Starr holding, as supplemented by our reliance upon former OAR 436-35-005(4). Accordingly, to the extent that the reasoning in McDonald and Clancy is contrary to this conclusion, it is expressly disavowed. Therefore, claimant's two disc derangements are combined for a total of 7.8 percent.

For a total rating of multiple residuals, the values are combined, not added. Former OAR 436-35-350(11). We combine the values for claimant's loss of range of motion, loss of repetitive use, and disc derangements, for a total impairment of 24.7 percent.

Computation of Unscheduled Permanent 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 8, the product is 16. When that value is added to claimant's impairment value 24.7, the result is 40.7 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 41 percent.

Assessed Fee Regarding Cross-Request for Reduction of Determination Order

The Referee awarded claimant a $1,400 assessed attorney fee for prevailing on the employer's cross-request seeking reduction of the permanent partial disability award granted by the Determination Order. We modify.

The employer argues that it did not cross-request a reduction of the Determination Order. Citing Frances Gentry, 40 Van Natta 1697 (1988), the employer further argues that as long as claimant is the party that initially raised the issue of extent of disability, no attorney fees should be awarded when the Referee elects not to reduce an award.

We find that the record shows that the employer cross-requested a reduction of the Determination Order. (Tr. 3-5). Furthermore, when a claimant requests a hearing asking for an additional award of permanent disability compensation, and an employer unsuccessfully seeks a reduction of the award, the claimant is entitled to an assessed attorney fee. Our holding to the contrary in Frances Gentry, supra, has been rejected by the Supreme Court. Kordon v. Mercer Industries, 308 Or 290 (1989); Jeffrey A. Guild, 42 Van Natta 191 (1990).

However, we conclude that the $1,400 fee awarded by the Referee is excessive, given the duplication of services involved in claimant's request for an increase in permanent partial disability. 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 concerning the cross-request is $1,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the aforementioned duplication of services, the complexity of the issue, and the value of the interest involved.

Medical Services

The Referee found that the employer's denial of chiropractic treatments in excess of two visits per month was an impermissible prospective denial. We disagree.

Prospective denials are impermissible. An employer 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 denial was not clearly prospective by its terms. The denial stated that claimant's "treatment exceeds the guidelines set forth by the Oregon Administrative Rules, and we are therefore denying treatment in excess of two visits per month." (Ex. 39-1). Furthermore, there were approximately $1,700 in unpaid billings at the time of the denial. (Ex. 45-2). On this basis, we conclude that the denial was not an impermissible prospective denial, and that it denied only current treatments in excess of the guidelines. See Green Thumb, Inc. v. Basl, 106 Or App 98 (1991).

The Referee also found that the chiropractic treatments in excess of the guidelines were reasonable and necessary on the merits. We disagree.

A claimant is entitled to all reasonable and necessary curative or palliative medical care required for recovery from a compensable injury or for relief of pain. See ORS 656.245(1); West v. SAIF, 74 Or App 317, 320 (1985); Wetzel v. Goodwin Bros., 50 Or App 101 (1981); McGarry v. SAIF, 24 Or App 883, 888 (1976). For example, palliative chiropractic treatment, on an as-needed basis, is compensable where it is necessary to relieve severe pain and permit claimant to work. West v. SAIF, supra at 320-21. Claimant has the burden of proving that the treatment is reasonable and necessary. McGarry v. SAIF, supra.

In determining what is reasonable and necessary, the Board may consider the frequency of treatment. James v. Kemper Ins. Co., 81 Or App 80 (1986); Stephen C. Marr, 38 Van Natta 1304 (1986). Guidelines issued by the Workers' Compensation Division identify two visits per month, after the initial 60 days, as the usual frequency of medical services. Former OAR 436-10-040(2)(a). However, a claimant is entitled to treatment in excess of the administrative guidelines if he or she proves that the treatment is necessary due to the nature of the injury or to the process of recovery. James v. Kemper, supra at 82-84; West v. SAIF, supra at 320; Kemp v. Worker's Comp. Dept., 65 Or App 659, 669 (1983), modified, 67 Or App 270, rev den 297 Or 227 (1984).

Here, the record shows that the chiropractic treatments often provided only transient relief. Claimant testified that he had pain in his lower back daily. (Tr. 25). He also variously testified that the treatments provided no pain relief, relief lasting only a couple of hours, and relief lasting all day. (Tr. 38, 44, 45). Claimant reported to Dr. Tilden, examining chiropractor, that the pain returned within one to five hours, and he always felt the same by the next morning. (Ex. 26-2).

Claimant testified that he stopped treating with Dr. Berardi on August 29, 1989 because he felt better and he wanted to see how his condition would fare without treatment. (Tr. 22, 23, 34, 35). Claimant returned to Dr. Berardi on October 3, 1989, at which time Dr. Berardi found claimant to be medically stationary based on the fact that claimant had gone a full month without any treatment during which time his range of motion had not worsened and he reported no increase in pain. (Exs. 45-2, 45A-29).

Dr. Berardi opined that claimant warrants palliative treatment in excess of the guidelines to manage his pain and promote his functional capacity. (Ex. 46-2). However, Dr. Berardi does not explain why the same benefit could not be achieved with two treatments per month. (Exs. 35, 45, 45A, 46). See Floyd E. Miller, 41 Van Natta 1453 (1989).

We conclude that claimant has not met his burden of proving that more than two treatments monthly are reasonable and necessary.

Finally, claimant argues that the denial should be set aside because the employer did not respond to Dr. Berardi's justification report within 30 days as required by former OAR 436-10-040(2)(a). We disagree. We do not construe the language of former OAR 436-10-040(2)(a) to authorize us to require the employer to pay for services not compensable on the merits. Rather, where the employer fails to respond within 30 days, as required by the OAR, it may be liable for a penalty and associated attorney fee. See Helen M. Chase, 42 Van Natta 1850 (1990).

Accordingly, we find that claimant is not entitled to treatments in excess of the guidelines, and we reverse the Referee's ruling on this issue.

Penalty and Attorney Fee For Medical Services Denial

The Referee assessed penalties and attorney fees on the grounds that the denial was prospective and that the employer did not comply with former OAR 436-10-040(1)(a) in that it repeatedly attacked Dr. Berardi's bills but did not refer those bills to the Medical Director. We disagree.

In light of our ruling that the denial was not prospective, the Referee erred in assessing penalties and attorney fees on that basis. As to former OAR 436-10-040(1)(a), assuming without so deciding that the employer unreasonably failed to comply with the rule, we have found that the underlying claim is not

compensable. Therefore, there are neither amounts due nor unreasonable resistance to the payment of compensation upon which to base penalties or attorney fees. See Ellis v. McCall Insulation, 308 Or 74 (1989). Accordingly, we reverse the penalty and attorney fee assessed by the Referee.

ORDER

The Referee's order dated January 12, 1990 is modified in part, and reversed in part. In lieu of the Referee's award and in addition to the 39 percent (124.8 degrees) unscheduled permanent disability awarded by Determination Order, claimant is awarded 2 percent (6.4 degrees) unscheduled permanent disability, giving him a total award to date of 41 percent (131.2 degrees) unscheduled permanent disability for a low back injury. That portion of the Referee's order which set aside the employer's medical services denial is reversed. The denial is reinstated and and upheld, and the Referee's $1,275 assessed attorney fee award for prevailing on the denied claim is reversed. Those portions of the Referee's order that assessed claimant a penalty of 25 percent of unpaid chiropractic bills and a related attorney fee of $250 are reversed. In lieu of the Referee's $1,400 assessed attorney fee for prevailing on the employer's cross-request seeking a reduction of permanent partial disability, claimant's attorney is awarded $1,000, to be paid by the employer.

March 22, 1991 Cite as 43 Van Natta 637 (1991)

In the Matter of the Compensation of
CAROLYN L. THOM, Claimant
WCB Case No. C1-00261
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Malagon, Moore, et al., Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

On February 19, 1991, 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 $7,500 by Wausau, claimant fully releases his right to future workers' compensation benefits, except medical services, for his February 24, 1989 compensable injury.

The agreement is in accordance with the terms and conditions prescribed by the Director. 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.

Parenthetically, the agreement provides that Wausau shall advance claimant a payment of $3,000 upon submission of the agreement to the Board. The agreement further provides that, if the agreement is disapproved by the Board, Wausau would consider the said $3,000 an overpayment on the claim and it would be deducted from any temporary total disability or permanent partial disability which may become payable on the accepted claim.

An agreement which allows the recovery of prepaid disapproved CDA proceeds against future compensation is permissible. Julian H. Combs, 43 Van Natta 327 (1991), amended 43 Van Natta 503 (1991). Thus, to the extent that the provision permits such a recovery it is not contrary to law. However, overpayments may be recovered only from future permanent disability benefits, not temporary disability benefits. Buddy Tillman, 41 Van Natta 239 (1989); Harold D. Bates, 38 Van

Natta 992 (1986). Inasmuch as the "offset" provision could be interpreted to encompass future temporary, as well as permanent disability, benefits, it would be contrary to law.

In any event, since the Board finds no basis for disapproving the agreement, this objectionable language is harmless and shall not preclude approval of the agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
STEVEN L. WOODS, Claimant
WCB Case Nos. 89-18989 & 89-18016
ORDER ON REVIEW
Max Rae, Claimant Attorney
Steven Cotton (Saif), Defense Attorney

Reviewed by Board Members Nichols and Crider.

Claimant requests review of those portions of Referee Myzak's order which: (1) upheld the SAIF Corporation's denial of claimant's medical services claim as not related to his compensable back condition; and (2) upheld SAIF's denial of claimant's aggravation claim for a back condition. On review, the issues are medical services and aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and make the following additional finding. By letter of August 28, 1989, SAIF denied compensability of the condition which gave rise to claimant's July 1989 need for medical services.

FINDINGS OF ULTIMATE FACT

Claimant's compensable low back condition is a material contributing cause of his current need for medical treatment.

Since the last arrangement of compensation, claimant has suffered a symptomatic exacerbation of his compensable low back injury rendering him less able to work.

CONCLUSIONS OF LAW AND OPINION

Medical Services

In order to establish entitlement to compensation for medical services, claimant must prove a causal relationship between the medical services and his compensable injury and the reasonableness and necessity of the medical services. ORS 656.245; Jordan v. SAIF, 86 Or App 29, 32 (1986); West v. SAIF, 74 Or App 317, 320 (1985). SAIF challenges only whether claimant's current condition is related to the compensable condition.

Claimant sustained a prior compensable out-of-state injury to his upper and lower back in October 1986. Claimant was treated conservatively and recovered with no permanent impairment, returning to his usual job without restrictions three and one-half weeks later. In January 1987, claimant experienced an exacerbation of left mid and upper lumbar back pain. After six and one-half weeks of

conservative treatment, claimant again recovered and resumed performing his usual job duties.

Claimant began working for SAIF's insured in September 1987. He worked without difficulty until October 1988 when he was again injured, sustaining a lumbosacral strain. Claimant was off work for three weeks. After returning to work, claimant continued to experience low back pain causing him to miss work occasionally. Then, in July 1989, claimant's back pain increased with pain radiating down the right leg and with numbness of the right foot.

SAIF asserts that claimant's current condition is related to either the prior October 1986 out-of-state injury or to his preexisting congenital anomaly rather than to the compensable injury. We disagree.

Since his July 1989 exacerbation, claimant has been treated by the Kaiser Permanente physicians, primarily Dr. Pribnow, and evaluated by orthopedic surgeon Gritzka. During his independent medical examination, Dr. Gritzka discovered that claimant has a congenital anomaly of the lumbosacral spine, Bertolotti's Syndrome. Only Dr. Gritzka has expressed an opinion as to the causal relationship between claimant's compensable injury and his current need for treatment.

Unlike the Referee, we find that Dr. Gritzka offers a well-reasoned explanation for his opinion that claimant's current condition is related to his compensable October 1988 injury. Furthermore, we do not agree with the Referee that Dr. Gritzka was not fully aware of claimant's prior injuries in relating claimant's current condition to his 1988 lumbosacral sprain. Dr. Gritzka took a patient history as part of his complete examination and claimant advised the doctor regarding his prior injuries. Also, Dr. Gritzka examined claimant for SAIF, and a reading of his report reveals that prior records accompanied claimant to the appointment.

In direct response to SAIF, Dr. Gritzka addressed the causation issue as it relates to claimant's 1986 injury. He reiterated that claimant's current condition is probably due to the industrial injury of October 1988. Specifically, he noted that the October 1988 incident could reasonably be expected to cause claimant's present complaints. This is consistent with claimant's work history and testimony which reveal that claimant worked steadily from March 1987 until the October 1988 injury, and was off work due to pain after the October 1988 injury.

After Dr. Gritzka made the new diagnosis of Bertolotti's Syndrome, Dr. Pribnow examined claimant again and prepared another report. However, Dr. Pribnow noted only that he had nothing more to offer to claimant and did not opine whether claimant's current condition is due to claimant's October 1986 or October 1988 compensable injuries or to some other etiology.

In addition, we note that no physician has suggested that claimant's current condition is due to his congenital anomaly alone. Dr. Gritzka stated that individuals with Bertolotti's Syndrome are not necessarily symptomatic as a natural consequence of the underlying complex; rather, they become symptomatic following an injury such as the one claimant suffered. There is no contrary opinion. We, therefore, find that claimant's condition is due in material part to his compensable 1988 injury. Consequently, claimant has established that his current need for medical services is compensable.

Aggravation

In order to establish a compensable aggravation claim under ORS 656.273(1), claimant must prove both a worsening of his condition since the last award or arrangement of compensation, and a material causal connection between the worsened

condition and the compensable injury. Smith v. SAIF, 302 Or 396 (1986); Stepp v. SAIF, 78 Or App 438 (1986). In this context, a "worsened condition" means increased symptoms or a worsening of the underlying condition, resulting in diminished earning capacity. Perry v. SAIF, 307 Or 654, on remand 99 Or App 52 (1989). If claimant suffered a symptomatic exacerbation and the prior award contemplated future symptomatic exacerbations accompanied by a diminished earning capacity, then claimant must also prove either that his earning capacity was diminished longer or in greater degree than was anticipated, or that his earning capacity resulted in 14 consecutive days of total disability or inpatient hospitalization. Gywnn v. SAIF, 304 Or 345 (1987), on rem 91 Or App 84 (1988); Edward D. Lucas, 41 Van Natta 2272 (1989).

We have concluded above that claimant's condition in July 1989 was materially related to the 1988 injury. Thus, we need only determine whether the condition has worsened since the last award of compensation.

Claimant sustained a compensable lumbosacral strain on October 12, 1988. He returned to his regular work as a nurse's assistant. His claim was closed by Determination Order issued December 12, 1988, awarding no permanent unscheduled disability. In July 1989, as a result of increased low back pain radiating into the right leg, Dr. Pribnow, claimant's treating physician, restricted claimant to light duty work with no lifting over 10 pounds, with no bending, no pushing/pulling, and no contacts with hospital patients. The employer had no work for claimant within these restrictions. On October 10, 1989, Dr. Pribnow permanently restricted claimant to light duty work.

Thus, claimant experienced increased symptoms in July 1989 so that he was less able to work than at the time of claim closure. As claimant was awarded no permanent disability under the Determination Order that last closed the claim, we find that future exacerbations resulting in a loss of earning capacity were not contemplated. See Louis A. Duchene, 41 Van Natta 2399, 2400 (1989). Consequently, any subsequent change in claimant's condition resulting in temporary or permanent loss of earning capacity is sufficient to prove increased disability. Accordingly, claimant has established a compensable aggravation of his low back condition.

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 aggravation and medical services issues is $3,200, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to this case (as indicated in counsel's statement of services), the complexity of the issues, the value of the interest involved, and the risk that counsel's services would go uncompensated.

ORDER

The Referee's order dated March 21, 1990 is affirmed in part and reversed in part. The SAIF Corporation's denials are set aside, and the claim is remanded to SAIF for acceptance and processing in accordance with the law. For services at hearing and on Board review regarding the aggravation and medical services issues, claimant's attorney is awarded an assessed fee of $3,200, payable by SAIF. The remainder of the order is affirmed.

In the Matter of the Compensation of
VERNON L. COPE, Claimant
WCB Case No. 90-10212
ORDER DENYING MOTION TO DISMISS
Borneman & Rossi, Claimant Attorneys
Dennis S. Martin (Saif), Defense Attorney

Claimant has moved the Board for an order dismissing the SAIF Corporation's request for review of a Referee's order on the grounds that the issue raised by the request has been rendered moot by events which have occurred after the issuance of the Referee's order. We deny the motion.

FINDINGS OF FACT

Claimant requested a hearing, contesting SAIF's denial of his fractured left forearm. In addition, claimant requested that penalties and attorney fees be assessed for an allegedly unreasonable denial. By order dated November 26, 1990, the Referee directed SAIF to accept claimant's claim and process it according to law. The Referee also directed SAIF to pay claimant's attorney a $1,700 assessed attorney fee for prevailing on the denial issue. Concluding that the denial was not unreasonable, the Referee declined to assess penalties and attorney fees.

On November 29, 1990, SAIF requested reconsideration of the Referee's order. On December 7, 1990, SAIF's counsel requested that the Referee abate his order by December 10, 1990, the date when it would be required to begin paying temporary total disability. On December 10, 1990, the Referee abated his order. That same day, SAIF's claims examiner directed a letter to claimant stating that SAIF's denial was rescinded and the claim was accepted as nondisabling. On December 11, 1990, SAIF paid claimant's attorney the $1,700 awarded by the Referee. On December 12, 1990, claimant's counsel advised the Referee of SAIF's acceptance and contended that the compensability issue was moot.

On December 14, 1990, upon receiving the Referee's abatement order, SAIF's claims examiner notified claimant that, in light of the Referee's abatement order, SAIF was rescinding its acceptance (i.e. reinstating its denial). Thereafter, SAIF's claims examiner advised claimant's counsel of its error and sought return of its $1,700. On December 18, 1990, the Referee issued an Order on Reconsideration adhering to his November 26, 1990 order. On December 20, 1990, SAIF's counsel advised the Referee that the claims examiner's denial rescission and payment of attorney fees had been issued in error and corrected.

CONCLUSIONS OF LAW

Claimant contends that SAIF's rescission of its denial and payment of the Referee's attorney fee award constitutes acceptance of the claim and moots its appeal of the Referee's order. We disagree.

To begin, the correspondence surrounding SAIF's claims examiner's December 10 letter persuasively establishes that the denial rescission notice and attorney fee check were issued in error. Of particular note is SAIF's counsel's December 7 letter, which demonstrates that SAIF was concerned about its claim processing obligations in response to the Referee's compensability ruling and the need for the Referee to abate his order by December 10. The timing of SAIF's claims examiner's December 10 denial rescission notice supports the conclusion that SAIF was complying with its processing duties unaware of the Referee's abatement order. The payment of claimant's attorney fee award on December 11 was not such a processing duty. However, as explained by both SAIF's claims examiner and its counsel, the payment was issued in error.

In light of these circumstances, we are not prepared to conclude that SAIF's claims examiner's December 10 notice has rendered its appeal of the Referee's order moot.

In any event, because SAIF timely requested Board review, the Referee's order has not become final. See ORS 656.289(3). After conducting our review, we are authorized to affirm, reverse, modify or supplement the Referee's order, as well as make such disposition of the case as it determines to be appropriate. ORS 656.295(6). Consequently, the issues raised and addressed in the Referee's order remain viable.

Despite its appeal, the insurer is required to comply with the Referee's order. ORS 656.313(1); Weyerhaeuser Company v. McCullough, 92 Or App 204 (1988); Theodore W. Lincicum, 40 Van Natta 1953 (1988). Thus, SAIF's actions in processing the claim would not deprive SAIF of its right of appeal. Loren Callihan, 41 Van Natta 1449 (1989).

The fact that subsequent actions have either been lawfully or erroneously taken in response to an appealed Referee's order does not resolve the question of whether the conclusions reached in that order were appropriate in the first instance. Loren Callihan, supra. Rather, that question remains subject to our jurisdiction. See ORS 656.289(3); 656.295(6).

Accordingly, the motion to dismiss is denied. SAIF's reply brief shall be due 14 days from the date of this order. Thereafter, this case shall be docketed for review.

IT IS SO ORDERED.

March 26, 1991 Cite as 43 Van Natta 642 (1991)

In the Matter of the Compensation of
MARY A. NAGEL, Claimant
WCB Case No. 90-09577
ORDER DENYING RECONSIDERATION
Malagon, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

The insurer has requested reconsideration of our February 28, 1991 Order on Review, as reconsidered March 8, 1991, that reversed a Referee's order which increased a Determination Order award of unscheduled permanent disability from 15 percent (48 degrees) to 45 percent (144 degrees). Specifically, the insurer seeks reduction of claimant's permanent disability award below that granted by the Determination Order.

The insurer did not cross-request a hearing asking for a reduction of the Determination Order award. Now the insurer seems to be arguing that the Board has the authority to reduce an award of permanent disability without such a request. Assuming, without deciding, that the insurer is correct, we adhere to our prior policy decision not to do so. Lori S. Pratt, 42 Van Natta 1989 (1990).

The request for reconsideration is denied. We adhere to our February 28, 1991 order, as reconsidered March 8, 1991. The parties' rights of appeal shall continue to run from the date of our March 8, 1991 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LAWRENCE WOODS, Claimant
WCB Case No. C1-00460
ORDER DISAPPROVING CLAIMS DISPOSITION AGREEMENT
Coons, et al., Claimant Attorneys
Mitchell, et al., Defense Attorneys

Reviewed by Board Members Crider and Nichols.

On February 27, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $3,200, less a 25 percent attorney fee, claimant "releases" his right to "10% unscheduled permanent partial disability giving him a 21% award for this claim." We set aside the disposition.

By virtue of a September 19, 1990 Determination Order, claimant has received 11 percent unscheduled permanent disability for a L5-S1 herniated nucleus pulposus. In consideration of the payment of $3,200 by the employer, claimant agrees to partially release his rights to workers' compensation benefits under his 1989 compensable injury. Specifically, claimant releases "10% unscheduled permanent partial disability giving him a 21% award for this claim."

Pursuant to ORS 656.236(1), the parties to a claim may make such disposition of any or all matters regarding a claim, except medical services, as the parties consider reasonable, subject to such terms and conditions as the Director may prescribe. In accordance with OAR 436-60-145(3)(h), the parties are required to specifically identify all benefits, rights and insurer obligations under the Workers' Compensation Law which are released by the agreement. "Release" means to discharge a claim one has against another. Black's Law Dictionary, Abridged Fifth Edition, 1983.

Here, the proposed disposition provides that claimant "releases" his right to 10 percent unscheduled permanent partial disability. Despite the use of the term "releases", the parties further agree that claimant's total unscheduled permanent disability under his claim shall be increased from 11 percent to 21 percent.

If claimant is releasing his right to 10 percent unscheduled permanent disability benefits, he cannot simultaneously acknowledge receipt of, and the employer receive credit for providing, such benefits. In this respect, the attempted dual purpose for the proceeds from this proposed disposition is not permissible.

If it is the parties' intention to increase claimant's total unscheduled permanent disability award to 21 percent, the result can be achieved only by means of a settlement stipulation. If such a stipulation resolves a dispute arising out of a claim closure, the stipulation can be submitted to the Hearings Division at any time after the conclusion of the reconsideration proceeding by the Evaluation Section under ORS 656.268. OAR 438-09-005(1). If, on the other hand, a stipulation does not resolve a dispute arising out of a claim closure, it may be submitted to the Hearings Division at any time. OAR 438-09-005 (2).

Since the claim has recently been closed and the agreement does not indicate either that the Determination Order is final or that a reconsideration proceeding has been concluded, the stipulation process would not appear to be the appropriate vehicle for resolving this matter at the present time.

If it is the parties' intention that claimant release his right to request reconsideration and/or a hearing concerning the September 19, 1990 Determination

Order in exchange for a stated sum of money, that purpose may be achieved by claim disposition agreement. Under such an agreement, claimant's total unscheduled permanent disability award would remain at 11 percent; it would not be increased to 21 percent as the disposition presently provides.

As currently drafted, the disposition provides for both the release of claimant's rights to 10 percent unscheduled permanent disability and the increase of his total award to 21 percent. For the reasons previously discussed, we find such an agreement to be contrary to OAR 436-60-145(3)(h) and, as such, unreasonable as a matter of law under ORS 656.236(1)(a). Accordingly, the proposed disposition is disapproved.

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

IT IS SO ORDERED.

March 27, 1991 Cite as 43 Van Natta 644 (1991)

In the Matter of the Compensation of
ROBERT A. DePRETTO, Claimant
WCB Case No. 90-01829
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Podnar's order that declined to award an assessed attorney fee for his counsel's services regarding the SAIF Corporation's prehearing rescission of its aggravation denial. On review, the issue is attorney fees.

FINDINGS OF FACT

We adopt the Referee's "Findings."

CONCLUSIONS OF LAW AND OPINION

In order to be entitled to an assessed attorney fee under ORS 656.386(1), claimant must "finally prevail * * * in a hearing before the referee." Here, SAIF rescinded its aggravation denial prior to hearing. Claimant has not finally prevailed before a referee. Therefore, he is not entitled to an assessed attorney fee under ORS 656.386(1). Duane L. Jones, 42 Van Natta 875 (1990).

ORDER

The Referee's order dated June 25, 1990 is affirmed.

In the Matter of the Compensation of
DONALD R. DODGIN, Claimant
WCB Case No. 90-01625
ORDER ON REVIEW (REMANDING)
Merrill Schneider, Claimant Attorney
Larry Schucht (Saif), Defense Attorney

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Podnar's order which dismissed his hearing request. On review, the issue is dismissal. We remand.

FINDINGS OF FACT

Claimant filed a claim for a left wrist injury. This claim was denied by SAIF on December 26, 1989. Thereafter, claimant requested a hearing concerning SAIF's denial. A hearing was scheduled for June 1, 1990.

Claimant, who was unrepresented, did not appear at the hearing. By order of June 18, 1990, the Referee dismissed claimant's request for hearing on the basis of claimant's failure to appear at the hearing.

Thereafter, claimant retained an attorney. On July 18, 1990, claimant's counsel requested reconsideration of the Referee's dismissal order. He attached affidavits from claimant which indicated that claimant had not appeared because he thought the claim was accepted and because he had been assigned to work in Seattle, Washington the week of the hearing. Attached to the affidavits were letters from SAIF to claimant indicating that it had approved payment for claimant's medical billings and that it was willing to accept his claim. The Referee declined to reconsider his opinion. Thereafter, claimant requested Board review.

CONCLUSIONS OF LAW AND OPINION

The Referee declined to reconsider his Order of Dismissal. We disagree.

Former OAR 438-06-071 provides:

> "Failure of a party or the party's representative to appear at the time and place scheduled for a hearing is a waiver of appearance. If the party that fails to appear is the party that requested the hearing, the referee shall issue an order dismissing the request for hearing for failure to appear unless a postponement is granted under 438-060-081."

Former OAR 438-06-081 prohibited postponements except upon a finding of extraordinary circumstances beyond the control of the party requesting the postponement.

Here, the SAIF Corporation wrote claimant two letters indicating that it was willing to accept his claim and that all medical billings connected with his injury had been approved for payment. These letters support claimant's belief that his claim had been accepted therefore making the hearing unneccesary. Further, the employer at-injury had scheduled claimant to work in Seattle, Washington on the date of hearing, which would have made it difficult for claimant to attend the hearing.

Under these circumstances, we conclude that claimant has established extraordinary circumstance beyond his control which would justify a postponement

of his hearing. Therefore, we vacate the Referee's order and remand this case to Referee Podnar for a hearing on the merits.

IT IS SO ORDERED.

March 27, 1991 Cite as 43 Van Natta 646 (1991)

In the Matter of the Compensation of
WILLIAM G. EDWARDS, Claimant
WCB Case Nos. 90-08419 & 90-07241
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The self-insured employer requests review of those portions of Referee McWilliams' order that increased claimant's scheduled permanent disability award for a left leg injury from 5 percent (7.5 degrees), as awarded by a Determination Order, to 20 percent (30 degrees); and (2) awarded 10 percent (15 degrees) scheduled permanent disability for a right leg injury, whereas a Determination Order had awarded no permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" as our own.

CONCLUSIONS OF LAW AND OPINION

We adopt that portion of the Referee's opinion which found claimant entitled to 10 percent scheduled permanent disability for the left leg, and 5 percent scheduled permanent disability for the right leg under an application of the standards. However, the Referee also found that claimant had established by clear and convincing evidence that her left leg and right leg disability was greater than that calculated under the standards. With this portion of the Referee's order we disagree, and modify the Referee's award accordingly.

For purposes of determining injury related permanent impairment disability, ORS 656.287(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. Former OAR 438-10-010.

Because claimant became medically stationary on February 9, 1990, and his claim was closed by Determination Orders dated March 21, 1990 and April 6, 1990, we apply the standards effective at the time of the Determination Orders in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-010 through 436-35-260 apply to the rating of claimant's scheduled permanent disability. Specifically, we apply those standards effective January 1, 1989.

We agree with the Referee that the medical and lay evidence establishes that claimant suffers from a chronic bilateral knee condition that limits repetitive use. Because of the compensable injury, claimant's ability to stand, walk, and run has been limited. Former OAR 436-35-010(7). Accordingly, claimant is entitled to a 5 percent impairment value for each leg representing loss of use or function for those limbs.

In addition, claimant has undergone a left medial meniscectomy. Although in a later report the treating surgeon opined that removal of the medial meniscus approximated 25 percent, we note that the surgical report indicates that a greater amount has been affected, specifically, one half of the meniscus flap was removed. Inasmuch as the surgical report provides a superior explanation of the procedure performed, we find it to be more persuasive. Thus, we conclude that claimant is entitled to a 5 percent value for a partial medial meniscectomy of the left leg.

We proceed to calculate claimant's disability. For a total value for loss of use or function of the left leg, the value for claimant's chronic condition (5) is combined, not added, to the value for the surgical procedure (5), for a value total of 9.75 percent for loss of use or function of the left leg. Former OAR 436-35-240(5). That disability figure is rounded to the next higher whole percentage. Therefore, claimant's loss of use or function of the left leg is 10 percent (15 degrees). Claimant's loss of use or function of the right leg is 5 percent (7.5 degrees). Former OAR 436-35-010(6).

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 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).

The Referee based the additional permanent disability upon findings in the left leg of disabling pain, chronic limitations, and weakness. The Referee based an additional award for the right leg on findings of catching, and pain and swelling associated with movement and activity, particularly walking.

In this regard, we note that claimant has returned to regular full time work. As an engineering aide, he is required to traverse through brush and uneven ground, occasionally packing up to 30 pounds. Despite this favorable return to work, his treating physician reports that claimant continues to experience discomfort in his knees with intermittent swelling and symptomology. Claimant's testimony corroborates this view. Accordingly, we find the above evidence supports the award of a chronic condition limiting repetitive use, but does not prove by clear and convincing evidence that claimant is entitled to more than his permanent disability awards under the standards.

ORDER

The Referee's order dated September 28, 1990 is modified. In lieu of the Referee's award, and in addition to the April 6, 1990 Determination Order award of 5 percent (7.5 degrees), claimant is awarded 5 percent (7.5 degrees) scheduled permanent partial disability for the loss of use or function of the left leg, for a total award to date of 10 percent (15 degrees). In lieu of the Referee's award, and in addition to the Determination Order, claimant is awarded 5 percent (7.5 degrees) permanent partial disability for the loss of use or function of the right leg.

In the Matter of the Compensation of
PAMELA L. FOSTER-CUNNINGHAM, Claimant
WCB Case No. 90-01933
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Roberts, 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) upheld the self-insured employer's denial of medical services that was issued on January 16, 1990; and (2) upheld the employer's "de facto" denial of an aggravation claim. The employer cross-requests review of those portions of the order that: (1) granted claimant interim compensation from December 19, 1989 to January 24, 1990; and (2) assessed a penalty and associated attorney fee for allegedly improper claims processing. The issues on review are compensability of medical services, aggravation, interim compensation and penalties and associated attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Denials

We affirm and adopt the Referee's conclusions on the medical services denial and on the merits of the aggravation denial. We disagree with the Referee that the denial that was issued on January 16, 1990 did not deny the aggravation claim. The denial was issued after the employer received information from the treating chiropractor, Dr. Bashin, that claimant began treating with him in November 1989 for severe neck, mid-back, and low-back pain and heart palpitations. In that same report, he indicated that claimant was not medically stationary and authorized time loss. The denial denied current treatment because it was not causally related to the accepted injury. We interpret this denial to be one of aggravation as well as of medical services. To establish an aggravation, claimant has the burden of proof to show that his current condition is the result of the original injury. Former ORS 656.273. Thus, under these circumstances, a denial of causal relationship would also encompass claimant's aggravation claim.

Interim Compensation

The Referee found that claimant was entitled to interim compensation from the date the employer received authorization of time loss until the date claimant requested a hearing on the "de facto" aggravation denial. The employer argues that the formal denial issued on January 16, 1990 terminated its responsibility to pay time loss. We agree based on our decision that the denial was also a denial of the aggravation claim. ORS 656.262(2). Therefore, claimant is entitled to time loss from December 19, 1989 until January 16, 1990.

Penalties and Attorney Fees

We affirm and adopt the Referee's conclusions regarding the assessment of a penalty and attorney fee based on the employer's failure to pay the interim compensation in a timely manner.

Inasmuch as penalties and attorney fees are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for successfully

defending the Referee's order concerning those issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated June 13, 1990 is affirmed in part and modified in part. That portion of the order that awarded interim compensation from December 19, 1989 until January 24, 1990 is modified to award interim compensation only until January 16, 1990. The remainder of the order is affirmed.

March 27, 1991 Cite as 43 Van Natta 649 (1991)

In the Matter of the Compensation of
LAWRENCE D. GRAZER, Claimant
WCB Case No. 90-04180
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Crider and Nichols.

Claimant requests review of that portion of Referee Quillinan's order that did not award an attorney fee in connection with the self-insured employer's cross request for hearing. Claimant also contends that the Referee should have assessed a penalty under ORS 656.382(3). On review, the issues are attorney fees and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant suffered a compensable injury. His claim was closed by Determination Order which awarded him unscheduled permanent partial disability of 4 percent. The award was based on lost range of motion.

Claimant requested a hearing seeking additional permanent partial disability. The self-insured employer cross-requested a hearing seeking a reduction in the award.

The Referee, in a portion of the order which is not before us on review, increased claimant's award to 5 percent. The Referee found that claimant had suffered no loss of range of motion due to the compensable injury but that he had suffered a loss of repetitive use due to the injury. The increased award was based on loss of repetitive use.

FINDINGS OF ULTIMATE FACT

On the self-insured employer's cross-request for hearing, the Referee found that claimant's compensation should not be disallowed or reduced.

CONCLUSIONS OF LAW AND OPINION

The Referee authorized a fee payable out of the increased compensation payable under her order. See OAR 438-15-040. However, although claimant's compensation was not disallowed or reduced pursuant to the self-insured employer's cross-request, she awarded no fee payable by the employer. Claimant contends that an employer-paid fee should have been awarded pursuant to ORS 656.382(2); OAR 438-15-065. The self-insured employer concedes that a fee should have been awarded. We agree. Kordon v. Mercer Industries, 308 Or 290 (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's

services at hearing concerning the cross-request is $800, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's statement of services which was submitted to the Referee), the minimal complexity of the issue, and the value of the interest involved. We note that the statement of services must include time spent preparing for hearing on the compensability issue (which was reserved) and on the request for additional compensation as well as on the employer's request for reduction. Claimant's attorney is not entitled to an employer-paid fee for services on these other issues at this time.

Claimant also contends that the Referee erred by failing to award a penalty under ORS 656.382(3). The statute does authorize the Referee to assess a penalty upon a finding that an employer's request for hearing was undertaken for the purposes of delay or other vexatious reason or without reasonable ground. Assuming, arguendo, that a Referee may assess a penalty for a frivolous cross-request undertaken for purposes of delay or the like, we are not persuaded that there is any evidence that the request for reduction was undertaken for such illegitimate purposes. The Determination Order was premised on the view that claimant had suffered a loss of range of motion; the Referee found that claimant had not in fact lost range of motion due to the injury; claimant has not challenged that finding on review. Although the employer did not prevail on its request for reduction, the employer's contention was clearly not without reasonable ground. Consequently, we find that the Referee did not err in this regard.

ORDER

The Referee's order dated July 3, 1990 is affirmed in part and reversed in part. For services at hearing on the cross-request, claimant's attorney is awarded an assessed fee of $800, to be paid by the self-insured employer. The balance of the order is affirmed.

In the Matter of the Compensation of
ROBERT E. GREER, II, Claimant
WCB Case No. TP-90055
THIRD PARTY DISTRIBUTION ORDER
Accident Victims Legal Clinic, Claimant Attorneys
J. David Thurber (Saif), Defense Attorney

The SAIF Corporation, as a paying agency, petitions the Board to resolve a dispute concerning a "just and proper" distribution of proceeds from a third party settlement. ORS 656.593(3). Specifically, the dispute pertains to: (1) SAIF's entitlement to a share of a $25,000 settlement between claimant and his former attorney arising from claimant's legal representation during a third party action; and (2) whether SAIF may recover a portion of its lien attributable to actual claim costs for which claimant contends he received no benefit or could have been obtained at a lesser cost. We conclude that SAIF may recover its actual claim costs from the third party recovery, which includes $12,500 of the $25,000 settlement between claimant and his former counsel.

FINDINGS OF FACT

In November 1985, while operating construction equipment, claimant suffered a compensable injury to his right hand. SAIF accepted the claim and has provided compensation. To date, SAIF has expended the following claim costs totalling $133,045.75:

$66,160.17 in medical benefits;
$35,015.47 in temporary total disability;
$ 5,337.10 in vocational temporary disability;
$17,908.01 in vocational rehabilitation costs; and
$ 8,625.00 in permanent disability.

Claimant eventually secured legal counsel, Mr. Jagger, for the purpose of investigating a third party action against the manufacturer of the construction equipment. Claimant and his attorney entered into a contingency fee retainer agreement. The contract provided that Jagger would receive 25 percent of any recovery obtained without the institution of action or arbitration; 33 percent of any recovery obtained if an action was instituted, but no trial or hearing was held; 40 percent of any recovery if trial or hearing had commenced; and 45 percent of any recovery if the case was appealed.

Claimant instituted a third party action. Following a trial, claimant obtained a $325,000 judgment. The third party appealed the judgment. While the appeal was pending, negotiations to settle the litigation ensued. During those negotiations, claimant was advised by his attorney that SAIF would not be able to recover its vocational rehabilitation costs. Based on this advice, claimant assumed he would receive $100,000 of a $300,000 settlement offer.

With SAIF's approval, claimant and the third party settled the action for $300,000. Claimant's attorney claimed a $100,000 attorney fee and $7,334,92 in litigation costs. SAIF asserted a lien, which included vocational assistance costs. Based on such a distribution, claimant's portion would be $64,234.54. When claimant learned of this proposed distribution, he sought another attorney, Mr. Goodman.

Thereafter, claimant demanded that his former attorney, Mr. Jagger, reduce his $100,000 attorney fee. Jagger refused to reduce his fee and subsequently filed a petition for a declaratory judgment regarding the dispute. In response, claimant filed a counter claim, alleging breach of contract, fraud, and professional negligence. Claimant sought $62,960.43 in economic damages, as well non-economic damages to be determined at trial, and cost and disbursements. After depositions were taken, the negligence claim was not pursued.

When SAIF learned of the dispute between claimant and his former attorney, Ms. Blair, its third party claims examiner, notified claimant's current attorney of its lien. Acknowledging claimant's dispute with his former counsel, Blair noted that claimant was entitled to 1/3 of the third party settlement remaining after the payment of claimant's attorney fee and legal costs.

Prior to the trial between claimant and his former attorney, settlement of further litigation was discussed. Jagger offered $25,000 in settlement. Unsure whether SAIF would seek a share of this settlement, Goodman contacted Blair by phone on August 13, 1990. Goodman represented to Blair that Jagger had offered to settle the "fraud claim" for $25,000, but still refused to reduce his attorney fee. Blair responded that SAIF had no interest in the settlement, provided that the attorney fee was not reduced. If the attorney fee was rebated, Blair asserted that SAIF's share of the third party settlement would be increased.

That same day, Goodman contacted Jagger's attorney, Mr. Wheatley. For $25,000, they agreed to settle further litigation. Goodman and claimant thought that the entire settlement was for claimant's "fraud claim." Jagger believed that the settlement solely pertained to an "attorney fee dispute." Wheatley understood that the settlement included the "fraud claim as well as the contract claim."

On August 14, Goodman received a letter from Blair, which set forth a proposed distribution of the third party settlement. Reducing claimant's attorney fee from $100,000 to $75,000, the distribution listed $72,555.03 as claimant's 1/3 share, $133.045.75 payable to SAIF for its actual claim costs, with the remaining $12,064.30 payable to claimant.

Goodman immediately contacted Blair by telephone. With Goodman's partner, Mr. Bradley, on the telephone line, they again discussed SAIF's position. Blair reiterated that SAIF's position remained that SAIF had no interest in a settlement of a fraud suit, but would seek a share of any reduction in claimant's attorney fee.

Later that day, claimant and Jagger executed a "Mutual Release of All Claims." In consideration of $25,000, they agreed to settle all claims arising out of Jagger's representation of claimant "including but not limited to any and all disputes regarding misrepresentation, fraud, breach of contract, and disbursement of proceeds, including known and unknown consequences thereof which may hereafter develop as well as those which have already developed or are now apparent."

SAIF's claim costs include expenses for the following services, totalling $22,193. $5,495 for claimant's tuition in an "Assured Construction Services" program. As a result of continuing disputes between claimant and his instructor concerning smoking in the classroom, this program was never completed. SAIF has also expended $770 for an electronics program at Lane Community College, $2,000 for air-fare to San Francisco for medical treatment, and $13,928 for approximately one year of temporary total disability incurred after the aforementioned unsuccessful vocational rehabilitation efforts.

Claimant does not contend that these expenses were not incurred. Rather, he argues that he obtained no benefits from these services and, had his claim been properly managed, his temporary total disability benefits could have been substantially reduced. Finally, claimant asserts that SAIF failed to seek a reduced air-fare concerning the San Francisco flight.

CONCLUSIONS OF LAW

If the worker settles a third party claim with paying agency approval, the agency is authorized to accept as its share of the proceeds "an amount which is just and proper," provided 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). Such an approach is taken 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. Marvin Thornton, 34 Van Natta 999, 1002 (1982). We find no persuasive reason to depart from that approach here.

Pursuant to ORS 656.593(1)(a), attorney fees and costs incurred shall be initially disbursed. Then the worker shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b). The paying agency shall be paid and retain the balance of the recovery to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under

ORS 656.001 to 656.794. ORS 656.593(1)(c). Any remaining balance shall be paid to the worker. ORS 656.593(1)(d).

Here, the dispute centers on what was resolved in the agreement between claimant and Jagger, his former attorney. Claimant contends that the settlement solely pertained to his fraud claim. Since SAIF has agreed that its lien does not attach to any proceeds from the fraud claim, claimant asserts that he is entitled to the entire $25,000 in settlement proceeds. SAIF counters that the $25,000 is entirely a reduction in claimant's attorney fee under the third party settlement. Thus, because claimant's attorney fee has been reduced, SAIF argues that its share of the third party recovery should be increased.

The parties to the $25,000 settlement have varying understandings of what was resolved by their agreement. Claimant and his current attorneys understood that the settlement only pertained to the fraud claim. On the other hand, Jagger, claimant's former attorney believed that the $25,000 solely represented a reduction of his attorney fee from $100,000 to $75,000. Finally, it was the understanding of Jagger's attorney, Wheatley, that both the fraud and contract claim were resolved in the $25,000 settlement.

A review of the August 1990 agreement between claimant and Jagger supports Wheatley's version. The settlement expressly provided that all claims arising out of claimant's former attorney's representation "including but not limited to any and all disputes regarding misrepresentation, breach of contract, and disbursement of proceeds" were resolved. Inasmuch as claims concerning fraud and breach of contract were in dispute at the time of the settlement and since the agreement expressly referred to such claims, we conclude that both claims were resolved in the settlement. Moreover, because the agreement is equally applicable to both claims and does not attempt to divide the $25,000 between the claims, we find it reasonable to equally apportion the proceeds. Consequently, we hold that $12,500 of the $25,000 settlement pertained to claimant's contract claim and is subject to SAIF's lien.

Claimant further argues that SAIF should not recover some $22,193 in claim costs, which primarily pertain to certain vocational and travel expenses. In so doing, claimant does not dispute that these expenses were incurred in conjunction with the processing of his claim. Instead, he asserts that he either received no benefit from the services or that the services could have been procured at a more economical price.

Claimant neither provides, nor are we aware of, any authority which would prohibit a paying agency from recovering from its share of a third party recovery claim costs that have been actually incurred while processing the claim. In any event, recovery of claim costs are not contingent upon the success or failure of a particular service. Rather, as provided in ORS 656.593(1)(c), the paying agency is entitled to retain the balance of a third party recovery to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical, or hospital service, as well as the present value of its reasonably to be expected future expenditures. Finally, even assuming that SAIF's recovery was based on the theory advanced by claimant, the record fails to establish that the disputed services were not of any benefit to claimant or, even if they were, that the failure of these services was attributable to mismanagement on the part of SAIF.

In conclusion, we hold that $12,500 of the $25,000 settlement between claimant and his former attorney is subject to SAIF's third party lien which totals $133,045.75. Under such circumstances, claimant's current attorney is directed to distribute the remaining balance of third party settlement proceeds in a manner that will achieve the following results, which we find to be "just and proper":

Third Party Settlement	$300,000.00
Attorney Fee	- 87,500.00
Litigation Costs	- 7,334.92
Sub-Total	$205,165.08
Claimant's 1/3 Share	68,388.36
Sub-Total	$136,776.72
SAIF's Lien	133,045.75
Remaining Balance to Claimant	$ 3,730.97

IT IS SO ORDERED.

March 27, 1991 Cite as 43 Van Natta 654 (1991)

In the Matter of the Compensation of
CLAUDE E. HARRIS, Claimant
WCB Case No. 89-20661
ORDER OF ABATEMENT
Ginsburg, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

The insurer has moved for abatement of our March 8, 1991 order, which awarded additional temporary disability, and assessed penalties and attorney fees for unreasonable claim processing. Contending that the parties intend to resolve this matter pursuant to a stipulated settlement, the insurer seeks abatement of our order to await submission of that agreement.

Based on the representations contained in the insurer's motion, the Board withdraws its March 8, 1991 order. Claimant is requested to submit his response within 10 days of this order. Upon receipt of the parties' agreement, the Board will proceed with its review. In the meantime, the parties are requested to keep the Board fully apprised of any further developments.

IT IS SO ORDERED.

March 27, 1991 Cite as 43 Van Natta 654 (1991)

In the Matter of the Compensation of
CHERYL L. McCARTHY, Claimant
WCB Case No. 89-23987
ORDER ON REVIEW
Charles Maier, Claimant Attorney
David Fowler (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of that portion of Referee Danner's order that awarded claimant 14 percent (44.8 degrees) unscheduled permanent disability for cervical, thoracic and left shoulder injuries whereas a Determination Order awarded no unscheduled permanent disability. On review, the issue is extent of unscheduled permanent partial disability. We modify.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following addition. Claimant has sustained a 34 percent loss of earning capacity as a result of her compensable 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 former ORS 656.283(7). Specifically, the Referee applied the version of OAR 436-35-001 et seq in force from January 1, 1989 until October 1, 1990, the rules in effect at the time of the November 22, 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. Former OAR 436-35-280.

The parties do not dispute the following values assigned by the Referee: age (0); education (4); and adaptability (2.5). We therefore discuss only the issue of impairment.

Impairment

The parties do not dispute the 4 percent value assigned by the Referee for claimant's loss of cervical range of motion.

Claimant argues that she is entitled to 5 percent loss of repetitive use in each of these three areas: neck, upper back and left shoulder. The "standards" define "impairment" as a decrease in the function of a body part or system, as measured by a physician. Former OAR 436-35-005(1). See Linda F. Wright, 42 Van Natta 2570 (1990). Dr. Gasser, treating chiropractor, limited claimant's repetitive use of her neck and left shoulder, but not her upper back. (Ex. 22-2). Claimant testified that she also could not repetitively use her upper back. (Tr. 17). However, there is no medical opinion documenting loss of repetitive use of the upper back. On this record, we find that claimant has lost repetitive use of her neck and left shoulder and assign a value of 5 percent for each body part. Former OAR 436-35-320(4); Larry L. McDougal, 42 Van Natta 1544 (1990).

Next, claimant argues that she is entitled to a value for the loss of range of motion in her left shoulder. We agree. We use the range of motion measurements closest to the hearing. Gettman v. SAIF, 289 Or 609 (1980). Dr. Michels, consulting chiropractor, measured claimant's retained range of motion as follows: forward elevation 115 degrees, valued at 2 percent under former OAR 436-35-330(1); backward elevation 35 degrees, valued at .5 percent under former OAR 436-35-330(3); abduction 110 degrees, valued at 2 percent under former OAR 436-35-330(5); internal rotation 30 degrees, valued at 1 percent under former OAR 436-35-330(9); and external rotation 70 degrees, valued at 2 percent under former OAR 436-35-330(11). These values are added for a total left shoulder loss of range of motion of 7.5 percent. Former OAR 436-35-330(17).

Claimant next argues that she is entitled to 4 percent for an unoperated cervical disc derangement. Contrary to SAIF's argument, claimant need not establish specific impairment resulting from an unoperated disc derangement. Any injury-related unoperated rupture, bulge or other disc derangement is entitled to a value of 4 percent. Former OAR 436-35-350(2). There is no requirement under the applicable version of former OAR 436-35-350(2) that there be clinically-related symptoms resulting in specific impairment. Daniel G. Huff, 42 Van Natta 2805 (1990).

However, claimant must prove that she has an unoperated disc derangement that is causally related to her compensable injury. Dr. Michels opined that claimant's experience of pain during cervical compression evidenced one of three conditions, one of which was a thoracocervical disc herniation. (Ex. 21-7). However, Dr. Michels stated that her intervertebral disc spaces appeared intact and well preserved. (Ex. 21-9). Moreover, Dr. Michels stated that further tests were needed to rule out any disc or neurological pathology. (Ex. 21-10). Dr. Michels then concluded that claimant has an unoperated disc derangement. (Id.) No further tests were performed and no other physician opined that claimant has this condition. On this record, claimant has not proven that she has an unoperated disc derangement.

Next, claimant argues that she is entitled to 5 percent impairment for loss of strength due to injuries to her spinal nerve plexus. Former OAR 436-35-350(4). However, the record does not establish that claimant's spinal nerve plexus was injured. As noted above, Dr. Michels only recommended further tests to rule out any neurological pathology. (Ex. 21-10). No further tests were performed and no physician opined that claimant suffered spinal nerve plexus injury. However, the record establishes that claimant has experienced a minimal loss of strength in her shoulder due to physical damage to her shoulder rather than damage to the spinal nerves. (Exs. 21, 22). See former OAR 436-35-330(19). Therefore, we find that claimant is entitled to a value of 5 percent for this loss.

Claimant next argues that she is entitled to 4 percent impairment for sensory loss in the shoulder. However, the standards provide no value for this loss.

Claimant's impairment values for her loss of cervical range of motion (4), loss of repetitive use of her neck (5) are combined for a total spinal impairment of 8.8. OAR 436-35-360(11). Claimant's loss of repetitive use of her shoulder (5), loss of shoulder range of motion (7.5), and loss of shoulder strength (5) are combined for a total shoulder impairment of 16.5. OAR 436-35-320(2). These values are combined for a total impairment of 23.8. 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 0 is added to her 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 23.8 the result is 33.8 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 34 percent.

ORDER

The Referee's order dated May 2, 1990, as amended May 8, 1990, and reconsidered June 22, 1990, is modified in part and affirmed in part. In addition to the Referee's award of 14 percent (44.8 degrees) unscheduled permanent disability, claimant is awarded 20 percent (64 degrees), giving her a total award to date of 34 percent (108.8 degrees) unscheduled permanent disability for her cervical, thoracic and left shoulder injuries. 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 shall not exceed $3,800.

In the Matter of the Compensation of
RICHARD S. OLSON, Claimant
WCB Case Nos. 89-23420 & 90-04400
ORDER ON REVIEW (REMANDING)
Dahn & Morrison, Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney
Darryl Nelson, Defense Attorney

Reviewed by Board Members Myers, Cushing and Crider.

Claimant requests review of Referee Livesley's order which dismissed his requests for hearing from denials issued by the SAIF Corporation and Liberty Northwest Insurance Corporation as untimely filed without good cause. On review, the issue is timeliness. We affirm in part, reverse in part, and remand.

FINDINGS OF FACT

Claimant sustained a compensable cervical and left shoulder, arm and hand injury on April 21, 1986 while working as a millwright for SAIF's insured. His claim was closed by Determination Order on January 20, 1987 with an award of 15 percent unscheduled permanent disability. Claimant did not seek medical treatment from 1986 until April 1989.

In early April 1989, while working for Liberty Northwest's insured, claimant experienced an onset of neck, bilateral shoulder and right arm symptoms and sought medical treatment.

On May 11, 1989, claimant filed a "new injury" claim with Liberty Northwest's insured, which issued a denial of both compensability and responsibility on September 19, 1989. Claimant received Liberty Northwest's denial on September 25, 1989.

On September 11, 1989, SAIF issued a denial of responsibility for claimant's aggravation claim. The denial was mailed by certified mail, return receipt requested. The earliest postmark date on the receipt was September 19, 1989. Claimant received SAIF's denial on September 20, 1989.

By letter dated November 14, 1989, claimant requested a hearing on SAIF's September 11, 1989 aggravation denial. The letter was mailed on November 17, 1989. The letter and hearing request were received by the Board on November 21, 1989.

By letter dated December 1, 1989, claimant submitted an "Amended" Request for Hearing which was identical to his earlier, November 14, 1989 Request for Hearing, except that it now included a reference to Liberty Northwest's denial of claimant's "new injury" claim. The "Amended" Request for Hearing was received by the Board on December 11, 1989.

On March 6, 1990, after interpreting claimant's December 1, 1989 "Amended" Request for Hearing as an initial request for hearing on Liberty Northwest's denial, Referee Livesley issued an Order of Consolidation, consolidating claimant's requests for hearing. The March 22, 1990 hearing date encompassed both denials.

At hearing, both Liberty Northwest and SAIF moved to dismiss on the grounds that the requests for hearing were untimely filed. Claimant moved for a continuance in order to establish good cause for the untimely hearing requests. The Referee denied the motion for continuance and dismissed claimant's request for hearing. No testimony concerning the merits of claimant's claims was taken.

Claimant mailed a hearing request concerning SAIF's denial within 60 days of the date of mailing of the denial. Claimant did not mail a request for hearing concerning Liberty Northwest's denial within 60 days of its mailing. Claimant has not established good cause for his failure to do so.

CONCLUSIONS OF LAW AND OPINION

The Referee dismissed claimant's requests for hearing as untimely. We agree as to the Liberty claim, but not the SAIF claim.

The time for requesting a hearing is specified in ORS 656.262(8) and ORS 656.319(1). Claimant has 60 days after notification to request a hearing on a denial, or 180 days if good cause for the failure to request within 60 days is shown. ORS 656.319(1). The date of mailing, not receipt, starts the running of the 60 day period. Wright v. Bekins Moving & Storage Co., 97 Or App 45 (1989). A Referee is without jurisdiction to extend claimant's statutory time limits for filing a request for hearing. See Nelson v. SAIF, 43 Or App 155, 159 (1979); Jose Curiel, 42 Van Natta 2328 (1990). A claimant has an obligation to request a hearing in response to each denied claim. ORS 656.319(1); See Naught v. Gamble Inc., 87 Or App 145 (1987).

SAIF's Denial

The Referee dismissed claimant's November 14, 1989 Request for Hearing, pertaining to SAIF's aggravation denial, as untimely. We disagree.

Although SAIF's denial is dated September 11, 1989, the record does not establish that the denial was mailed on that date. SAIF refers to a handwritten note on its certified mail receipt which states "Denial - 9-11-89." However, that notation neither expressly nor implicitly supports a conclusion that the denial was mailed on September 11, 1989. The receipt does carry a postmark date of September 19, 1989. Therefore, that is the date from which the statutory 60 day period shall commence. See ORS 656.319(1)(a); Wright v. Bekins Moving & Storage Co., 97 Or App 45 (1989).

Under such circumstances, claimant's hearing request from SAIF's denial should be filed with the Board no later than November 18, 1989. ORS 656.319(1)(a). "Filing" means the physical delivery of the hearing request to any permanently staffed office of the Board or the date of mailing. OAR 438-05-046(1)(a). Where nothing in the enabling statute seems to stand in the way, a Board rule that relies on the date of mailing as the date of filing is permissible. See Weyerhaeuser Company v. Miller, 306 Or 1 (1988).[1]

Moreover, we find support for our conclusion that a request for hearing is "filed" on the date of mailing in analagous statutory provisions dealing with Court of Appeals' review of Board orders. In this regard, an appeal to the court from a Board order is accomplished by "filing" an appeal with the court within 30 days after mailing of copies of such order to the parties. ORS 656.298(3) and 656.295(8). In turn, ORS 19.028 provides, in part:

> "(1) Filing of a notice of appeal in the Court of Appeals * * * may be accomplished by mail. The date of filing such notice shall be the date of mailing, provided it is mailed by registered or certified mail and the party filing the notice has proof from the post office of such mailing date." (Emphasis supplied).

Similarly, ORS 656.319(1) requires "filing" of a request for hearing within 60 days of notification of a denial, and ORS 656.283(3) provides that a request for hearing "may be made by any writing * * * mailed to the board." In

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[1] We do not share the same interpretation of the appellate holdings cited by the dissent. In Norton v. Compensation Department, 252 Or 75 (1968), the Supreme Court was concerned with when the 60-day period to appeal a denial began, not when it ended. The Norton court held that the 60 days ran from the date of mailing of the denial, rather than the date the claimant received the denial. The issue of whether a hearing request mailed within 60 days of a denial's mailing date but not received until after 60 days had expired was present in the case. However, that issue was not contested by the parties. Moreover, no Board rule such as OAR 438-05-046(1)(b), which defines "filing" under ORS 656.319(1)(a), was in existence.

In Bergeron v. Ontario Rendering Co., 34 Or App 1025, 1027, rev den 284 or 80 (1978), the court held that a hearing request mailed before, but not received until after, the expiration of one year from the mailing date of a Determination Order was untimely. The Bergeron court cited Norton as support for the proposition that a hearing request mailed within the period provided by ORS 656.319(1)(a) but not received by the Board until after that period had expired is untimely. As discussed above, the Norton holding addressed the commencement rather than the termination of the period to request a hearing. Furthermore, no Board rule such as OAR 438-05-046(1)(b), which defines "filing" under ORS 656.319(1)(a), was in existence.

Voorhies v. Wood, Tatum, Mosser, 81 Or App 336 (1986), solely pertained to the issue of whether claimant had established good cause for an untimely hearing request from a denial. As in Norton, it was not contested that a hearing request mailed before but not received until after the expiration of the 60-day period was timely. Since the Voorhies holding concerned the issue of good cause for an assumed untimely hearing request and did not address a Board rule defining the "filing" of a hearing request, we do not consider the decision dispositive.

Finally, the Supreme Court's decision in Weyerhaeuser Company v. Miller, 306 Or 1 (1988), is the only case which discussed a Board rule defining "filing." In addressing the forerunner of OAR 438-05-046(1)(b) for purposes of determining whether a request for Board review of a Referee's order is filed upon mailing, the Supreme Court held that:

> "if the Board chooses to use the word 'filing' to describe how a party submits a request for review or other document to the Board, and then provides (in the regulation at issue here) that one who relies on the date of mailing as the date of filing must have specified proof in case of dispute, nothing in the statute [ORS 656.295(2)] seems to stand in the way." 306 Or at pages 4 - 5. (Emphasis supplied).

Here, nothing in the enabling statute, ORS 656.319, "seems to stand in the way" of OAR 438-05-046(1)(b). Since ORS 656.319 expressly uses the term "filed" throughout the section for requesting a hearing and does not seek to define that term, we conclude that there is nothing in the statute that prohibits the adoption of the Board rule defining "filing" of a hearing request as either physical delivery or by means of mailing by a specified method. Consequently, in light of the above discussion and particularly considering the Miller Court's recent holding, we apply OAR 438-05-046(1)(b) in determining whether claimant's hearing request was "filed" when it was mailed to the Board.

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

Here, claimant's November 14, 1989 hearing request concerning SAIF's denial was received by the Board on November 21, 1989. Since the denial was not mailed by registered or certified mail and November 21, 1989 is more than 60 days after the mailing date of SAIF's denial, the hearing request is presumed untimely unless claimant establishes that the mailing is timely. OAR 438-05-046(1)(b).

The letter containing claimant's hearing request is postmarked November 17, 1989. Apparently based on that postmark, the Referee found that claimant's hearing request was mailed November 17, 1989. Not only has SAIF not contested the mailing date for claimant's hearing request, but it has expressly accepted the Referee's statement of facts. Such circumstances cause us to conclude that claimant mailed his hearing request regarding SAIF's denial on November 17, 1989, which is within 60 days of the mailing date of its denial. Consequently, claimant has successfully overcome the presumption that the mailing of his hearing request from SAIF's denial was untimely. OAR 438-05-046(1)(b).

Inasmuch as claimant's hearing request is timely, the issues raised by his request should be addressed. However, no testimony was taken at the hearing on the merits of claimant's SAIF claim. Under such circumstances, we conclude that the record regarding claimant's hearing request from SAIF's denial has been insufficiently developed. Accordingly, we remand to the Referee for a hearing concerning the issues raised by claimant's hearing request from SAIF's denial. ORS 656.295(5).

Liberty Northwest's Denial

The Referee dismissed claimant's request for hearing pertaining to Liberty Northwest's "new injury" denial as untimely. We agree.

Liberty Northwest's denial was dated September 19, 1989. Claimant received that denial on September 25, 1989. In the absence of a mailing date, we conclude that claimant was "notified" of the denial on the date of receipt. See ORS 656.319(1)(a). Therefore, to be timely, claimant should have filed a Request for Hearing pertaining to Liberty Northwest's denial no later than November 24, 1989.

Claimant first contends that his Request for Hearing, of SAIF's denial, dated November 14, 1989, and mailed November 17, 1989, was legally sufficient under ORS 656.283(1) and (3) to constitute a Request for Hearing regarding Liberty Northwest's denial. We disagree.

The threshold question, here, is whether claimant's November 14, 1989 Request for Hearing, which made reference only to SAIF's aggravation denial, also put Liberty Northwest's September 19, 1989 "new injury" denial at issue, even though Liberty Northwest's denial was not specified in the November 14, 1989 Request for Hearing. We find that it did not. We base our finding on our interpretation of ORS 656.283 and ORS 656.319.

ORS 656.283 and ORS 656.319 regulate the filing of requests for hearing. ORS 656.283, in pertinent part, provides:

> "(1) . . . any party or the director may at any time request a hearing on any question concerning a claim. . . .
>
> "(3) A request for hearing may be made by any writing, signed by or on behalf of the party and including the address of the party, [sic] requesting the hearing, stating that a hearing is desired, and mailed to the board. . . .
>
> "(5) At least 10 days' prior notice of the time and place of hearing shall be given to all parties in interest by mail. . . ." (Emphasis added).

ORS 656.319(1) provides, in pertinent part:

> "(1) With respect to objection by a claimant to denial of a claim for compensation under ORS 656.262, a hearing thereupon 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." (Emphasis added).

Here, claimant filed two separate claims: one against SAIF alleging an aggravation; and one against Liberty Northwest alleging a "new injury." Claimant received two separate denials: SAIF's aggravation denial and Liberty Northwest's "new injury" denial. Therefore, claimant could object to either or both denials by filing a request for hearing on the denied claims pursuant to ORS 656.283 and 656.319. Claimant was under no obligation to appeal either denial or both. See Debbie L. Stadtfeld, 43 Van Natta 94 (1991).

After our review of claimant's November 14, 1989 Request for Hearing, we find that it pertained solely to SAIF's aggravation denial. Claimant's November 14, 1989 Request for Hearing indicated a date of injury of April 8, 1989 and listed a claim number of 4785957C. April 8, 1989 was the date of claimant's original compensable injury which occurred while working for SAIF's insured, South Coast Lumber Company. Further, the claim number was one assigned by SAIF. Finally, under the insurer and employer sections of the request, SAIF and its insured were listed, not Liberty Northwest and its insured. There was no mention in the request for hearing of Liberty Northwest or its insured, nor did it, in any way, make reference to Liberty Northwest's "new injury" denial.

Finally, ORS 656.283(5) states that "[a]t least 10 days' prior notice of the time and place of hearing shall be given to all parties in interest by mail. . ." That provision leads us to conclude that the purpose of a request for hearing is to put the "parties in interest" on notice that a hearing has been requested pertaining to issues to which they are a party.

Based on our interpretation of ORS 656.283 and 656.319, we find that claimant's November 14, 1989 Request for Hearing pertained solely to SAIF's aggravation denial, and not to Liberty Northwest's "new injury" denial.

Claimant also argues that his "Amended" Request for Hearing, dated December 1, 1989, was not intended to be a new request for hearing, but was merely intended to amend the original request.

As noted earlier, ORS 656.319(1) sets time limits within which a claimant must request a hearing on a denial of a claim. Time limits prescribed by law are limits upon the right to obtain compensation and are not subject to exceptions. Neither the Board nor the court may waive these requirements. See Nelson, supra; Naught, supra; Jose Curiel, supra.

Therefore, regardless of claimant's characterization of the December 1, 1989 request, the fact remains that a claimant may not make amendments in a hearing request in an attempt to avoid the statutory time limits. Nelson, supra; Naught, supra; Jose Curiel, supra.

Thus, we do not find claimant's argument regarding his attempted amendment of his November 14, 1989 request for hearing to be persuasive in regards to the time of filing his request for hearing pertaining to Liberty Northwest's denial.

Given the above, we find that claimant's first request for hearing pertaining to Liberty Northwest's "new injury" denial was claimant's December 1, 1989 "Amended" Request for Hearing. Therefore, because that request was filed after November 24, 1989, we conclude that claimant failed to file a timely request for hearing on Liberty Northwest's "new injury" denial.

The final issue is whether claimant established good cause for his failure to request a hearing within 60 days. The record establishes that claimant's original counsel was replaced and substituted by another counsel on the eve of the March 22, 1990 hearing. No explanation was given for claimant's untimely request for hearing which would establish good cause, i.e., mistake, inadvertence, surprise or excusable neglect. Anderson v. Publishers Paper Co., 78 Or App 513, rev den 301 Or 666 (1986); see also Brown v. EBI Companies, 289 Or 455 (1980).

Consequently, we find that claimant has failed to establish good cause for the untimely filing of his request for hearing regarding Liberty Northwest's denial. Accordingly, we affirm that portion of the Referee's order which dismissed claimant's hearing request from Liberty Northwest's denial.

ORDER

The Referee's order dated April 6, 1990 is affirmed in part and reversed in part. That portion of the order that dismissed claimant's hearing request from SAIF's denial is reversed. Claimant's "SAIF" hearing request is reinstated and this portion of the case is remanded to Referee Livesley for further proceedings consistent with this order. The remainder of the order is affirmed.

Board Member Crider concurring in part and dissenting in part.

I concur in that portion of the order that holds that claimant failed to file a request for hearing within 60 days of the mailing of Liberty Northwest's denial and further failed to establish good cause for the untimely filing. I must disagree, however, with that portion of the order that holds that claimant timely filed his request for hearing on SAIF's denial by mailing the request within 60 days of the mailing of SAIF's denial. Therefore, I dissent in part.

ORS 656.319(1)(a) provides that a request for hearing must be filed not later than the 60th day after notification of the denial. As the Board observes, "notification" for purposes of this section is the date of mailing.

Madewell v. Salvation Army, 49 Or App 439 (1980). "Filing" for purposes of this section is the date the Board receives the request for hearing, not the date the request is mailed. Norton v. Compensation Department, 252 Or 75 (1968); Voorhies v. Wood, Tatum, Mosser, 81 Or App 336 (1986); Bergeron v. Ontario Rendering Company, 34 Or App 1025 (1978).

Despite these cases which specifically hold that mailing on the 60th day does not satisfy the statutory requirement, the Board holds that claimant timely filed his request for hearing by mailing his request on the 60th day. The Board relies on an administrative rule which provides that filing means "physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing." OAR 438-05-046(a). I submit that while the Board certainly may, by rule, permit filing by mail, the Board cannot by rule define a request for hearing as timely when the courts have concluded such a filing is untimely under ORS 656.319(a).

In Weyerhaeuser Company v. Miller, 306 Or 1 (1988), the Supreme Court held that the Board was authorized to adopt a rule of procedure requiring that, to establish timely mailing of a request for review, a party must mail the request by certified or registered mail. However, chapter 656 permits submission of a request for review by mailing within the 30-day appeal period. Therefore, the rule upheld in Miller merely restricted the means of proof of timely mailing. The Board's rule, as applied in this case, on the other hand, actually expands the time for filing by treating a request for hearing received by the Board after the 60th day as timely. This, I believe, is beyond the Board's authority. Therefore, I dissent.

March 27, 1991 Cite as 43 Van Natta 663 (1991)

In the Matter of the Compensation of
MICHELE R. SUNSERI, Claimant
WCB Case No. 89-21481
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Claimant requests review of that portion of Referee Podnar's order that upheld the self-insured employer's denial to the extent that it denied claimant's medical services claim for physical therapy and acupuncture treatment. The employer cross-requests review of that portion of the Referee's order that set aside its denial of claimant's medical services claim for chiropractic treatments in excess of that suggested by the guidelines. On review, the issue is medical services. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Physical Therapy and Acupuncture Treatment

In determining the propriety of the employer's denial of claimant's physical therapy and acupuncture treatment, the Referee relied on OAR 436-10-040(4)(a), which provides that physical therapy and acupuncture need not be reimbursed unless carried out under a written treatment plan signed by the

attending physician before the beginning of treatment. Finding that no such qualifying plans were submitted, the Referee concluded that the medical services were not compensable.

After our de novo review of the record, we agree that the attending physician failed to submit advanced treatment plans. We add, however, that the proper inquiry does not end there. In Susan L. Spencer, 39 Van Natta 781 (1987), the Board concluded that strict compliance with OAR 436-10-040(4)(a) was not necessary where the acupuncture treatments were shown to be reasonable and necessary. In reaching that decision, the Board relied on Kemp v. Workers' Comp. Dept., 65 Or App 659, 659 (1983), which held that it would be inconsistent with the clear policy of the Workers' Compensation Act that a claimant be compensated for reasonably necessary medical bills incurred as a result of a compensable injury. See ORS 656.245(1).

Thus, regardless of the procedural deficiencies, we must determine whether claimant has established that her physical therapy and acupuncture treatments were reasonable and necessary. Medical expenses for purely palliative purposes are recoverable where they are necessarily and reasonably incurred in the treatment of an injury for which permanent partial disability has been awarded. Wetzel v. Goodwin Brothers, 50 Or App 101 (1981).

Claimant testified that she benefited from both the physical therapy and acupuncture treatment. She stated that the physical therapy helped her strength and flexibility, which made her better able to function. She explained that the accupuncture treatments relieved her low back and leg spasms, relaxed and loosened up her upper body muscles and relieved her tension headaches. She said that, for the most part, she felt better for a few days after each treatment. She also stated that, while the benefit often varied from visit to visit, she gradually got better after she underwent the therapy and treatment in September 1989. Claimant's testimony is supported by the medical evidence. On March 3, 1990, the Western Medical Consultants reported that claimant's lumbar flexion had improved since November 1989 and the physical therapy had "afforded her significant palliation." (Ex. 140A-5).

On this record, we conclude that claimant's testimony, together with the medical evidence, is sufficient to support a finding that it was reasonable and necessary for claimant to receive physical therapy and accupuncture treatments to relieve her of pain and to increase her functional capacity. Accordingly, the employer's denial of such medical services is set aside.

Chiropractic Treatment

The Referee found that claimant's condition improved steadily in late 1989 and, therefore, concluded that her chiropractic treatment was reasonable and necessary. We agree, and the employer does not dispute, that the treatment was of a reasonable and necessary type. Nonetheless, as the court said in James v. Kemper Ins. Co., 81 Or App 80, 84 (1986):

> "Simply because the Board determines that it is reasonable for an injured worker to receive some chiropractic treatments does not mean that she may expect to be compensated for any number of treatments without a showing that the treatments are reasonable and necessary."

At the time of this dispute, guidelines issued by the Workers' Compensation Division identified two visits per month, after the initial 60 days, as the usual frequency of medical services. Former OAR 436-10-040(2)(a). A claimant

is entitled to treatment in excess of the administrative guidelines if she proves that the treatment is necessary due to the nature of the injury or the process of recovery. James v. Kemper Ins. Co., supra.

After claimant began physical therapy and acupuncture treatments in September 1989, she continued to treat with Dr. Beeson. She received numerous treatments each week, often on the same day she had received the other medical services. Her treatment was not scheduled on an as needed basis, but rather was scheduled in advance without regard to her condition. Compare Milbradt v. SAIF, 62 Or App 530 (1983).

On November 2, 1989, the Western Medical Consultants, in an independent medical examination, found claimant medically stationary and concluded that further chiropractic treatment was neither reasonable or necessary. Nonetheless, claimant continued chiropractic treatment. On March 3, 1990, the Western Medical Consultants, in a follow-up examination, reported that claimant's condition had improved and that claimant felt that she was benefiting from chiropractic treatment. However, they noted that claimant was simultaneously receiving physical therapy, which included some passive treatments, and that claimant felt that that was helping her more than chiropractic treatments.

After our de novo review of the record, we conclude that claimant has failed to prove entitlement to chiropractic treatment in excess of that suggested by administrative guidelines. In light of evidence that claimant was also receiving frequent passive treatments during her physical therapy, and that claimant believed that such treatment was more beneficial than those with Dr. Beeson, we conclude that claimant has failed to prove that the every other day chiropractic treatments were reasonable and necessary for the nature of her injury or for the process of her recovery.

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 at hearing and on Board review concerning the medical services denial of acupuncture and physical therapy is $1,600, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 1, 1990 is reversed. The employer's denial of claimant's medical services claim for physical therapy and acupuncture treatment is set aside. For services at hearing and on Board review concerning the physical therapy and acupuncture treatment, claimant's counsel is awarded an assessed attorney fee of $1,600, payable by the self-insured employer. The employer's denial of claimant's medical services claim for chiropractic treatment in excess of the administrative guidelines is reinstated and upheld. The Referee's $1,500 assessed attorney fee on this issue is reversed.

In the Matter of the Compensation of
THOMAS M. TAPSCOTT, Claimant
WCB Case No. 89-15656
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Darryl Nelson, Defense Attorney

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Garaventa's order which: (1) upheld the insurer's partial denial of his claim for a psychological condition; (2) declined to assess a penalty or attorney fee for an allegedly untimely denial; and (3) found that his claim had not been prematurely closed by an August 1989 Determination Order. On review, the issues are compensability, penalties and attorney fees and premature closure. 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 of Psychological Condition

We adopt the conclusions and reasoning as set forth in the "Compensability of Psychological Disorder" section of the Referee's order with the following supplementation.

In reaching her conclusion that claimant's psychological condition was not compensable, the Referee stated that claimant must establish that he has a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community pursuant to ORS 656.802(2)(c). We disagree.

ORS 656.802(2)(c) applies to psychological conditions in an occupational disease context. It does not apply to psychological conditions resulting from a compensable injury. To establish compensability of a psychological condition stemming from a compensable injury, claimant only need show that the compensable injury was a material contributing cause of his disability or need for medical treatment. See Grace v. SAIF, 76 Or App 511 (1976); Randolph P. Gaul, 42 Van Natta 592 (1990).

Although the Referee stated that claimant had to show a diagnosis of a mental disorder accepted in the medical community, her conclusion is based on the persuasiveness of the medical evidence. We agree with the Referee that the opinions of Drs. Turco and Glass are more persuasive than the opinions of Drs. Henderson and Metzger. Accordingly, claimant has failed to establish that his compensable injury is a material contributing factor to his psychological condition or need for treatment.

Penalties and Attorney Fees

We adopt the conclusions and reasoning as set forth in the "Penalties and Fees" section of the Referee's order.

Premature Closure

We adopt the conclusion and reasoning as set forth in the "Premature Closure" section of the Referee's order.

ORDER

The Referee's order dated June 18, 1990 is affirmed.

In the Matter of the Compensation of
MIGUEL A. TORRES, Claimant
WCB Case No. 89-07974
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
David Ray Fowler (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of that portion of Referee Nichols' order that affirmed a Determination Order which awarded 36 percent (54 degrees) scheduled permanent disability for loss of use of his right hand. On review, the issue is extent of scheduled disability.
We modify.

FINDINGS OF FACT

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

Claimant's second and third digits were surgically amputated at the proximal interphalangeal (PIP) joint.

As a result of his injury, for each of his amputated fingers (middle and index), claimant has loss of opposition to the thumb and loss of flexion at the metacarpophalangeal joint.

Due to disabling pain in his fingers and hand, claimant is unable to use a hoe or pruning shears. He is unable to lift boxes during field work because his hand hurts. Claimant cannot write for more than half an hour at a time and his hand becomes numb and sore when exposed to cold temperatures. Claimant's fingertips hurt when he washes dishes or bumps into objects.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was entitled to 34 percent disability under the standards, for the loss of use of his right hand. By awarding a value of 2 percent for disabling pain, the Referee concluded that claimant was adequately compensated by the Determination Order award of 36 percent. We apply the "standards" in effect on December 5, 1988, the date of the Determination Order, and modify.

Amputations

The Referee concluded that claimant's amputation was made in the middle phalanx between the distal interphalangeal (DIP) and PIP joints but she awarded claimant 50 percent for his loss for amputation. Former OAR 436-35-030(6). On review, claimant contends that there is no evidence that Dr. Nisbet's operation amputated claimant's second and third digits at the DIP joint. Claimant argues that Dr. Nisbet only stated in his pre-operative report that the saw that injured claimant had essentially routed out all the bone distal to the DIP joint.

Dr. Ellison treated claimant surgically following initial emergency treatment. It is clear from Dr. Ellison's follow-up chart notes, physical therapy notes and subsequent surgical procedures to lengthen the remaining metacarpal bone by grafting, that amputation was performed surgically at the PIP joint (i.e., a proximal interphalangeal disarticulation). (Exs. 10, 12, 19 and 21).

We conclude that claimant's amputations were at the PIP joint, rather than between the PIP and DIP joints. Accordingly, claimant is entitled to a value of 70 percent for each of his two amputations at the PIP level. Former OAR 436-35-030(6).

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 loss of opposition of claimant's index and middle fingers at the PIP joint, 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 contends that he is entitled to a combined loss of range of motion for each finger in the amount of 58 percent. We disagree. Although the Referee found that claimant had lost 90 degrees of motion in the PIP joint, we have concluded that claimant's surgical amputation took place at the PIP joint. Accordingly, we decline to award loss of range of motion at the PIP joint.

Claimant has lost 15 degrees of flexion at the metacarpophalangeal joint of both the index and middle fingers. A value of 9 percent is assigned to each finger (index and middle) for loss of motion. Former OAR 436-35-060(5).

Disabling Pain/Fingers

Disabling pain, resulting in loss of use or function beyond that to be expected from an amputation, may be taken into consideration and assessed based on the loss of use or function which results. See Barbara J. Glenzer, 42 Van Natta 1879 (1990); former OAR 436-35-010(2).

Here, claimant testified that washing dishes hurts his fingers at the location at which the fingers were amputated. The tips of his amputated fingers hurt when he is working and when he bumps into things. Claimant testified that the pain in the tips of his amputated finger affects his ability to use his hand.

We conclude that, for each of his amputated fingers, claimant has sustained 10 percent loss of use or function of the finger due to disabling pain.

Total Permanent Partial Disability

As the Referee noted, there are two methods for rating the amount of total impairment claimant has sustained due to his 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).

In the present case, however, we have found that claimant suffers disabling pain in his hand, in addition to the disabling pain in his fingers. Accordingly, we conclude that conversion of finger values to a value for loss of

use of the hand is required, in order to rate the permanent partial disability of the hand.

Conversion Method to Loss of Use of Hand

The total value of loss of use of claimant's hand is calculated 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 conversion chart. Former OAR 436-35-070(3).

Index Finger: The amputation rating of 70 percent, loss of motion of 9 percent and 10 percent value for disabling pain are combined for a total of 75.4 percent which converts to a 19 percent loss of use of the hand. Former OAR 436-35-070(5).

Middle Finger: The amputation rating of 70 percent, loss of motion of 9 percent and 10 percent for disabling pain are combined for a total of 75.4 percent which converts to a 15 percent loss of use of the hand. Former OAR 436-35-070(6).

The converted values are added. Former OAR 436-35-070(2). Claimant's loss of use of his fingers is equivalent to a 34 percent (51 degrees) loss of use of his hand.

Disabling Pain/Hand

Claimant contends that his pain interferes with his use and function of his right hand. See Barbara J. Glenzer, supra. Claimant is unable to use gardening utensils and cannot lift boxes during field work. He is also unable to write for more than half an hour at a time, due to pain in his hand. In addition, his hand becomes numb and sore when exposed to cold temperatures.

We conclude that claimant has sustained 5 percent loss of use or function due to disabling pain in the right hand, beyond that expected from the amputation of his index and middle fingers. When combined with 34 percent, the result is 37.3 percent loss of use or function of the right hand. That value is rounded to the next higher whole number or 38 percent. Former OAR 436-35-010(6).

We do not find clear and convincing evidence of permanent disability less than or greater then 38 percent. Former ORS 656.295(5).

ORDER

The Referee's order dated August 23, 1989 is modified. In addition to the 36 percent (54 degrees) scheduled permanent disability awarded by Determination Order, claimant is awarded 2 percent (3 degrees) scheduled permanent disability, giving him a total award to date of 38 percent (57 degrees) scheduled permanent disability for loss of use or function of the right hand. Claimant's attorney is awarded 25 percent of the increased compensation awarded herein, not to exceed $3,800.

In the Matter of the Compensation of
GLORY YANKAUSKAS, Claimant
WCB Case No. 89-18765
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Darryl Nelson, Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Neal's order that upheld the insurer's denial of claimant's head injury claim, on the basis that the claim was barred because of untimely filing. On review, the issues are timeliness of the claim and if timely, compensability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

ULTIMATE FINDINGS OF FACT

Before March 1989, the employer did not have knowledge of claimant's injury which would have lead a reasonable employer to conclude that workers' compensation liability was a possibility.

The insurer has been prejudiced by claimant's failure to timely file her claim.

CONCLUSIONS OF LAW AND OPINION

Timeliness

The Referee found that claimant had not given notice of her accident within 30 days and the employer did not have knowledge that her claim was work-related.

On review, claimant first argues that the insurer waived any defense as to late filing of the claim, as the issue was not raised until claimant rested her case at hearing. We disagree.

ORS 656.265(5) provides that the issue of failure to give notice must be raised at the first hearing on a claim for compensation in respect to the injury or death. Here, the insurer properly raised the issue of failure to give notice at the first hearing. Had claimant required additional time to prepare for that issue, she could have requested a continuance. See OAR 438-06-031 and 438-06-091.

Claimant contends that, if the defense of timeliness was not waived, the employer had knowledge of the injury on the date it occurred. 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 insurer 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).

The Referee concluded that, although the employer had knowledge that claimant was in an auto accident, it had no reason to know that the accident was

related to her employment. We agree. The assistant superintendent, Mr. Carpenter, first learned that claimant had been involved in an auto accident when he phoned to check in with his office that morning. The superintendent's secretary reported that claimant was on her way to work when the accident occurred. Because the accident happened on the way to work, as opposed to at work, Mr. Carpenter did not consider that "it would be a workers' compensation claim."

Mr. Carpenter testified that the district's normal procedure for filing a workers' compensation claim involved the form being filled out by the employee. After receipt of the form in the district's office, it was forwarded to the carrier for processing. The school district employees were informed of the procedure for filing a workers' compensation claim. To Mr. Carpenter's knowledge, no "801" form was ever filed in claimant's case and he was not aware of any third party settlement.

We conclude that, under the circumstances, knowledge of the injury did not include enough facts to lead a reasonable employer to conclude that workers' compensation liability was a possibility. See Argonaut v. Mock, 95 Or App 1 (1989).

The Referee concluded that the employer was prejudiced by claimant's failure to provide notice. We agree. By waiting to file a workers' compensation claim until after a third party settlement has taken place, claimant has the potential to avoid a statutory lien. In addition, such action deprives an employer or insurer of its right to participate in and approve the settlement. See ORS 656.580(2); 656.587. Accordingly, we conclude that the insurer was prejudiced by claimant's failure to provide notice until after settlement of her claim against a third party.

Failure to give the employer notice within the 30-day period bars a claim unless the carrier has begun payments as required under ORS 656.001 to 656.794. ORS 656.265(4)(b). Here, there is no evidence that the insurer had begun payments as provided under ORS 656.001 to 656.794.

Finally, claimant has not shown that good cause existed for failing to give notice of the claim within 30 days. See ORS 656.265(4)(c).

We conclude that claimant's injury claim was untimely and the Referee correctly found that the claim was time-barred.

Compensability

As we have herein concluded that the injury claim is barred, we do not reach the issue of compensability.

ORDER

The Referee's order dated January 31, 1990 is affirmed.

In the Matter of the Compensation of
JEFFREY M. MILLER, Claimant
WCB Case No. 89-01618
ORDER ON REVIEW
John E. Uffelman, Claimant Attorney
Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation requests review of Referee Schultz' order that set aside its denial of claimant's ulcerative colitis. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant first became employed with SAIF's insured in November 1987 as a mason's assistant. The owner of the business, while teaching claimant the trade of masonry, subjected claimant to offensive and foul language and excessive criticism which he usually delivered by yelling at claimant. Claimant found his work environment extremely stressful. He continued, however, to work for SAIF's insured until his treating physician, Dr. Kleikamp, removed him from work on November 29, 1988.

One month prior to his employment with SAIF's insured, claimant developed ulcerative colitis, for which he received treatment from Dr. Kleikamp. Claimant's symptoms progressed after he began working for the employer. Claimant also developed a major depressive disorder, single episode.

On November 30, 1988, claimant filed a claim for ulcerative colitis, related to job stress. SAIF denied claimant's claim by letter dated January 18, 1989.

FINDINGS OF ULTIMATE FACT

Claimant has a mental or emotional disorder which is generally recognized in the medical or psychological community. This mental disorder did not require medical services, nor was it disabling. The evidence is not clear and convincing that this mental disorder arose out of and in the course of employment. Nor is there evidence that this disorder materially contributed to claimant's ulcerative colitis.

CONCLUSIONS OF LAW AND OPINION

For an occupational disease claim, the date of "injury" is the date upon which the claimant was last exposed to the employment conditions which could have caused the disease. Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986). Claimant's last exposure to the working conditions which he argues caused his ulcerative colitis was November 29, 1988, the date he was last employed by SAIF's insured. Accordingly, we apply former ORS 656.802 as amended effective January 1, 1988. Donna E. Aschbacher, 41 Van Natta 1242 (1989). See Johnson, supra at 146-48.

The Referee analyzed claimant's occupational disease claim for a stress-related physical condition under ORS 656.802(1)(c). We disagree. In Ronald V. Dickson, 42 Van Natta 1102 (1990), we held that an occupational disease claim for a stress-related physical condition is properly analyzed under former ORS 656.802(1)(b). In other words, claimant must establish that the causative factor of stress is compensable in its own right as a mental disorder. Dickson, supra; Charlene Newman, 43 Van Natta 368 (1991).

Consequently, this claim must be analyzed under former ORS 656.802(1)(b) and (2). Claimant must, therefore, establish that: (1) he has a mental or emotional disorder which is generally recognized in the medical or psychological community; (2) the disorder required medical services or was disabling; (3) the evidence is clear and convincing that the mental disorder arose out of and in the course of employment; (4) the mental disorder was due to employment conditions which were real and objective; and (5) such employment conditions are not generally inherent in every working environment.

Dr. Kleikamp initially related claimant's colitis to "job entailed severe psychological stress." However, stress, in and of itself, is not a generally recognized mental disorder. Dickson, supra. We defer to Dr. Beavers, psychiatrist, who examined claimant and diagnosed a major depressive disorder, single episode. (Ex. 15A-5). We find that this condition is generally recognized in the psychological community. (See DSM III 296.2x).

Although Dr. Beavers recommended regular psychiatric follow up, there is no evidence in the record of treatment for claimant's depressive disorder. Nor is there evidence in the record that the depressive disorder was disabling.

Furthermore, the evidence is not clear and convincing that the depressive disorder arose out of and in the course of employment. Only Dr. Beavers diagnosed a mental disorder, and he only tentatively concluded that claimant's depressive disorder could be linked to stress at work. (Ex. 15A-5). This possibility does not rise to the level of clear and convincing evidence. Gormley v. SAIF, 52 Or App 1055, 1060 (1981).

For these reasons, we conclude claimant has not established a compensable mental disorder. Moreover, assuming his depression and stress were compensable, claimant has not established that those conditions materially contributed to his colitis. No physician related the depressive disorder to claimant's ulcerative colitis. Instead, the medical opinions focused on whether stress at work affected claimant's colitis. Dr. Kleikamp initially stated that job stress had likely precipitated the colitis. However, he later opined that job stress may have contributed. Similarly, Dr. Beavers opined that there was a possibility that psychological stress at work could have contributed to the development of claimant's ulcerative colitis. (Exs. 19-3, 20). The possibility of a causal relationship is not sufficient to satisfy claimant's burden of proof. Gormley v. SAIF, supra.

Dr. Baumeister, an expert in gastrointestinal disease, stated that, although the cause of ulcerative colitis was unknown, psychological and emotional factors play a part; however, the medical community is not sure how these factors are involved. (Exs. 11-3, 16-21, 16-32). Furthermore, Dr. Baumeister opined that, although psychological and emotional factors contributed to the onset or worsening of ulcerative colitis in this case, he could not, to a medical probability, connect work as a causal factor of claimant's ulcerative colitis. (Exs. 16-3, 16-17, 16-20). We find Dr. Baumeister's well-reasoned opinion more persuasive. Furthermore, Baumeister's opinion is supported by that of Dr. Lyon, examining internist, who opined that the etiology of ulcerative colitis was unknown and the onset of claimant's ulcerative colitis was not related to any job stress. (Exs. 15-3, 17).

Accordingly, we conclude that claimant's ulcerative colitis is not compensable, and we reverse the Referee's ruling to the contrary.

ORDER

The Referee's order dated June 30, 1989 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's award of a $3,200 assessed attorney fee is reversed.

In the Matter of the Compensation of
DIXIE M. RUNGE, Claimant
WCB Case No. 89-25785
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Nichols and Crider.

Claimant requests review of Referee McCullough's order that affirmed a Determination Order which awarded no unscheduled permanent disability for a cervical and thoracic spine injury beyond the 15 percent (48 degrees) awarded by a prior stipulated order. On review, the issue is extent of unscheduled permanent partial disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Because claimant's condition became medically stationary on November 10, 1989, and her claim was closed by Determination Order on December 12, 1989, the Referee correctly applied the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. ORS 656.283(7) and 656.295(5); OAR 438-10-010. Former OAR 436-35-001 et seq. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled 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. Former OAR 436-35-280.

Where the claimant has returned to his or her usual and customary work, no value is assigned to the age, education and adaptability categories under former OAR 436-35-290(2)(a), 436-35-300(2)(a) and 436-35-310(2)(a).

Here, claimant has returned to her usual and customary work as a sewing machine operator. Therefore, no values will be assigned to the categories of age, education and adaptability. Former OAR 436-35-290(2)(a), 436-35-300(2)(a) and 436-35-310(2)(a).

Claimant argues that she returned only to modified work. However, the record shows that she returned to her regular job operating sewing machines full-time without missing any work due to her cervical condition. (Tr. 20, 22, 30, 36). Her supervisor tried to keep her comfortable by moving her to various machines and did not require her to perform sewing operations which involved stretching elastic. (Tr. 32). However, claimant's neck condition did not limit the types of sewing machines she could work with and all employees were rotated among the various machines. (Tr. 33, 35). Thus, we find that claimant has returned to her usual and customary work.

Impairment

At hearing, claimant and the SAIF Corporation agreed that claimant is entitled to a 3 percent value for loss of range of motion in the cervical spine and a 5 percent value for loss of repetitive use of the cervical spine. The Referee concluded that claimant's total impairment was 8 percent. Based on the values stipulated by the parties for age, education and adaptability, he concluded that claimant's total permanent disability under the "standards" was 13 percent. On this basis, he affirmed the December 12, 1989 Determination Order which awarded no increase in permanent disability over the 15 percent granted by the November 1988 Stipulated Order.

On review, claimant argues that she is entitled to 6 percent impairment for loss of range of motion in her cervical spine. We disagree. Claimant's value for this impairment remains at the 3 percent she stipulated to at hearing.

Next, claimant argues that she is entitled to an impairment value of 4 percent for a disc bulge at C5-6. We disagree. Dr. Poulson, M.D., provides the only medical evidence regarding the relationship of this disc bulge to claimant's work injury and he states that it is not related. (Ex. 11). On this basis, we find that claimant has not established that this disc bulge is related to her compensable injury.

Claimant next argues that she is entitled to an impairment value of 4 percent for the removal or destruction of the C6-7 disc by clinical means which she claims occurred during her C6-7 foraminotomy and laminotomy surgery in February 1989. We disagree. No evidence was presented that indicated the surgery resulted in the removal or destruction of the disc.

Claimant next argues that she is entitled to an impairment value of 4 percent for a disc herniation at C6-7. We disagree. There is no evidence that a disc herniation remained after claimant's surgery. The surgery disclosed that what had been thought, after the first MRI, to be a herniation was in fact a hard ridge. Nothing in the interpretation of the post-surgery MRI would lead us to believe that a new herniation, caused by the compensable injury, had occurred.

Claimant next argues that she is entitled to an impairment value of 5 percent for loss of repetitive use of her thoracic spine. We disagree. The record does not establish any loss of repetitive use of the thoracic spine as distinct from the cervical spine. Therefore, no additional award for loss of repetitive use is appropriate.

Finally, claimant argues that she is entitled to an impairment value for loss of range of motion in her thoracic spine. We agree. Although the November 25, 1988 Stipulated Order continued to deny a thoracic sprain condition, it stated that "all complaints and symptoms involving the thoracic area and left brachial area are connected to the compensable cervical condition and covered as part of this claim." (Ex. 13-1). We find that the thoracic loss of range of motion is a thoracic symptom and as such is covered by the Stipulated Order. Dr. Buttler, treating chiropractor, provides the most current measurements. He found that claimant retained 70 degrees of flexion, 20 degrees of extension, and 20 degrees of lateral flexion bilaterally. (Ex. 27-2). These impairments are valued at 2 percent, 1 percent, 2 percent and 2 percent, respectively. Former OAR 436-35-360. These values are added for a total thoracic loss of range of motion of 7 percent. Former OAR 436-35-360(10).

The 7 percent loss of thoracic range of motion, 5 percent loss of repetitive use of the cervical spine and 3 percent loss of cervical range of motion

are combined for a total spinal impairment of 15 percent. Former OAR 436-35-360(11).

Because claimant has returned to her usual and customary work, claimant's permanent disability under the "standards" is 15 percent.

Claimant's entitlement under the standards does not exceed her prior award. Therefore, claimant is entitled to no further award.

ORDER

The Referee's order dated May 21, 1990 is affirmed.

March 28, 1991 Cite as 43 Van Natta 676 (1991)

In the Matter of the Compensation of
GEORGE T. TAYLOR, Claimant
WCB Case No. C1-00495
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Olson, Rowell & Walsh, Claimant Attorneys
Beers, et al., Defense Attorneys

On March 1, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

OAR 436-60-145(4) requires that a claim disposition agreement contain specified information concerning claimant and the history of the claim. A proposed disposition that does not contain the required information will not be approved by the Board. See OAR 436-60-145(5); 438-09-020(1). Such an agreement is deemed unreasonable as a matter of law. ORS 656.236(1)(a); OAR 438-09-020(2).

Here, the proposed disposition provides that in consideration of $3,757.71, of which $2,257.71 has already been paid in time loss benefits, claimant releases his right to temporary and permanent disability, vocational rehabilitation and survivor's benefits. Pursuant to ORS 656.210 and 656.212(1), the insurer presumably had a legal duty to pay time loss benefits. Therefore, those amounts may not be treated as separate consideration for this agreement. The consideration under the agreement is, therefore, $1,000. Because claimant's attorney's fee exceeds the allowable 25 percent of that amount, the agreement may not be approved. See ORS 656.236(4); OAR 438-09-020(2); 438-115-052. Accordingly, we decline to approve the agreement and return it to the parties.

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARIA GUERRA, Claimant
WCB Case Nos. 90-14023, 89-23982 & 89-23010
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney
Cowling & Heysell, Defense Attorneys
Mitchell, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Liberty Northwest Insurance Corporation requests review of that portion of Referee Mongrain's order which found that claimant's request for hearing was timely. On review, the issue is jurisdiction. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Timeliness

The Referee reasoned that claimant's November 29 request for hearing against Liberty was an amendment to the November 13 request for hearing against Crawford & Company. He concluded that the November 13 request for hearing (as amended) was timely, as it was within 60 days of Liberty's September 22 denial. We disagree.

ORS 656.319(1) provides that a hearing will not be granted with respect to objection by a claimant to denial of a claim for compensation 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 the denial."

In the present case, claimant argues that the November 13, 1989 request for hearing was within 60 days of Liberty's September 22, 1989 denial. Although we agree that the request was made within 60 days, we do not agree that the request constituted an effective request for hearing from Liberty's denial.

The November 13 request for hearing specified Crawford & Company as the employer's insurer. The request did not raise compensability as an issue and did not refer to Liberty's denial of compensability. On the other hand, the November 29, 1989 request for hearing clearly was a request in response to Liberty's denial of compensability. The November 29 request specified that Liberty was the employer's insurer and the request for hearing was being made against the September 22 denial of compensability.

A claimant is required to request a hearing in response to each denied claim in order to place the denial before the Referee. See Naught v. Gamble, Inc., 87 Or App 145 (1987). Here, claimant is not entitled to rely upon her November 13 request for hearing against Crawford and Company as an effective

request for hearing from Liberty's denial. See Richard S. Olson, 43 Van Natta 657 (1991). We, therefore, conclude that claimant's November 29, 1989 request for hearing from Liberty's September 22 denial was untimely.

Good Cause

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 later 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 contends that she has shown good cause for her untimely filing. Claimant argues that she relied upon information provided by the Employer's Index that Crawford & Company was the appropriate carrier, which led her to initially request a hearing against Crawford, rather than Liberty. We do not agree that claimant's reliance in this case constitutes good cause. Under the circumstances, claimant's reliance upon the Index might have provided an explanation for a delay in the filing of her claim, but it does not provide a reasonable explanation for a delay in requesting a hearing.

Here, claimant was aware of Liberty's September 22 denial, but did not request a hearing from that denial until November 29. In addition, in October, claimant was contacted by Crawford, who reported that they could not identify the injury, did not have a file established and would continue to investigate claimant's case. We conclude that claimant's lack of due diligence does not constitute good cause for her untimely request for hearing. Accordingly, we lack jurisdiction to reach the issue of compensability of her claim against Liberty.

ORDER

The Referee's order dated October 19, 1990 is reversed. Claimant's request for hearing concerning Liberty Northwest's denial is dismissed. The Referee's assessed attorney fee award of $2,500 is also reversed.

In the Matter of the Compensation of
CLAUDE E. HARRIS, Claimant
WCB Case No. 89-20661
ORDER ON RECONSIDERATION
Ginsburg, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

On March 27, 1991, we abated our March 8, 1991 Order on Review, which awarded additional temporary disability, and assessed penalties and attorney fees for unreasonable claim processing. We took this action to consider a proposed stipulation from the parties which would resolve this matter in lieu of our order.

We have now received the parties' proposed "Stipulated Order." In return for the sum of $3,200, claimant agrees that the Board's March 8, 1991 order shall be vacated and withdrawn and that the Referee's December 8, 1989 order

shall be reinstated. In addition, claimant agrees that his request for Board review shall be dismissed with prejudice.

We have approved the parties' agreement, thereby fully and finally resolving this matter, in lieu of our March 8, 1991 order. Accordingly, the request for review is dismissed with prejudice.

IT IS SO ORDERED.

March 29, 1991 Cite as 43 Van Natta 679 (1991)

In the Matter of the Compensation of
KATHY K. MASON, Claimant
WCB Case No. 88-20177
ORDER ON REVIEW
Parker & Bush, Claimant Attorneys
Edward Olson, Defense Attorney

Reviewed by Board Members Cushing and Myers.

The self-insured employer requests review of Referee Schultz's order that: (1) set aside its November 11, 1988 denial of claimant's July 1988 aggravation claim; (2) set aside the July 24, 1988 Notice of Closure and February 24, 1989 Determination Order as premature; and (3) awarded claimant temporary total disability benefits from October 1981 through September 1983. On review, the issues are aggravation, premature claim closure, temporary total disability and, alternatively, permanent partial disability. We vacate the aggravation issue as moot, vacate the premature claim closure as not properly before the Referee, affirm the award of temporary total disability and rate claimant's permanent disability.

FINDINGS OF FACT

Claimant, a sewing machine operator, experienced pain in her right hip in early 1980. She attributed the pain to difficulties in operating a defective sewing machine and reported the pain to her employer. She did not, however, seek any medical treatment for the pain or file a claim for compensation for the hip condition at that time.

In September 1980, claimant sustained a compensable low back injury when a furniture frame fell on her. The low back injury was accepted and closed in February 1981 with an award of medical benefits and temporary disability.

Thereafter, claimant continued to treat with Dr. Feinberg, a chiropractor. In 1982, he reported that claimant's back injury had resolved but that she needed additional care for her right hip. The employer refused to pay for further treatment, and that issue was litigated before Referee Leahy in May 1983. He dismissed the claim, finding that, because claimant had never perfected a claim for the right hip condition, the employer had no duty to deny it.

Shortly after Referee Leahy's order had issued, claimant attempted to file a claim for the right hip condition. The employer denied the claim, and the issue of compensability was litigated before Referee Shebley on August 22, 1984. He found the hip claim barred by res judicata. The Court of Appeals, however, reversed that holding and remanded for determination on the issue of compensability. Calkins v. Westcraft Chair, Inc., 84 Or App 320 (1987).

Meanwhile, claimant had returned to work for a second employer. On April 6, 1987, she felt a "twinge" in her back while moving office furniture. She finished her shift without pain and went home. The next morning, however, she experienced severe pain in her low back and right hip and became emotionally distraught.

Claimant returned to Dr. Feinberg, who referred her to Kaiser's Industrial Medicine Clinic. An EMG and MRI proved normal. She also was seen by Dr. Tilden, a chiropractor, and the Western Medical Consultants. Medical reports indicated that she was suffering from hip pain of unknown etiology and from hysteria.

A hearing was held before Referee Shebley on January 29, 1988. Concerning the issue on remand, he concluded that the right hip condition was compensable and ordered the employer to accept the 1980 hip claim. Concerning the April 6, 1987 incident, he concluded that claimant had not sustained an aggravation or a new injury and, accordingly, upheld the employer's "de facto" denial of the aggravation claim as well as the second employer's denial of a "new injury" claim for the same condition. (Ex. 48).

Pursuant to the order, the employer accepted the 1980 hip claim and issued a Notice of Closure on July 14, 1988. It also issued a July 13, 1988 denial of the alleged 1987 aggravation. Claimant subsequently requested the issuance of a Determination Order and filed a request for hearing, raising the propriety of the July 13, 1988 denial, premature claim closure and the extent of permanent partial and temporary total disability.

Meanwhile, claimant had returned to work for a third employer. On July 12, 1988, she experienced a severe increase in symptoms after spending several days packing boxes to move. She consulted Dr. Quattlebaum, a chiropractor, who believed that claimant had aggravated her 1980 hip injury. He referred her to Dr. Ho, an osteopathic physician, who recommended and later performed trigger point injections and acupuncture.

On November 10, 1988, a Stipulated Order was approved in which the parties agreed: (1) that the July 13, 1988 denial was surplusage and moot because Referee Shebley had previously upheld the employer's "de facto" denial for the same alleged aggravation; (2) that the other issues raised in claimant's request for hearing were premature until a Determination Order was issued; (3) that the issue concerning the alleged July 1988 aggravation claim was premature and that the employer would process the claim according to law without prejudice to either party's rights; and (4) that claimant's request for hearing was moot. (Ex. 59).

On November 11, 1988, the employer denied the alleged July 1988 aggravation claim. (Ex. 61). It subsequently informed claimant that she was entitled to interim compensation from October 13, 1988 to November 11, 1988 and requested wage rate information. (Ex. 62).

In January 1989, claimant was examined by Dr. Cottrell and Dr. Bellville. Dr. Cottrell found a right low back strain, "possibly sacroiliac sprain" and recommended that she continue her treatment. (Ex. 60). Dr. Bellville, a psychiatrist, found that claimant had a histrionic personality that led her to exaggerate her symptoms, but believed that she had "real physical problems." (Ex. 60).

On January 16, 1989, Dr. Ho reported that he considered claimant to be medically stationary and that he was releasing her from further treatment. (Ex. 63A).

On February 1, 1989, the insurer filed a Form 1502, which indicated that claimant's July 1988 aggravation claim had been accepted and that temporary disability had been paid from October 13, 1988 to November 11, 1988. (Ex. 66). On February 2, 1989, the employer filed a Form 1503, which also indicated that the claim had been accepted and benefits had been paid. (Ex. 67).

A Determination Order was issued on February 24, 1989, which awarded temporary disability from August 23, 1988 to November 11, 1988 with no permanent disability. The determination order also found claimant to be medically stationary on January 16, 1989. (Ex. 68).

On May 30, 1989, Dr. Ho reported that he had instructed claimant to stop work because of hip pain she sustained in a potential aggravation in February 1989. At the time of the hearing, the employer had not formally accepted or denied this latest aggravation claim.

CONCLUSIONS OF LAW AND OPINION

July 1988 Aggravation

The Referee concluded that claimant had sustained a compensable aggravation of her 1980 compensable hip injury and, accordingly, set aside the employer's November 1988 denial. On review, we do not reach this issue because of our conclusion that the November 1988 denial has been rendered moot by the employer's subsequent course of conduct.

Shortly after claimant's 1980 hip claim was closed by a July 14, 1988 Notice of Closure, Dr. Ho submitted a report indicating the need of further medical treatment. Although the employer initially denied that aggravation claim, it subsequently filed 1502 and 1503 forms with the Compliance Section. Both forms indicated that the claim had been accepted; one requested that the claim be examined and further compensation, if any, be determined. Shortly thereafter, a Determination Order issued on February 24, 1989, awarding temporary disability benefits from August 23, 1988, the date Dr. Ho recommended further treatment, through November 11, 1988, the date claimant returned to work. That determination also indicated that claimant's five year aggravation rights ran from July 14, 1988, the closure date for her original 1980 hip injury.

On this record, we conclude that the employer's actions, when viewed as a whole, constitute a rescission of its earlier denial and an acceptance of the July 1988 aggravation. It reported that the claim had been accepted and requested a determination. When that determination issued, it did not challenge the payment of post-closure benefits and, presumably, paid them. On this record, we find that the employer's denial has been rendered moot. Thus, we need not address the merits of the claim.

Premature Closure

The Referee concluded that claimant became medically nonstationary on July 12, 1988 and, therefore, set aside the July 14, 1988 Notice of Closure and the February 24, 1989 Determination Order as premature.

While claimant initially raised the issue of premature claim closure in her request for hearing, her counsel did not raise the issue at hearing and, in the statement of services, indicated that that issue had been dropped. Under those circumstances, we conclude that claimant had waived the issue and, consequently, the Referee lacked authority to decide whether the closures were premature. See Theodore W. Lincicum, 40 Van Natta 1760 (1988), aff'd mem 100 Or App 100 (1989), but see Liberty Northwest v. Alonzo, 105 Or App 458 (1991).

Accordingly, we vacate that portion of the Referee's order that set aside the July 14, 1988 Notice of Closure and February 24, 1989 Determination Order as premature.

Temporary Disability

The Referee concluded that claimant was entitled to additional temporary disability from October 1981 through September 1983. We agree.

Whether a claimant is entitled to temporary total disability benefits depends on whether a preponderance of the evidence indicates that she was disabled during that time due to the compensable claim. Botefur v. City of Creswell, 84 Or App 627 (1987). A doctor's verification of an inability to work is certainly evidence of disability, but is is not necessarily the only relevant evidence. Garbutt v. SAIF, 297 Or 148 (1984).

In this case, claimant testified that, during late 1981 through 1983, she had limited ability to walk and was unable to work because of her pain. She indicated that her hip would "pop out" and that anything she did would aggravate it. The Referee, based on demeanor, found claimant's testimony credible. We defer to that finding. Humphrey v. SAIF, 58 Or App 360 (1982). Claimant's testimony is supported by the medical record. Dr. Feinberg, the treating chiropractor at the time in question, reported that claimant left her job with the employer due to "continued and increasing pain and irritation to the injured area." (Ex. 53A). He further reported that claimant was unable to return to work because of the stress to her low back and hip, and reported that she was temporary and totally disabled from October 1981 through September 1983.

After our review of the record, we find that a preponderance of the evidence indicates that claimant was disabled from October 1981 through September 1983 due to her compensable hip condition. Therefore, we conclude that claimant is entitled to temporary total disability benefits for that period.

Permanent Disability

The issue of permanent disability under the February 24, 1989 Determination Order was raised by claimant at hearing. The Referee did not address it, however, having found a premature closure. As we have reversed the Referee on the issue of premature closure, we must determine whether to rate claimant's disability at this time.

In Kociemba v. SAIF, 63 Or App 557 (1987), the court held that the extent of an injured worker's disability cannot be determined until she is medically stationary from all conditions resulting from the compensable injury. The Board has applied this rule where a worker was medically stationary at the time the claim was initially closed but, at the time of hearing, the claim was in open status or the worker was not medically stationary because of a subsequent compensable aggravation. See Raymond E. Pardee, 41 Van Natta 548 (1989); Teresa Skoyen, 39 Van Natta 462 (1987).

In this case, claimant sustained an alleged aggravation shortly after her claim was closed and, consequently, was not medically stationary at the time of hearing. However, as of the date of hearing, the employer had not formally accepted or denied the aggravation and, therefore, had not reopened her claim. Due to that fact, the parties did not address, nor did the Referee decide, the compensability of claimant's current condition. It is conceivable that claimant's current aggravation claim could be found, at some later time, to be noncompensable. Thus, if we abstain from rating claimant's disability at this time, claimant may be prohibited from ever raising the extent of her permanent

disability if, in fact, her claim is never reopened and the Determination Order becomes final by operation of law.

Thus, while a claimant's permanent disability is generally evaluated at the time of hearing, Gettman v. SAIF, 289 Or 609 (1980), we conclude that, under the circumstances, claimant is entitled to a rating of permanent disability as of the time immediately prior to the alleged aggravation. Cf. Tarna D. Palmer, 42 Van Natta 2088 (1990).

To establish the extent of claimant's permanent disability, we apply the standards as adopted by the Director of the Department of Insurance and Finance pursuant to ORS 656.726(3)(f). See ORS 656.283(7). Specifically, we apply former OAR 436-35-000 et seq, which were in effect at the time of the February 24, 1989 Determination Order and at the time immediately prior to the alleged aggravation.

In calculating the extent of claimant's disability, we rely on the independent medical examination performed by Dr. Cottrell. (Ex. 60). Based on that report, we find that claimant is entitled to an award of 8 percent loss of motion for a retained internal hip rotation of 10 degrees to the left, as well as the same award for a retained internal hip rotation of 10 degrees to the right. Former OAR 436-35-220(9). We also find that claimant retains 30 degrees external hip rotation to the right, for an award of 5 percent loss of motion, and 45 degrees external hip rotation to the left, for an award of 1.5 percent loss of motion. Former OAR 436-35-220(10).

We note that Dr. Cottrell also reported a loss of surface sensation on the leg. No award is warranted, however, as loss of surface sensation is not considered disabling. Former OAR 436-35-230(1). Nor is claimant entitled to an award for loss of strength, as there is no evidence that such loss is caused from spinal nerve damage. Former OAR 436-35-230(8).

Furthermore, after our review of the record, we conclude that claimant is not entitled to an additional award for disabling pain. Pain is considered to the extent that it results in measurable impairment. Former OAR 436-35-320(1). The record does not attribute measurable impairment to claimant's pain. Moreover, claimant testified that her condition had greatly improved during the period immediately prior to the alleged aggravation. In addition, Dr. Cottrell reported that claimant "did not complain of pain while sitting, standing, walking or running. Throughout the examination, she was largely free of pain." (Ex. 60-2).

The values for loss of motion are added for a total award of 22.5 percent scheduled permanent disability. That figure is rounded up to the next higher one percent step. Former OAR 436-35-010(6). Therefore, claimant's permanent disability under the standards is 23 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 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, (1987).

On this record, we do not find clear and convincing evidence that claimant's disability at the time immediately prior to the alleged aggravation is greater or less than indicated by the standards. See Thomas L. Swanger, 42 Van Natta 887 (1990).

ORDER

The Referee's order dated July 24, 1990, as amended August 3, 1990, is vacated in part, reversed in part, modified, and affirmed. That portion that set aside the insurer's denial of claimant's July 1988 aggravation claim is vacated. The Referee's $4,000 attorney fee award is reversed. That portion that set aside the July 14, 1988 Notice of Closure and February 24, 1989 Determination Order as premature is reversed. Claimant is awarded 23 percent (34.5 degrees) scheduled permanent disability for loss of motion of her hip. 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. The remainder of the Referee's order is affirmed.

March 29, 1991 Cite as 43 Van Natta 684 (1991)

In the Matter of the Compensation of
JAMES L. POPKEN (Deceased), Claimant
WCB Case No. TP-91003
THIRD PARTY DISTRIBUTION ORDER
Henderson, et al., Claimant Attorneys
Barbara Woodford, Defense Attorney

Donna Popken, the personal representative of the deceased worker's estate, (hereafter referred to as "claimant"), has petitioned the Board for resolution of a dispute concerning the "just and proper" distribution of proceeds from a third party settlement. ORS 656.593(3). Specifically, the dispute concerns whether the lien of Liberty Northwest Insurance Corporation, as a paying agency, for its claim costs extends to the decedent's minor children's shares of the third party settlement. We conclude that the children are beneficiaries under the Workers' Compensation Law and that Liberty Northwest's lien extends to their shares of the third party settlements.

FINDINGS OF FACT

In August 1986, the Deceased worker died, while performing his work activities, as a result of a motor vehicle accident. Decedent was survived by two minor children and his wife, who was appointed personal representative of his estate.

The decedent's death claim was accepted by Liberty Northwest, the paying agency. The surviving spouse is receiving monthly benefits of $749.88 per month. The spouse is also receiving $300 per month on behalf of the two children. To date, Liberty Northwest has provided $58,699.28 in survivor benefits.

Claimant, as the personal representative for the estate, retained legal counsel to pursue a third party action stemming from the fatal motor vehicle accident. Thereafter, the third party action was settled for $25,000.

After deducting claimant's 1/3 attorney fee ($8,333.34) and $779.73 in litigation expenses, a $15,886.93 balance remains. Following deduction of the beneficiaries' statutory 1/3 share ($5,295.64), Liberty Northwest asserts entitlement to the remaining balance of $10,591.29. Claimant rejects Liberty Northwest's proposed distribution, contending that its lien did not attach to the surviving children's shares.

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, or if death results from the injury, the other beneficiaries, 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 or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593(1). "Beneficiary" means an injured worker, and the husband, wife, child or dependent of a worker, who is entitled to receive payments under Chapter 656. ORS 656.005(2).

Here, the decedent's wife and their two minor children are beneficiaries under the workers' compensation statutes. ORS 656.005(2); Theresa J. Lester, 43 Van Natta 338 (1991). Consequently, they are entitled to receive workers' compensation benefits as a result of the decedent's death and their respective shares of the third party settlement proceeds are subject to Liberty Northwest's statutory lien. See Scarino v. SAIF, 91 Or App 350, 355, rev den 306 Or 660 (1988); Theresa J. Lester, supra.

Here, claimant contends that the minor children are not beneficiaries because their mother receives the survivor benefits. We disagree.

As children of the deceased worker, the two minor children are expressly included within the definition of beneficiary under ORS 656.005(2). As such, their share of any third party recovery is subject to a paying agency's lien. ORS 656.593(1).

The fact that the minor children are not directly receiving their survivor benefits does not alter our reasoning. The statutory scheme for death benefits clearly envisions that the surviving spouse shall receive the minor children's survivor benefits on their behalf. See ORS 656.204(2).

In conclusion, because the decedent's two minor children are beneficiaries under ORS Chapter 656, their respective shares of the third party settlement are also subject to Liberty Northwest's lien as a paying agency. Based on such reasoning, the $25,000 third party settlement shall be distributed in the following manner, which we find to be just and proper under ORS 656.593(3).

Settlement	$25,000.00
1/3 Attorney Fee	-$8,333.34
Litigation Expenses	- $779.73
Sub-total	$15,886.93
1/3 Statutory Share (Estate)	$ 5,295.64
Liberty Northwest's Share	$10,591.29

The parties are directed to apportion the settlement proceeds in a manner that will achieve this distribution.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM K. STARK, Claimant
WCB Case No. 90-03702
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Roderick Peters (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Tenenbaum's order which upheld the SAIF Corporation's denial of claimant's medical services claim for vitamin treatment for his compensable neck and low back injuries. On review, the issue is medical services.

The Board affirms and adopts the order of the Referee with the following comment. The Director acted within the delegated authority of former ORS 656.245(4) in promulgating OAR 436-10-040(7). Mary A. Thomas, 42 Van Natta 1538, 1539 (1990).

ORDER

The Referee's order dated July 18, 1990 is affirmed.

In the Matter of the Compensation of
THERON STIEHL, Claimant
WCB Case No. 89-10062
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

The SAIF Corporation requests review of those portions of Referee Mongrain's order that: (1) set aside its denial of claimant's medical services claim for injection treatment from a naturopathic physician; (2) assessed penalties and related attorney fees for SAIF's "de facto" denial of the injection treatment and SAIF's allegedly unreasonable failure to pay for that treatment; (3) awarded an $850 assessed fee for services rendered regarding the injection treatment; and (4) ordered SAIF to pay additional mileage reimbursement. On review, the issues are jurisdiction, medical services, penalties and attorney fees. We reverse in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

FINDINGS OF ULTIMATE FACT

SAIF underpaid claimant's mileage reimbursement in the amount of $258.81.

Dr. Kadish's injection treatment is outside the statutory treatment limitations for naturopathic physicians.

SAIF's failure to issue a formal response to claimant's surgery request was an unreasonable resistance to the payment of compensation.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The Referee ruled that because SAIF had challenged the propriety of Dr. Kadish's injection treatment pursuant to ORS 656.327, he lacked jurisdiction to decide the issue of whether such treatment was inappropriate. The Referee then found that the treatments were reasonable and necessary and held that SAIF is responsible for payment for the injection treatment.

ORS 656.327(1) provides:

> "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 the treatment by a medical panel, the injured worker, insurer, self-insured employer or director shall so notify the parties and the director. Within five days after such notice the director may authorize the establishment of a medical panel as provided in this section . . . ." (emphasis added).

Where a carrier requests a review under this provision and the Director accepts jurisdiction, the Director has sole jurisdiction over the matter, the carrier cannot deny the claim, and the claimant cannot request a hearing. See Lillie M. Willis, 42 Van Natta 1923 (1990).

While SAIF has requested review and the application of sanctions by the Director, there is no evidence that the Director has exercised his discretion under ORS 656.327(1) to review this case. Therefore, this matter is not held in abeyance and the Board retains jurisdiction over the medical services issue.

Compensability of Injection Treatment

An injured worker is entitled to all reasonable and necessary curative or palliative medical care required for a compensable injury. See ORS 656.245(1); West v. SAIF, 74 Or App 317, 320 (1985); Wetzel v. Goodwin Bros., 50 Or App 101 (1981); McGarry v. SAIF, 24 Or App 883, 888 (1976).

Here, claimant received "trigger point injections" in the joints of his fingers and wrist, and in a surgical scar. SAIF argues that claimant's injection treatments are not compensable under OAR 436-10-040(1) because they are unnecessary or inappropriate according to accepted professional standards. In particular, SAIF contends that the injections are inappropriate treatment under ORS 685.030, which establishes limitations on care provided by naturopaths. That provision reads in pertinent part:

> "Nothing in [Chapter 685] shall be construed to . .
> .
> "(4) Authorize the administration of any substance by the penetration of the skin or mucous membrane of the human body for a therapeutic purpose". (emphasis added).

We conclude that a medical service is not reasonable and necessary if it is not performed either by a physician practicing within the scope of the

physician's license, or pursuant to the supervision of one whose license authorizes him or her to perform such services. See e.g., Terrance A. Benboe, 42 Van Natta 298, 301 (1990).

The Oregon Board of Naturopathic Examiners has the authority to license doctors of naturopathy. ORS 685.110. In a June 5, 1986 letter to Dr. Kadish, the Naturopathic Examiners Board (NEB) stated that, after reviewing the technique of "trigger point injections," they found the practice to be within the scope of naturopathy. There is no evidence in this record as to whether the injections addressed in this letter were to be used for diagnostic, preventative or therapeutic purposes. The NEB subsequently informed SAIF that another naturopathic physician's injections were within the statutory limits because they were for diagnostic or preventative purposes. (Ex 6E).

On April 14, 1989, Dr. Norton, SAIF's medical advisor, opined that Dr. Kadish's treatments for claimant were not within the scope of the Naturopathic Practice Act because they were for therapeutic purposes. On April 25, 1989, SAIF requested that the NEB determine whether Dr. Kadish's injection treatments were within the scope of naturopathic practice. On August 15, 1989, the NEB reported that they had not completed their investigation of Dr. Kadish. The record is devoid of evidence whether the NEB subsequently determined that Dr. Kadish's injection treatments were within the scope of Dr. Kadish's licensure.

The chart notes of Dr. Kadish indicate the injections at issue here were given for therapeutic purposes after other types of treatments had been unsuccessful. Dr. Norton's report also supports the finding that this type of treatment was for therapeutic purposes. Treatment that is for therapeutic purposes and thus exceeds the statutory limits placed on a naturopath is not reasonable. To be compensable, medical services have to be both reasonable and necessary. Accordingly, the injection treatments are not compensable, and we reverse the Referee's ruling on this issue.

Penalties and Related Attorney Fees

Penalties and attorney fees may be assessed for an insurer's unreasonable refusal to pay compensation or unreasonable delay in accepting or denying a claim. ORS 656.262(10); ORS 656.382(1). Here, the Referee assessed a penalty and related attorney fee for SAIF's unreasonable resistance to the payment of Dr. Kadish's medical treatment and its untimely processing of the claim for that treatment. We disagree.

SAIF's failure to pay Dr. Kadish's billings was not unreasonable. In light of ORS 685.030(4), it had a legitimate doubt, from a legal standpoint, whether or not Dr. Kadish's injection treatments were reasonable and necessary. Norgard v. Rawlinsons, 30 Or App 999 (1977).

Nevertheless, SAIF had a duty to process the claim for the injection treatments in a timely manner. However, assuming that SAIF unreasonably delayed acceptance or denial of the claim, there are no "amounts due" against which to assess a penalty. ORS 656.262(10). Because the denied claims were not compensable, there was no compensation "then due." Ellis v. McCall Insulation, 308 Or 74 (1989). Furthermore, because the unpaid bills were not compensation, SAIF did not unreasonably resist the payment of compensation. An attorney fee is, therefore, not authorized under ORS 656.382. Ellis, supra; Lloyd L. Cripe, 41 Van Natta 1774 (1989).

Mileage Reimbursement

The Referee found that SAIF had paid claimant $2792.35 and, therefore, underpaid claimant's travel expenses by $243.35. On review, SAIF argues that it has overpaid claimant.

Exhibit 5 contains photocopies of the checks for travel expenses cashed by claimant. Three are duplicates. Adding these amounts to the $1,663.20 already paid equals $2,792.79. Exhibits 1, 4 and 5 show claimant's travel vouchers. Exhibit 1 duplicates vouchers in exhibit 4. Three dates in exhibits 4 and 5 are duplicated. Taking the duplicate vouchers into account, adding the mileage produces a total of 15,258 miles. At 20 cents per mile, this equals $3,051.60. Therefore, SAIF underpaid claimant $258.81, rather than $243.35. However, since claimant did not seek additional reimbursement, we will not disturb the Referee's award.

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 regarding the mileage reimbursement issue is $500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to this issue, as represented by claimant's respondent's brief, and the complexity of the issue.

ORDER

The Referee's order dated October 30, 1989, as amended November 21, 1989, is affirmed in part and reversed in part. The disputed injection treatments from claimant's naturopathic physician are not compensable. The Referee's $850 attorney fee award is reversed. The Referee's assessment of a penalty and associated attorney fee are reversed. The remainder of the order is affirmed. For services on review regarding the mileage reimbursement issue, claimant's attorney is awarded $500, to be paid by SAIF.

March 29, 1991 Cite as 43 Van Natta 689 (1991)

In the Matter of the Compensation of
EDWARD C. WINTERS, Claimant
WCB Case No. 89-05833
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
David Schieber (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Brown's order that: (1) upheld the SAIF Corporation's denial of his aggravation claim for a low back condition and a mental disorder; and (2) declined to award additional temporary disability compensation. On review, the issues are aggravation and temporary disability compensation.

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

The Referee found Dr. Henderson unpersuasive and concluded that claimant had not shown a change in his psychological condition since the last arrangement of compensation.

By Order on Review of July 9, 1990, we held claimant's psychological condition unrelated to his 1984 compensable injury. In the present case, claimant's treating psychiatrist, Dr. Henderson, initially opined that claimant's condition had worsened since October 1988. In a subsequent deposition, however, Dr. Henderson testified that a comparison of testing performed on June 30, 1988, and again on March 3, 1989, revealed that the level of claimant's psychological condition was not significantly changed. As Dr. Henderson's initial opinion is inconsistent with the diagnostic studies, we do not give it great weight. We rely on the opinion of independent examining psychiatrist Thompson, who opined that claimant's psychological condition had not worsened since the hearing of October 1988.

We conclude that claimant's psychological condition has not worsened since October 1988. As claimant's condition is unchanged it remains unrelated to his compensable injury and cannot be the basis of an aggravation claim. See Argonaut Ins. Co. v. Rush, 98 Or App 739 (1989). Accordingly, the Referee's order is affirmed.

ORDER

The Referee's order dated November 1, 1989 is affirmed.

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IN THE COURT OF APPEALS OF THE
STATE OF OREGON

STATE ACCIDENT INSURANCE FUND
CORPORATION,
Appellant,
v.
Alyson Marie MEREDITH,
aka Alyson Marie Taylor,
Respondent.

(88-CV-0035-TM; CA A61506)

Appeal from Circuit Court, Deschutes County.

Larry T. Coady, Judge pro tempore.

Argued and submitted April 2, 1990.

John A. Reuling, Jr., Assistant Attorney General, Salem, argued the cause for appellant. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

G. Kenneth Shiroishi, Portland, argued the cause for respondent. With him on the brief were Robert L. Nash and Dunn, Carney, Allen, Higgins & Tongue, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Reversed and remanded.

BUTTLER, P. J.

SAIF brought this action pursuant to ORS 656.591 as the assignee of an injured worker's third party tort action. As an affirmative defense, defendant contended that SAIF is not the real party in interest, because the injured worker's cause of action for personal injuries could not be assigned to it. The trial court agreed and dismissed the action. Because we conclude that the worker's cause of action could be assigned to SAIF under the Workers' Compensation Act, we reverse and remand.

The parties have stipulated to the material facts for the purposes of this appeal. The worker, Karen Hayes, suffered a compensable injury in the course of her employment with Tumalo Emporium. SAIF, the employer's workers' compensation insurance carrier, accepted the claim and paid Hayes benefits for time loss and medical services. Before the claim was closed, but not in the course of her employment, Hayes was involved in an automobile accident with a car driven by defendant. The accident did not cause new injuries to Hayes, but worsened her symptoms and prolonged her recovery from her employment-related injury. SAIF was required to pay Hayes additional workers' compensation benefits as a result of the accident, because the compensable injury was a material contributing cause of Hayes' additional disability and need for treatment. *Grable v. Weyerhaeuser Company,* 291 Or 387, 631 P2d 768 (1981).

Hayes accepted workers' compensation and assigned her cause of action against defendant to SAIF pursuant to ORS 656.591. SAIF brought this action in its name for general and special damages, including the amounts that it was obligated to pay Hayes as a result of the aggravation of her compensable injury. Although SAIF concedes that a cause of action for personal injuries is not assignable at common law, it contends that it is authorized to bring this action by ORS 656.591(1),[1] which permits an assignment to the paying

agency of a third party action that a worker is entitled to maintain pursuant to ORS 656.154.

ORS 656.154 provides:

> "If the injury to a worker is due to the negligence or wrong of a third person not in the same employ, the injured worker, or if death results from the injury, the spouse, children or other dependents, as the case may be, may elect to seek a remedy against such third person."

ORS 656.578 provides:

> "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 (other than those exempt from liability under ORS 656.018), entitling the worker under ORS 656.154 to seek a remedy* against such third person, such worker or, if death results from the injury, the other beneficiaries shall elect whether to recover damages from such employer or third person." (Emphasis supplied.)

Clearly, Hayes could have brought a tort action against defendant. The question is whether that would have been a "third party" action that she was entitled to maintain under ORS 656.154 and, therefore, subject to assignment under ORS 656.578 and ORS 656.591.

In *Wimer v. Miller,* 235 Or 25, 383 P2d 1005 (1963), the plaintiff sought to recover damages from the defendant, a physician, alleging that, while the plaintiff was under the defendant's care for a work-related injury to his wrist, the defendant negligently treated him, inflicting new injuries. The defendant contended that, because the new injuries were compensable and because the plaintiff had elected to receive workers' compensation benefits for those injuries, he was barred from bringing a tort action against his physician for the aggravation of the original injury.

The court reasoned that the legislature intended, by enacting ORS 656.154,[2] to permit a worker who suffers a com-

[1] ORS 656.591(1) provides:

"An election made pursuant to ORS 656.578 not to proceed against the employer or third person operates as an assignment to the paying agency of the cause of action, if any, of the worker, the beneficiaries or legal representative of the deceased worker, against the employer or third person, and the paying agency may bring action against such employer or third person in the name of the injured worker or other beneficiaries."

The parties recognize that, if this cause of action is assignable, the complaint must be amended to show Hayes as the plaintiff. Defendant has abandoned the contention that SAIF is not the real party in interest.

[2] At the time, ORS 656.154 contained its present text and an additional sentence that exempted from its terms third persons "on premises over which he had joint supervision and control with the employer of the injured workman and was an employer subject to ORS 656.002 to 656.590." The defendant did not contend that he fell within the exemption.

pensable injury to bring a third party action against any person whose negligent or intentional conduct caused the injury if that person is not otherwise immune from liability under the Workers' Compensation Act. In reaching that conclusion, the court discussed the term "third party" as it is used in ORS 656.154(1). It stated the general maxim that, in the absence of a clear legislative intent to the contrary, the court is bound to give to the words of a statute their natural and ordinary meaning. *Wimer v. Miller, supra,* 235 Or at 30. It concluded that the term "third party" as used in ORS 656.154 has its usual meaning and, quoting *Industrial Commission v. Standard Insurance Co.,* 370 P2d 156 (Colo 1962), stated:

> "[The term 'third person'] applies to any one incurring a common law liability for injury to workmen not immune to suit under the Act." *Wimer v. Miller, supra,* 235 Or 32.

The court held that the defendant was a third party within the meaning of ORS 656.154 and that the plaintiff could maintain a third party action against him for the aggravation of his compensable injury.

As in *Wimer,* Hayes' condition following the accident was a compensable aggravation for which SAIF was responsible. Because it was allegedly caused by defendant's negligence and defendant is not immune from common law liability under the Workers' Compensation Act, Hayes was entitled to maintain an action against defendant. Her common law right to do so has been expressly reserved in ORS 656.154.[3] ORS 656.578 provides for the assignment of a cause of action for the negligence or wrong of a third person "entitling the worker under ORS 656.154 to seek a remedy." Because Hayes was entitled under ORS 656.154 to bring a common law action, SAIF is entitled to an assignment of that action pursuant to ORS 656.578.

Reversed and remanded.

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[3] As the Supreme Court stated in *Wimer:*

> "Although we have mentioned several sections of our Workmen's Compensation Act, we wish to make it clear that plaintiff did not derive the cause of action mentioned in his complaint from any provision of that act. His cause of action came to him from the common law, and our purpose in mentioning the Workmen's Compensation Act has been to show that * * * [our earlier decisions] no longer prevent an injured workman who is the victim of malpractice from enforcing his cause of action against the physician whose negligence injured him." 235 Or at 37.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Henry R. Borisoff, Claimant.

STATE ex rel Henry R. BORISOFF,
Appellant,

v.

WORKERS' COMPENSATION BOARD,
Respondent.

(88C-11352; CA A60630 (Control))

In the Matter of the Compensation of
Michael E. Pederson, Claimant.

STATE ex rel Michael E. PEDERSON,
Appellant,

v.

WORKERS' COMPENSATION BOARD,
Respondent.

(88C-11350; CA A60631)

Clyde BEAVERS,
Appellant,

v.

T. Lavere JOHNSON,
Evelyn Scott Ferris and Lynn-Marie Crider,
Respondents.

(88C-11323; CA A60632)
(Cases Consolidated)

Appeal from Circuit Court, Marion County.

Duane R. Ertsgaard, Judge.

Submitted on record and briefs September 24, 1990.

Donald D. Dartt, Portland, and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland, filed the briefs for appellants.

Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and Jas. Adams, Assistant Attorney General, Salem, filed the brief for respondents.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

ROSSMAN, J.

Affirmed.

ROSSMAN, J.

In these separate mandamus proceedings, relators, who are injured workers, sought to compel the Workers' Compensation Board to exercise its own motion jurisdiction to increase their permanent disability awards.[1] In each case, the trial court issued an alternative writ of mandamus but dismissed the writ after considering its merits. We consolidate the appeals for opinion and affirm the trial court.

Each relator suffered a compensable injury. After the expiration of his aggravation rights under ORS 656.273, each petitioned the Board to exercise its own motion jurisdiction and award him additional permanent disability benefits due to the worsening of his condition. In each case, the Board refused to consider the request and held that ORS 656.278 does not permit the Board to award permanent disability benefits on its own motion. The Board was correct.

As amended by the 1987 Legislature, ORS 656.278(1)(a) provides:

> "(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 the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the board[.]"

We held in *Independent Paper Stock v. Wincer,* 100 Or App 625, 788 P2d 466, *rev den* 310 Or 195 (1990), that, under the statute as amended, after January 1, 1988, the Board no longer has authority to award permanent partial disability benefits on its own motion. We adhere to that holding. We write only to address whether the statute as amended is unconstitutional.

Relators contend that, because it no longer permits own motion review of permanent disability, ORS 656.278 violates Article I, section 10, of the Oregon Constitution.[2] Their argument is premised on the theory that own motion jurisdiction is, in part, a right provided to replace a common law remedy that existed before the Workers' Compensation Act and that to eliminate that right would deprive them of a remedy by due course of law. We note, however, that, when it had jurisdiction to entertain requests for an increase of an award of permanent disability, the Board did so in its own discretion. The worker was not entitled to be heard as a matter of right.

We have held in other contexts that the imposition of limitations on the bringing of a workers' compensation claim does not infringe a claimant's constitutional rights. In *Stone v. SAIF,* 57 Or App 808, 811, 646 P2d 668, *rev dismissed,* 294 Or 442 (1982), we held that the five-year limit on the filing of a claim for an asbestos-related occupational disease under *former* ORS 656.807(1) did not violate Article I, section 10. We stated, citing *Josephs v. Burns & Bear,* 260 Or 493, 503, 491 P2d 203 (1971), that it is a permissible legislative function "to balance the possibility of outlawing legitimate claims against

[1] No one suggests that this case is not a proper subject for mandamus. We note that none of the relators could have sought direct review of the Board's order, because the order neither diminished nor terminated a former award. ORS 656.278(3).

[2] Article I, section 10, provides, in part:

"[E]very man shall have remedy by due course of law for injury done him in his person, property, or reputation."

the public need that at some definite time there be an end to potential litigation." 57 Or App at 811. Similarly, the legislature could legitimately decide that claims for permanent disability should not be subject to adjustment for more than five years after the last arrangement of compensation. The legislature has not violated relators' rights under Article I, section 10, by eliminating the Board's discretionary jurisdiction to modify permanent disability awards on its own motion.

Relators also contend that ORS 656.278 violates Article I, section 20, of the Oregon Constitution[3] and the Equal Protection Clause of the Fourteenth Amendment by giving the privilege to be heard by the Board to those whose requests for own motion relief were acted upon before January

1, 1988, and denying that privilege to those whose requests were not acted upon by that date.

Section 20 prohibits the granting of privileges to any "class" of citizens. A class is a group that exists by virtue of antecedent personal or social characteristics. *Hale v. Port of Portland,* 308 Or 508, 525, 783 P2d 506 (1989). A class defined only by the law in question is simply a natural result of lawmaking, for "every law itself can be said to 'classify' what it covers from what it excludes." *State v. Clark,* 291 Or 231, 240, 630 P2d 810, *cert den sub nom Clark v. Oregon,* 454 US 1084 (1981); *Atlantic Richfield Company v. Greene,* 100 Or App 16, 20, 784 P2d 442 (1989), *rev den* 309 Or 698 (1990). In this case, there is no identifiable class cognizable under section 20, because the "favored" class exists only by reference to the challenged law, *i.e.,* those workers whose request for own motion relief were considered by the Board before January 1, 1988, the effective date of the amendment to ORS 656.278. The statute treats all injured workers the same. It is not unconstitutional.[4]

Affirmed.

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[3] Article I, section 20, provides:

"No law shall be passed granting to any citizen or class of citizens privileges, or immunities, which, upon the same terms, shall not equally belong to all citizens."

[4] No separate argument is made under the Equal Protection Clause.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

Sandra L. HICKEY,
Personal Representative of the Estate
of Danny Michael Hickey, deceased,
Appellant,

v.

UNION PACIFIC RAILROAD COMPANY,
Umatilla County, Oregon, City of Hermiston,
and Public Utility Commissioner of the State of Oregon,
Respondents,

and

James E. DELP, Jr.,
dba Frank's Sewer Service,
Defendant.

(CV87-908; CA A51046)

Appeal from Circuit Court, Umatilla County.

Robert B. Abrams, Judge.

Argued and submitted February 12, 1990.

Garry L. Reynolds, Hermiston, argued the cause and filed the briefs for appellant.

Thomas W. Brown, Portland, argued the cause for respondent Union Pacific Railroad Company. With him on the brief was Cosgrave, Kester, Crowe, Gidley & Lagesen, Portland.

I. Franklin Hunsaker, Portland, argued the cause for respondents Umatilla County and City of Hermiston. With him on the brief were Douglas R. Andres, Lisa E. Lear and Bullivant, Houser, Bailey, Pendergrass & Hoffman, Portland.

Jas. Adams, Assistant Attorney General, Salem, argued the cause for respondent Public Utility Commissioner of the State of Oregon. With him on the brief were Dave Frohnmayer, Atrtorney General and Virginia L. Linder, Solicitor General, Salem.

DEITS, J.

Affirmed.

DEITS, J.

Plaintiff, as personal representative of the estate of her husband (decedent), seeks damages for his death against City of Hermiston (City), Umatilla County (County), the Public Utility Commissioner (PUC), Union Pacific Railroad

(Railroad) and James Delp.[1] The trial court dismissed with prejudice the claims against city, county and PUC on the ground that those defendants are immune from liability under ORS 30.265(3)(a), because the death was compensable under the Workers' Compensation Law. Plaintiff's claims against Railroad were tried to a jury, which returned a verdict for Railroad. Plaintiff appeals the dismissal of her claims against the public entities; she also appeals the judgment in favor of Railroad, arguing that the trial court erred in allowing evidence of PUC surveys and data. We affirm.

Decedent was employed as a warehouse foreman for the Church of Jesus Christ of Latter-day Saints. His scheduled work day was from 7:30 a.m. to 5 p.m. There were no scheduled swing, graveyard or weekend shifts at the warehouse. During his 10 months on the job, decedent had occasionally stayed late in order to complete his work. His wife testified that, on a few occasions, he had gone back to work after returning home. However, his supervisor had instructed him to do his work during regular hours whenever possible. While his supervisor was out of town, decedent had the authority to decide when it was necessary to work outside his regular hours. He usually drove across the South First Street railroad crossing on his way to and from work. Two trains regularly passed the crossing each day: one going north between 8 p.m. and 9:30 p.m. and one going south between 11 p.m. and 12:30 a.m.

On August 27, 1986, decedent worked his regular hours. He was supposed to have loaded a truck that had to leave at 4 the next morning. However, the driver arrived late and the truck was not ready to be loaded until 5 or 5:30 p.m. Decedent's supervisor was out of town, and he decided to go to a church meeting that he and his wife had planned on attending and then return to load the truck. He returned to work around 11 p.m. He completed the job and started home on his

motorcycle along his usual route. At approximately midnight, his motorcycle collided with the south bound train at the First Street crossing, and he was killed.

Plaintiff argues that the trial court erred in concluding that decedent's death was compensable under the Workers' Compensation Law and that, therefore, defendants City, County and PUC were immune from liability under ORS 30.265(3)(a).[2] We conclude that the death was compensable and that, accordingly, defendants City, County and PUC are immune.

A compensable injury or death is one "arising out of and in the course of employment." ORS 656.005(7)(a). As a general rule, injuries sustained by an employee going to or

[1] On plaintiff's motion, the claim against Delp was dismissed before trial.

[2] ORS 30.265(3)(a) provides:

"Every public body and its officers, employees and agents acting within the scope of their employment or duties, or while operating a motor vehicle in a ridesharing arrangement authorized under ORS 276.598, are immune from liability for:

"Any claim for injury to or death of any person covered by any workers' compensation law."

coming from work are not compensable under the Workers' Compensation Law. *Hendrickson v. Lewis,* 94 Or App 5, 8, 764 P2d 577 (1988). However, there is an exception to the "going and coming" rule if an injury or death occurs while an employee is on a "special errand" for the employer. *Philpott v. State Ind. Acc. Com.,* 234 Or 37, 41, 379 P2d 1010 (1963). This exception is explained by Larson:

> "When an employee, having identifiable time and space limits on his employment, makes an off-premises journey which would normally not be covered under the usual going and coming rule, the journey may be brought within the course of employment by the fact that the trouble and time of making the journey, or the special inconvenience, hazard, or urgency of making it in the particular circumstances, is itself sufficiently substantial to be viewed as an integral part of the service itself." 1 Larson, *Workmen's Compensation Law* 4-204, § 16.10 (1985). (Footnotes omitted.)

In *Davis v. SAIF,* 15 Or App 405, 515 P2d 1333 (1973), we discussed the application of the "special errand" exception. The claimant was injured in an auto accident on her way home after an office meeting that had required her to

work 43 minutes past her scheduled shift. We concluded that, generally, staying late or coming early to work does not take a claimant's regular commuting outside the general rule that it is not within the course and scope of employment for purposes of Workers' Compensation coverage. We recognized, however, that, if the change in work schedule made the journey between home and work substantially more inconvenient or hazardous, the special errand rule might apply. We concluded in *Davis* that the rule was not applicable to the facts of that case:

> "Here [the claimant] worked 43 minutes overtime. It was still afternoon and the public buses upon which she normally traveled were running at the regular, daily, half-hour intervals. Nothing in connection with her overtime work or her employment significantly altered the normal risk attendant upon her journey home." 15 Or App at 410.

Here, decedent did not simply leave work late or go to work early. He made an extra, late night trip to work. In the absence of his supervisor, he was authorized to determine when it was necessary to work outside his normal hours. He made the extra trip because the truck needed to be loaded for its departure the next morning. Because of personal commitments, he could not stay overtime and complete the required work. The trial court found that decedent's return to work occurred during darkness and at the only hours during which a train would pass over the crossing and that those facts "substantially increased and created a risk of injury over and above that which decedent normally bore going to and from work during his regular work hours." We agree that the late night trip was more hazardous than his normal trip home.

Plaintiff contends that, because decedent was performing his "usual work," the loading and unloading of trucks, his activities could not come within the special errand exception. However, under the exception, the work being performed need not be different from that usually done by the claimant. As the court said in *Baroid v. Workers' Comp. Appeals Bd.,* 121

Cal App 3d 558, 175 Cal Rptr 633 (1981), in discussing situations where the special errand rule was applicable:

> "In all of the foregoing cases the common thread is that something about the location of the work, the nature of the work, or the hour the work was performed deviated from that which was the customary, fixed or usual norm." 121 Cal App 3d at 569.

Here, it was unusual for decedent to work outside his normal working hours, in particular, to make a trip back to work after returning home. His wife testified that she only remembered him returning to work on a few occasions. We conclude that decedent's return to work at the late hour was a deviation from his customary work.

Plaintiff also contends that decedent's activities did not fall within the special errand exception, because he could have unloaded the truck right after work; instead, because of personal commitments, he had to return late at night to complete the work. However, the fact that he did not make the journey at the time most convenient to his employer does not take his activities out of the special errand exception. When a claimant's activity benefits both the employer and the claimant, it may still come within the special errand exception, if the primary benefit is to the employer. *See Hendrickson v. Lewis, supra,* 94 Or App at 8; *Gumbrecht v. SAIF,* 21 Or App 389, 392-93, 534 P2d 1189 (1975). 1 Larson, *supra,* § 4-208.39. Even though decedent, for personal reasons, returned to work after his church meeting rather than staying late, the extra trip was a special errand in the course of his employment. The primary benefit was to the employer, who needed the work done. The requirement that decedent work after hours was extraordinary in relation to his routine duties. Because he had no advance notice, returning rather than staying late was necessary. *See Green v. Workers' Comp. Appeals Bd.,* 187 Cal App 3d 1421, 232 Cal Rptr 465 (1986). The necessity of completing the work during off-duty hours is what distinguishes this case from *Runyan v. Pickerd,* 86 Or App 542, 547, 740 P2d 209 (1987), where the employee voluntarily returned to his place of work after hours to do work that could have been, and generally was, done during regular working hours. We hold that, because of the added hazard, the deviation from normal working hours, the lack of advance notice and primary benefit to employer, decedent's trip home was within the special errand rule and his injury was compensable under the Workers' Compensation Law.

Plaintiff's second assignment of error is that the trial court erred in allowing Railroad's witness, Riley, to testify about the likelihood of an accident at this crossing, using a diagnostic tool devised by PUC called "the Jaqua Formula."

Plaintiff argues that 23 USC § 409 prohibits the introduction of the formula in evidence.

23 USC § 409 proscribes evidence of

> "surveys * * * or data compiled for the purpose of identifying, evaluating, or planning the safety enhancement of * * * rail-

way-highway crossings, pursuant to sections 130 * * * and 152 of (Title 23) or for the purpose of developing any highway safety construction project which may be implemented utilizing Federal-aid highway funds * * *."

However, there is no indication in this record that the information used by Riley was compiled for any of the specific purposes covered by 23 USC § 409. He testified that the formula has been used by the state since 1968 to identify railroad crossings that are potentially dangerous and to rank each crossing on the basis of predicted accidents. He also testified that, according to the formula, the crossing ranked 500 to 600 out of approximately 1,500 crossings in the state. The data that he used in applying the formula was compiled by PUC in its routine periodic inspections of crossings and by Riley himself in preparing for his testimony. Accordingly, the trial court did not err in allowing Riley's testimony.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of John L. Katzenbach, Claimant.

BOISE CASCADE CORPORATION,
Petitioner,

v.

John L. KATZENBACH,
Respondent.

(85-14924; CA A62304 (Control), A62560)
(Cases Consolidated)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 18, 1990.

H. Scott Plouse, Medford, argued the cause and filed the brief for petitioner.

Robert L. Chapman, Medford, argued the cause and filed the brief for respondent.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.

Affirmed.

Warren, P. J., dissenting.

RIGGS, J.

Employer seeks review of an order of the Workers' Compensation Board on remand from the Supreme Court. *Boise Cascade Corp. v. Katzenbach,* 307 Or 391, 767 P2d 443 (1989). We review for substantial evidence and errors of law and affirm. *Armstrong v. Asten-Hill,* 90 Or App 200, 752 P2d 312 (1988).

Claimant was working on a green chain in June, 1985, when he suffered a nondisabling injury that was diagnosed as right wrist tendonitis. Employer accepted the claim, described on the notice of injury form as "right wrist strain." Claimant continued to have pain in his right wrist. Four months after the first report of injury, claimant's condition was diagnosed as avascular necrosis. Employer denied compensability of that condition, and claimant sought Board review of the denial.

The referee approved employer's denial of compensation for avascular necrosis; the Board reversed. Employer sought review, and we affirmed the Board's holding that the claim was compensable. The Supreme Court accepted review and remanded to the Board for it to consider whether employer's denial was the equivalent of a back up denial under *Bauman v. SAIF,* 295 Or 788, 670 P2d 1027 (1983), *Johnson v. Spectra Physics,* 303 Or 49, 733 P2d 1376 (1987), and *Georgia Pacific v. Piwowar,* 305 Or 494, 753 P2d 948 (1988). On remand, the Board concluded that the wrist strain and the avascular necrosis are two separate conditions and that *Bauman* and its progeny do not preclude denial of the necrosis claim after acceptance of the claim for wrist strain.

The Board then considered the compensability of the necrosis condition. The medical evidence was that necrosis is ordinarily caused by a traumatic injury. The Board determined that, because employer had accepted the wrist strain condition, it also had accepted the fact that an injury had occurred. It proceeded to decide only whether the accepted strain injury was the kind of occurrence that could cause necrosis.

Employer makes two assignments of error. First, it asserts that the Board erred in holding that acceptance of an occupational injury necessarily implies the acceptance of a specific traumatic incident. Second, it argues that, if the

Board's order is viewed as containing a finding that there was a specific traumatic incident, the finding is not supported by substantial evidence. Claimant responds, first, by arguing that, under *Georgia Pacific v. Piwowar, supra,* employer cannot deny the claim for necrosis, because it accepted the claim for wrist strain. Under *Bauman v. SAIF, supra,* he argues, employer cannot now argue that no injury in fact occurred. He further argues that there is substantial evidence to support the Board's finding that there was a work-related traumatic injury that was a material contributing cause of the condition.

The Board found that wrist strain and avascular necrosis are separate conditions. There is no challenge to that finding. Accordingly, claimant's reliance on *Georgia-Pacific v. Piwowar, supra,* is misplaced. The rule of *Piwowar* is that an employer who accepts compensability of a condition cannot deny compensability of the disease that causes that condition. Here, the strain and the necrosis are separate conditions. Employer's acceptance of the strain is not an acceptance of a claim for avascular necrosis.

Employer argues that the Board erred in failing to consider whether there actually was an injury. The Board stated:

> "In our view, the issue of whether claimant sustained an 'injury' was not before the Referee. That narrow factual question had been finally determined by the insurer's initial acceptance. * * * It is beyond dispute that the insurer accepted an 'injury' that occurred on 'June 11, 1985.' *Id.* If the insurer wished to litigate whether claimant, in fact, sustained an injury, it should have done so. It did not. We will not do indirectly, what the insurer declined to do directly.
>
> "In short, we conclude that the rule in *Bauman* narrowly operates to procedurally bar the insurer from retroactively denying its acceptance of an 'injury.' "

Claimant argues, in effect, that employer's acceptance of the wrist strain includes acceptance that there was a work-related injury. Therefore, he asserts, it cannot deny that a work-related injury in fact occurred that caused the separate condition, necrosis.

We agree. By accepting claimant's June 11, 1985, right wrist injury claim, employer necessarily agreed that a

traumatic event had happened. Employer cannot now challenge whether, in fact, an injury occurred. *See Crumley v. Combustion Engineering,* 92 Or App 439, 443, 758 P2d 878, *rev den* 307 Or 101 (1988). Consequently, when we turn to employer's second assignment of error, we conclude that there is substantial evidence to support the Board's finding that the June, 1985, traumatic injury is a material contributing cause of claimant's avascular necrosis.

Affirmed.

WARREN, J., dissenting.

I agree with the majority that employer's acceptance of the wrist strain was not acceptance of a claim for avascular necrosis. *Georgia Pacific v. Piwowar,* 305 Or 494, 753 P2d 948 (1988). The claim could be and was denied, and claimant had the burden to prove its compensability. He presented no evidence that a discrete traumatic event caused the necrosis.

His theory is that, because employer accepted the wrist strain, it cannot deny that there was a work-related injury. That far, he is correct. He also appears to contend, however, that, because there was an injury, there was a trauma as a matter of law. In that, he is mistaken. Although he is correct that employer cannot deny that there was an injury, that does not resolve the question of whether the injury was traumatic or, if it was, whether the trauma caused the necrosis condition.

The majority erroneously characterizes employer's acceptance of the wrist strain as an agreement "that a traumatic event had happened." 104 Or App at 735-36. Employer's acceptance of the strain condition is only a concession that a work-related injury occurred. An injury is not *necessarily* a "traumatic event." In *Valtinson v. SAIF,* 56 Or App 184, 187, 641 P2d 598 (1982), we explained that one of the distinctions between an on-the-job injury and an occupational disease is that an injury is "sudden in onset." "Sudden in onset" is not equated with instantaneous; it may occur during a discrete period of time. 56 Or App at 188; *accord: Donald Drake Co. v.*

Lundmark, 63 Or App 261, 663 P2d 1303 (1983), *rev den* 296 Or 350 (1984). By accepting a claim for a work-related *injury*, an employer does not necessarily agree that a *traumatic event* occurred.

The medical evidence is that avascular necrosis could be caused by trauma. The problem with the Board's order is that it equated the statutory term "injury" with the medical term "trauma." The Board did not decide whether the accepted injury was traumatically caused or whether, if so, trauma caused the separate necrotic condition. Those issues were not necessarily resolved by the employer's acceptance of the wrist strain. I would remand for findings on those issues.

Accordingly, I dissent.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Gloria A. Severson, Claimant.

SAIF CORPORATION and Oregon Health Sciences University, *Petitioners,*

v.

Gloria A. SEVERSON, *Respondent.*

(87-13614; CA A63131)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 29, 1990.

David L. Runner, Assistant Attorney General, Salem, argued the cause for petitioners. With him on the briefs were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Thomas Cary, Eugene, argued the cause for respondent. With him on the brief was Coons & Cole, P.C., Eugene.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Remanded with instructions to award attorney fees not to exceed $425; otherwise affirmed.

DEITS, J.

The Worker's Compensation Board awarded claimant insurer-paid attorney fees for legal services that she received during the Director's review of her vocational assistance claim. Petitioners contend that the Board erred in awarding fees.

Claimant was injured in 1984. SAIF accepted her claim, and she received an award of 45 percent unscheduled

permanent partial disability. In March, 1986, claimant, through her attorney, requested vocational assistance. SAIF decided that she had sufficient transferable skills to obtain suitable employment and developed a Direct Employment Plan (DEP) for her. She was assisted in her search for employment, but she did not find a job. The DEP ended in September, 1986. In December, 1986, her attorney asked SAIF to provide additional vocational assistance, specifically, an Authorized Training Plan (ATP). After consulting with its vocational assistance provider, SAIF refused.

Claimant, with the aid of counsel, then sought review by the Director under ORS 656.283(2). The Director decided that SAIF should provide claimant with an ATP and issued an order. The order did not award attorney fees. Claimant's attorney then filed a request for hearing on the issue of attorney fees under ORS 656.283(1). The referee found that SAIF's resistance to providing vocational rehabilitation was unreasonable and awarded attorney fees. SAIF sought Board review, and the Board affirmed.

SAIF argues that the Board lacked authority to award attorney fees for legal services provided during the Director's administrative review of the claim. It contends that ORS 656.283(2) governs all matters concerning vocational rehabilitation assistance and that, because the statute does not provide for an award of attorney fees, the Director lacks authority to grant them. SAIF further argues that the statute limits Board review to matters addressed in the Director's order and, because that order could not and did not address the issue of attorney fees, the Board lacks authority to do so.

ORS 656.283(1) provides that a party or the Director may request a hearing on any question concerning a workers' compensation claim. Both parties concede that the issue here

involved a worker's compensation claim. However, the legislature adopted ORS 656.283(2), which creates a separate, less adversarial procedure for vocational rehabilitation assistance.[1] That procedure requires a worker who is "dissatisfied with an action of the insurer or self-insured employer regarding vocational assistance" to seek review by the Director before requesting a hearing.[2]

[1] ORS 656.283(1) was amended to restrict Board review of decisions regarding vocational assistance in 1979. *See* Or Laws 1979, ch 839, § 7. The legislative history of that amendment confirms that its intent was that vocational assistance matters "should not be subject to the adversary process." *See* Minutes, Senate Committee on Labor, April 12, 1979, p 10 (statement of Senator Kulongoski); *see also* Minutes, April 3, 1979, p 7, April 5, 1979, pp 3-4, & Ex F, pp 7-9 (statements of Cliff Allison, Legal Counsel to Workers' Compensation Department); Minutes, House Committee on Labor, June 20, 1979, p 6 (statement of Roy Green, Director of Workers' Compensation Department). The amendment was based on a Workers' Compensation Board rule to the same effect: *former* OAR 436-61-060 (WCB Admin. Order 1-1976). *See* Minutes, Senate Committee on Labor, April 5, 1979, pp 3-4 & Ex F, pp 7-9 (statement of Cliff Allison).

[2] ORS 656.283(2) provides:

> "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. Such application must be made not later than the 60th day after the date the worker was notified of the action. The director shall complete the review within a reasonable time, unless the worker's dissatisfaction is otherwise resolved. The decision of the director may be modified only if it:
>
> "(a) Violates a statute or rule;
>
> "(b) Exceeds the statutory authority of the agency;
>
> "(c) Was made upon unlawful procedure; or
>
> "(d) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion."

We agree with SAIF that the Director does not have authority to award attorney fees. However, the Director's lack of authority does not preclude the Board from awarding fees. ORS 656.382(1) provides in part:

> "If an insurer or self-insured employer refuses to pay compensation due under an order of a referee, board or court, or otherwise unreasonably resists the payment of compensation, the employer or insurer shall pay to the claimant or the attorney of the claimant a reasonable attorney fee as provided in subsection (2) of this section * * *."

Although, under ORS 656.283(2), requests for vocational rehabilitation assistance are handled initially in an informal administrative process, nothing in that statute takes away the

authority of the Board to award attorney fees under ORS 656.382(1). The question of whether claimant is entitled to attorney fees is a matter concerning a claim that is within the Board's jurisdiction.

SAIF contends that allowing fees for attorney involvement in the administrative review process for vocational rehabilitation matters is contrary to the legislative purpose in adopting the process and will interfere with its effectiveness. In the construction of statutes, however, we may not ignore what has been provided or insert what has been omitted. ORS 174.010; *State ex rel Cox v. Wilson,* 277 Or 247, 252, 562 P2d 172 (1977). If the legislature intended to preclude the award of attorney fees in these circumstances, it needed to say so. We hold that the Board was authorized to award attorney fees.

Petitioner also argues that the Board erred in concluding that its refusal to authorize a training program for claimant was unreasonable. Our standard of review is explained in *Brown v. Argonaut Insurance Company,* 93 Or App 588, 591, 763 P2d 408 (1988):

> "Whether a denial or delay is unreasonable involves both legal and factual questions. We review for errors of law in examining whether the Board applied the correct legal standard. ORS 183.482(8)(a). That standard is whether, from a legal standpoint, [insurer] had a legitimate doubt as to its liability. If so, the denial was not unreasonable. *Norgard v. Rawlinsons,* 30 Or App 999, 1003, 569 P2d 49 (1977). 'Unreasonableness' and legitimate doubt are to be considered in the light of all the evidence available to the insurer. *See Finter v. Woodburn United Methodist Church,* 62 Or App 118, 122, 659 P2d 434 (1983).
>
> "Using the legal standard, the Board makes a factual finding about reasonableness. *See Lester v. Weyerhaeuser Co.,* 70 Or App 307, 311, 689 P2d 342, *rev den* 298 Or 427 (1984). We review that finding for substantial evidence. ORS 183.482(8)(c); *see also Williams v. SAIF,* 31 Or App 1301, 1305, 572 P2d 658 (1977)."

The Board did apply the correct legal standard. The Director's decision was not appealed, so the Board was only reviewing the referee's award of attorney fees to determine if SAIF had a legitimate doubt as to its liability. The Board noted that the objectives of vocational assistance are "to return the worker to employment which is as close as possible to the worker's regular employment at a wage as close as

possible to the worker's wage at the time of injury." *Former* ORS 656.340(6). It recognized that an employer must provide a DEP if it finds direct employment services to be necessary for the worker to achieve an earlier return to work or to obtain suitable employment, which means employment for which the worker has the necessary knowledge, skills and abilities and that provides a wage as close as possible to the wage then being paid for the kind of employment that the worker held when injured. *Former* OAR 436-120-100(1). Finally, the Board noted that an ATP must be provided if the DEP is not sufficient for the worker to obtain suitable employment for reasons other than the condition of the labor market, *former* OAR 436-120-120(1)(a), and concluded that SAIF did not have a legitimate basis for refusing to refer claimant for vocational training.

SAIF contends that the Board's conclusion that the refusal was unreasonable is not supported by substantial evidence. It contends that it had a legitimate doubt, because it relied on the opinions of a vocational assistance provider and a vocational evaluator. However, the Board found:

> "We are persuaded that the vocations identified for the DEP were not suitable. They were not of the kind for which claimant has the necessary knowledge, skills and abilities. They all require considerable clerical skills and/or public contact. Claimant is not competitive in clerical work, because she acquired her clerical training over 30 years ago and has not worked in that field since then. She failed the state clerical examination and was not qualified for positions to which she was referred by her vocational counselor. Moreover, although claimant has prior work experience involving public contact, her lack of public contact skills is well documented in the vocational reports. Her vocational counselor made numerous reference to claimant's poor physical appearance, grooming and personal hygiene. Indeed, the counselor later recommended closure of claimant's vocational file, describing her appearance as a 'detriment' to her reemployment.
>
> "Furthermore, the vocations identified for the DEP did not provide starting wages comparable to the wage currently being provided for claimant's employment at injury, *i.e.*, custodial worker. Those vocations offer starting wages ranging from $3.35 to $4.26. That is far lower than the $7.09 hourly wage that claimant could be earning as a custodial worker.
>
> "Because the DEP was inadequate to return claimant to suitable employment, SAIF should have referred claimant for vocational training. *See former* OAR 436-120-120(1)(a)."

We conclude that there is substantial evidence to support the conclusion that SAIF was unreasonable in not providing more training.

SAIF also argues that the Board erred in allowing $500 in attorney fees rather than $425. Claimant requested "$425+" in her statement of services. The referee awarded $500 in its original order and $425 in another order eleven days later. The Board ordered $500. The Board abused its discretion in awarding attorney fees greater than claimed by claimant's attorney. *See* ORS 656.388; OAR 438-15-010(5).[3]

Remanded with instructions to award attorney fees not to exceed $425: otherwise affirmed.

[3] OAR 438-15-010(5) provides:

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

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Robert R. Brown, Claimant.

Robert R. BROWN,
Petitioner,

v.

LIBERTY NORTHWEST INSURANCE CO.,
and Parr Lumber Co.,
Respondents.

(88-15039; CA A64644)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 14, 1990.

Cynthia L. Barrett, Portland, argued the cause and filed the brief for petitioner.

Janet C. Knapp, Portland, argued the cause for respondents. With her on the brief were Ronald W. Atwood and Williams, Zografos & Peck, P.C., Portland.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

EDMONDS, J.

Affirmed.

EDMONDS, J.

Claimant seeks review of an order of the Workers' Compensation Board denying compensation for his injury. He argues that the Board erred in concluding that his injury was not work-related. ORS 656.005(7)(a).[1] We affirm.

The Board found that claimant, a retail sales representative at a lumber yard, went to the lumberyard to check on a customer's order. While he was there, another co-worker threw a glove at him, and he tossed it back. Claimant began to run toward a pile of lumber, and the co-worker ran after him. Claimant and his co-worker became entangled while jumping over a pile of lumber and fell. Later, they admitted that they had been "horsing around." Claimant injured his left knee in the fall, and he applied for workers' compensation benefits.

[1] ORS 656.005(7)(a) provides:

"A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means. However, 'compensable injury' does not include:

"(A) Injury to any active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties; or

"(B) Injury incurred while engaging in or performing, or as the result of engaging in or performing, any recreational or social activities solely for the worker's personal pleasure."

His claim was denied. The Board found that employer was actively engaged in a program to keep horseplay activity under control and had not acquiesced in the horseplay. It held that there was no causal relationship between claimant's injury and a risk connected with his employment, and so it concluded that his injury did not arise out of or in the course and scope of his employment.

Claimant relies on *Stark v. State Industrial Acc. Com.*, 103 Or 80, 204 P 151 (1922), and *SAIF v. Noffsinger*, 80 Or App 640, 723 P2d 358, *rev den* 302 Or 342 (1986). He does not argue that there was not substantial evidence to support the Board's findings. Instead, he argues that injuries that result from horseplay are always compensable, because horseplay in the workplace is so commonplace that "it is automatically within the scope of employment."

In *Rogers v. SAIF*, 289 Or 633, 616 P2d 485 (1980), the court said:

> " 'The statutory phrase "arising out of and in the course of employment" must be applied in each case so as to best effectuate the socio-economic purpose of the Worker's Compensation Act: the financial protection of the worker and his/her family from poverty due to injury incurred in production, regardless of fault, as an inherent cost of the product to the consumer. 1 Larson, Workmen's Compensation Law § 2.20. Various concepts have arisen from attempts to rationalize that purpose, e.g., the going and coming rule, special errands, lunch hour cases, dual purpose trips, impedimenta of employment, horseplay, etc. Each is helpful for conceptualization and indexing, but there is no formula for decision. *Etchison v. SAIF*, 8 Or App 395, 398, 494 P2d 455 (1972). Rather, in each case, every pertinent factor must be considered as a part of the whole. It is the basic purpose of the Act which gives weight to particular facts and direction to the analysis of whether an injury arises out of and in the course of employment.' " 289 Or at 643, quoting with approval *Allen v. SAIF*, 29 Or App 631, 633, 564 P2d 1086, *rev den* 280 Or 1 (1977).

Thus, it is clear that injuries resulting from horseplay are not "always" compensable. An employer is not liable for any and all injuries to its employees regardless of the cause. A claimant must show a causal link between the occurrence of the injury and a risk connected with his or her employment. *Phil A. Livesley Co. v. Russ*, 296 Or 25, 29, 672 P2d 337 (1983).

Both *Stark v. State Industrial Acc. Com., supra*, and *SAIF v. Noffsinger, supra*, are not to the contrary. In *Stark*, the claimant had been scuffling with another employee and was fatally injured when he stumbled while holding an air hose. The court examined the working conditions under which the claimant was injured, including the fact that horseplay was customary and did not violate any company rules. 103 Or at 98. The court said:

> "There must be a causal connection between the employment and the injury and the injury must be the rational consequence of some hazard connected with the employment." 103 Or at 94.

The court concluded that, under the facts, the accident arose out of and in the course of employment and was compensable.

In *Noffsinger*, the issue was whether the claimant's

depression, which arose from job pressures and harassment and horseplay by his co-workers, was an occupational disease. We considered the actual conditions of the claimant's job and noted that, when claimant asked his supervisor to put a stop to the horseplay and harassment, the supervisor denied that they had occurred. We concluded:

> "The horseplay and harassment by the claimant's fellow employes were sufficiently work-connected that any illness that arose therefrom could be considered to have arisen out and in the scope of claimant's employment within the meaning of [*former*] ORS 656.802(1)(a)." 80 Or App at 648.

Because injuries arising from horseplay are not work-related as a matter of law, and claimant does not challenge the sufficiency of evidence to support the Board's conclusion that the incident in which claimant was injured was not work-related, the Board did not err in concluding that claimant's injury was not compensable.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Dick L. Barnett, Claimant.

Dick L. BARNETT,
Petitioner,

v.

EBI COMPANIES
and Capitol Chevrolet Cadillac,
Respondents.

(85-16010; CA A62112)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 8, 1990.

Quintin B. Estell, Salem, argued the cause and filed the brief for petitioner.

Mildred J. Carmack, Portland, argued the cause for respondents. With her on the brief was Schwabe, Williamson & Wyatt, Portland.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

ROSSMAN, J.

Affirmed.

ROSSMAN, J.

Claimant seeks review of a Workers' Compensation Board order reversing the referee and holding that he did not have a compensable worsening of his work-related injury.

Claimant suffered an injury to his right elbow in September, 1981, while working for employer as a mechanic. Employer accepted the claim as an injury to the arm. Dr. Blake diagnosed "hyperextension injury." Blake later reported that claimant had severe degenerative joint disease of the elbow as a result of the injury. In April, 1982, Blake reported that claimant had told him that he had seen Dr. Winkler, who had told him that his X-rays showed a fracture in the elbow region. Blake reported that he had examined the X-rays and had seen "an osteophyte or irregularity of the radian neck probably from an old fracture." Claimant received an award of 5% permanent partial disability in a June 10, 1982, determination order. By stipulation, the award was increased to 15% permanent partial disability in December, 1982.

Claimant's joint disease worsened and, in July, 1985, he filed an aggravation claim for the elbow. Employer neither accepted nor denied the claim. In November, 1986, Blake reported that the last time he had seen claimant, in July, 1985, he had believed that the degenerative problem had been caused by the 1981 injury. Dr. Hardiman examined claimant in January, 1987, and found advanced degenerative changes in the right elbow. On the basis of a history provided by claimant that he had fractured his elbow in the 1981 incident, Hardiman diagnosed post traumatic degenerative osteoarthritis and concluded that it had resulted from the 1981 injury.

In July, 1987, without having seen claimant since 1985, Blake changed his opinion and reported that claimant's 1981 injury had caused only a temporary worsening of a preexisting condition. He testified in a deposition that he did not believe that the 1981 injury involved a fracture; rather, he believed that the fracture and the degenerative disease had preexisted the injury. The referee, relying on Hardiman's opinion, ordered employer to accept the claim. The Board reversed the referee and reinstated employer's denial. It held that, in view of Blake's having changed his opinion, it could not accept his original opinion that the present degenerative

condition is work related. It held, further, that the record did not show that claimant had experienced a fracture at the time of the 1981 injury and that it could not, therefore, accept Hardiman's opinion that the elbow condition, which allegedly resulted from the fracture, is related to the employment.

Claimant argues that employer, having accepted the original claim and awarded benefits for permanent disability, cannot now contend that claimant's degenerative condition pre-existed the industrial injury and is not compensable. Contrary to claimant's contention, however, employer is not attempting to relitigate the compensability of the original injury. Employer accepted an injury to the arm. It is only contending that the present degenerative condition is not related to the injury. It may do that. In order to recover benefits for a worsening of his degenerative condition, claimant must prove that the worsening is related to the compensable injury. *Smith v. SAIF*, 302 Or 396, 399, 730 P2d 30 (1986). There is substantial evidence to support the Board's findings that both the fracture and the degenerative condition preexisted the injury.

Affirmed.

No. 8 January 9, 1991 167

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Reubin B. Coleman, Claimant.

PACCAR-WAGNER MINING,
Petitioner - Cross-Respondent,

v.

Reubin B. COLEMAN,
Respondent - Cross-Petitioner.

(88-02573; CA A63383)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 2, 1990.

G. Joseph Gorciak, Portland, argued the cause for petitioner - cross-respondent. With him on the briefs were Scott H. Terrall and Terrall & Miller, Portland.

Daina Upite, Portland, argued the cause for respondent - cross-petitioner. With her on the brief was Royce, Swanson & Thomas, Portland.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

PER CURIAM

Affirmed on petition; reversed on cross-petition and remanded for reconsideration of attorney fees. *Diamond Fruit Growers v. Davies,* 103 Or App 280, 796 P2d 1248 (1990).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Arthur N. Gwin, Claimant.

Arthur N. GWIN,
Petitioner,

v.

LIBERTY NORTHWEST
INSURANCE CORPORATION
and Jensen Drilling Co.,
Respondents.

(88-03491; CA A63116)

In Banc

Judicial Review from Workers' Compensation Board.

Argued and submitted July 25, 1990; resubmitted in banc December 12, 1990.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief was Philip H. Garrow, Bend.

Paul L. Roess, Portland, argued the cause for respondent. With him on the brief was Acker, Underwood, Norwood & Hiefield, Portland.

BUTTLER, J.

Affirmed.

De Muniz, J., dissenting.

BUTTLER, J.

Claimant seeks review of an order of the Workers' Compensation Board affirming the referee's decision that an injury that he suffered while travelling to his home from employer's work site is not compensable. We affirm.

We take the facts from the referee's findings that were adopted by the Board and are not challenged by claimant. Claimant, a driller, was on a six-month assignment at Bonneville Dam for his Eugene-based employer. On that assignment, as on others, he was dispatched from his home in Redmond and he travelled from his home directly to the job site. Generally, he worked a 40-hour week, four 10-hour days, and was not on call after the completion of his scheduled work. He was paid union scale; his hourly pay was determined on the basis of the distance of the job site from the nearest union hall, not, as claimant suggests, on the distance of the job site from his home. He was free to stay where he wished. Because of the distance from his home to the job site, claimant lived in his own trailer in a campground near the job site during the week and commuted home on weekends. Some workers commuted to and from their homes on a daily basis and were paid on the same basis as was claimant.

Because claimant was a senior driller, employer pro-

vided him with a company pickup truck for company business. The truck carried fuel to run equipment on the job, company-owned welding and safety equipment, large company-owned tools and parts and claimant's hand tools. Claimant was permitted to drive the truck to and from the job site, but could not use it at his home, except for company business. Employer paid for all insurance, gas, oil and maintenance. It did not pay claimant for his travel time. On a job such as this one, lasting six months, it would have been practical for claimant to bring his own car to the job site for personal use after work and to return home on weekends. Claimant, by his own choice, was driving employer's pickup toward his home for the weekend at the time of the injury in question.

Generally, under the "going and coming" rule, injuries sustained while travelling to and from work are not compensable. *See SAIF v. Reel,* 303 Or 210, 216, 735 P2d 364 (1987); *Nelson v. Douglas Fir Plywood Co.,* 260 Or 53, 488 P2d 795 (1971). There are some exceptions. For example, an injury

may become compensable if the claimant was a "travelling employee" exposed to additional hazards as a result of the travel that was required as a part of his employment. *SAIF v. Reel, supra,* 303 Or at 216. As the Supreme Court suggested in *Reel,* however, whether or not a case falls within the "travelling employee" rule, the underlying question to be answered is whether the injury arose out of and in the course of employment. The court stated:

> "The risk inherent in travel may arise out of the employment where such travel is a necessary incident of the employment. That is, when the travel is essentially part of the employment, the risk remains an incident to the employment even though the employe may not actually be working at the time of the injury." *SAIF v. Reel, supra,* 303 Or at 216.

Claimant would have us hold that, when a worker is required by the job to travel to a remote location, all travel necessitated by that location is a part of the risk of the employment. He asks us to adopt an exception to the "going and coming" rule for employees who live "unusual" distances from their jobs.

There is no doubt that employer derived some benefit from permitting claimant to drive the company pickup truck. For example, it was necessary that someone drive the truck with employer's equipment in it to the job site. If claimant had been injured while doing that, the injury would be compensable. The narrow issue here, however, is whether claimant's travel *home on weekends* was part of his employment. The referee and the Board found that, because the job was a 6-month assignment, it would have been practical for claimant to bring his own car to the job site for personal use and commuting. He does not dispute that. It was by his own choice that he was driving employer's pickup home when he was injured. Employer derived no benefit from permitting claimant to commute home on weekends in the company truck. The fact that claimant was provided with a truck for which employer paid expenses is not determinative. The question is whether the travel itself was a substantial part of the service performed. *See SAIF v. Reel, supra,* 303 Or at 316; 1 Larson,

Workers' Compensation Law § 16.32 (1990). Although the initial travel to the job site with the company truck was part of the service performed, weekend travel home was not for the benefit of employer.

There were other senior employees on the job who lived only a short distance from the job site and who commuted daily to and from work in a company truck. Claimant conceded at oral argument that, if one of those employees were injured while going to and from work, the injury would not be compensable. Apart from the distance, there is nothing to distinguish claimant's weekend commuting from that of any other driller.

The Board's conclusion that claimant's trip home was personal is supported by its findings, and it did not err in concluding that the injury is not compensable.

Affirmed.

DE MUNIZ, J., dissenting.

The ultimate inquiry is whether "the relationship between the injury and the employment [is] sufficient [so] that the injury should be compensable[.]" *Rogers v. SAIF,* 289 Or 633, 642, 616 P2d 485 (1980). In determining whether an injury is sufficiently work related, several factors are to be considered, including: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employee at the time of hiring or later; (3) whether the activity was an ordinary risk of, and incidental to, the employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed by or acquiesced in by the employer; and (7) whether the employee was on a personal mission of his own. No single factor is dispositive. *See Preston v. SAIF,* 88 Or App 327, 330, 745 P2d 783 (1987); *Mellis v. McEwen, Hanna, Gisvold,* 74 Or App 571, 575, 703 P2d 255, *rev den* 300 Or 249 (1985).

Job sites in the construction industry are not permanent. Skilled workers, such as claimant, do not normally live near employer's job sites. Claimant is dispatched by employer to jobs throughout Oregon, Washington and California. Accordingly, it is within the contemplation of employer that drillers will have to travel long distances to various jobs. Claimant's willingness to travel extended distances to employer's job sites is a benefit to employer.

The use of a company pickup to travel to and from the job site, although a benefit to claimant, is also a benefit to

employer. Claimant's use of the company pickup enables employer to make sure that he, as well as company equipment, parts and fuel for the equipment are efficiently transported to employer's remote job sites. Use of the company pickup was, therefore, an integral part of the work that claimant performed for employer.

In *I-L Logging Co. v. Mfgrs. & Whlse. Ind. Exc.,* 202 Or 277, 273 P2d 212, 275 P2d 226 (1954), the Supreme Court

indicated that an employment relationship may exist during travel to and from work if the employer provides transportation to the job or pays the travel costs between the worker's home and the job site:

> "An employer may agree, either expressly or impliedly, that the relationship between himself and his employe shall continue during the period of 'going to and coming from' the actual job site, in which case it is generally held that an accidental injury sustained by the employe while 'going or coming' is one that 'arises out of and in the course of the employment.' This is particularly true where, as here, the employer furnishes transportation to and from the work as a necessary part of the contract of employment. The same situation may arise when an employer, as a part of the contract of hire, pays the workman an extra sum of money to cover the cost of transportation, or where the employer compensates the employe for the period of time required in going to or from the work. Each case is decided upon its own facts. There is no fixed rule decisive of all cases." 202 Or at 326. (Citations omitted.)

Although claimant was not being paid a wage while travelling, employer was paying the cost of his travel to and from the job site by furnishing the pickup and paying all of the expenses associated with operation of the truck. That is no different than furnishing the cash equivalent of the value of the use of claimant's own vehicle. Under either circumstance, the employer has interested itself in the employee's transportation to and from work and is furnishing something of value, *i.e.*, compensation, to the employee for undertaking the trip. *See* 1 Larson, *Workmen's Compensation Law* 4-208.62 n 53, § 16.31 (1990). Employer's assignment of the company pickup to claimant and payment of all expenses associated with its operation is strong evidence that employer and claimant intended the employment relationship to continue while claimant was travelling to and from a job site.

In *SAIF v. Reel, supra,* the Supreme Court said:

> "The risk inherent in travel may arise out of the employment where such travel is a necessary incident of the employment. *That is, when the travel is essentially part of the employment, the risk remains an incident to the employment even though the employe may not actually be working at the time of the injury.*" 303 Or at 216. (Emphasis supplied.)

Considering all of the factors listed above, I would conclude that extended travel by claimant to and from employer's job site in the company pickup was an integral part of the employment relationship and a risk that should be borne by the employer in this case. I would hold that claimant's injury arose out of and in the course of his employment and, therefore, must respectfully dissent.

Rossman and Riggs, JJ., join in this dissent.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Masum J. Vijan, Claimant.
RAY SCHULTEN'S FORD
and EBI Companies,
Petitioners,
v.
Masum J. VIJAN,
Care Unit, Physicians & Surgeons Hospital
and GAB,
Respondents.
(87-12515, 88-03052; CA A63115)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 2, 1990.

Craig A. Staples, Portland, argued the cause for petitioners. With him on the brief was Roberts, Reinisch, Mackenzie, Healey & Wilson, P.C., Portland.

Daina Upite, Portland, argued the cause for respondent Masum J. Vijan. With her on the brief was Royce, Swanson & Thomas, Portland.

Marianne Bottini, Portland, argued the cause for respondents Care Unit, Physicians & Surgeons Hospital and GAB. With her on the brief was Bottini & Bottini, Portland.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

BUTTLER, P. J.

Award of attorney fees vacated; otherwise affirmed.

BUTTLER, P. J.

Ray Schulten's Ford (Schulten's) seeks review of an order of the Workers' Compensation Board holding that it, and not Care Unit, Physicians and Surgeons Hospital (Care Unit), is responsible for claimant's left ankle condition and awarding attorney fees to claimant for having succeeded in establishing that Schulten's is the responsible employer. We affirm on the question of responsibility and write only to address the question of attorney fees.

Claimant developed a compensable asthma condition while working for Schulten's. Subsequently, while working for Care Unit as a kitchen helper, he slipped and fell, injuring his left ankle. He filed a claim with Care Unit, which accepted it. He also pursued a claim against Schulten's, on the theory that the fall occurred when he temporarily lost consciousness while having an asthma attack. Schulten's denied responsibility for that claim.

Claimant sought a hearing. Pursuant to Schulten's request, Care Unit was joined in the hearing. The referee assigned responsibility to Schulten's, finding that claimant's fall was caused by the asthma condition, and ordered Schulten's to pay claimant's attorney fees. The Board affirmed and assessed an additional attorney fee under ORS 656.307(5). That section applies only to cases in which the director has designated a paying agent and has appointed a referee to arbitrate the dispute concerning responsibility. It has no application here. Neither does ORS 656.386(1),[1] which applies only when the claimant finally prevails on an appeal of a decision denying compensation. Here, Schulten's appealed the referee's decision *allowing* the claim.

The only possible authorization for an award of attorney fees is ORS 656.382(2):

> "If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, *and the referee, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced,* the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in an amount set by the referee, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal." (Emphasis supplied.)

We have held that, in order to recover attorney fees under that section, the claimant must have prevailed in a proceeding in which he risked the loss of or reduction in compensation. *Howard v. Willamete Poultry,* 101 Or App 584, 792 P2d 447 (1990); *Dilworth v. Weyerhaeuser Co.,* 95 Or App 85, 91, 767 P2d 484, *rev den* 307 Or 658 (1989). Although claimant participated in the proceedings below with the objective of holding Schulten's responsible for the claim and succeeded in that objective, neither employer ever contested the compensability of the claim. The right to, or amount of, compensation was not the subject of the proceeding. Care Unit had accepted the claim, and claimant had been paid. There was no risk that he would lose his right to compensation or that his compensation would be reduced if the Board determined that Care Unit, and not Schulten's, was responsible. Even though claimant had a legitimate interest in establishing a causal relationship between his asthma and the fall, an adverse determination of that question did not involve any risk of loss of, or diminution in, compensation for the injury. Claimant is not entitled to insurer-paid attorney fees.

Award of attorney fees vacated; otherwise affirmed.

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[1] ORS 656.386(1) provides:

> "In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee. In the event a dispute arises as to the amount allowed by the referee or board or appellate court, that amount shall be settled as provided for in ORS 656.388(2). Attorney fees provided for in this section shall be paid by the insurer or self-insured employer."

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Patrick R. Baur, Claimant.
MORELOCK WOOD PRODUCTS
and Liberty Northwest Insurance Corporation,
Petitioners,
v.
Patrick R. BAUR
and Bend Millworks,
Respondents.
(WCB 87-06646, 88-06417; CA A63679)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 3, 1990.

Paul L. Roess, Portland, argued the cause for petitioners. On the brief was Acker, Underwood, Norwood & Hiefield, Portland.

Warren John West, Bend, filed the brief for respondent Patrick R. Baur.

Craig A. Staples, Portland, argued the cause for respondent Bend Millworks. With him on the brief was Roberts, Reinisch & Klor, Portland.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

EDMONDS, J.

Affirmed.

EDMONDS, J.

Morelock Wood Products (Morelock) seeks judicial review of an order of the Workers' Compensation Board that assigned it responsibility for claimant's knee injury. We affirm.

In 1983, claimant injured his left knee while he was working as a press feeder for Bend Millworks. Dr. Carlson, an orthopedic surgeon, performed reconstructive surgery on the knee. Claimant was released to return to work and was awarded a 30% scheduled left knee disability benefit. In 1985, he started working as a forklift driver for Morelock. In late 1986, Morelock began processing pine products, which left a slippery residue on the plant floor, on which claimant fell numerous times. He noticed that his knee was less stable after each fall. Carlson examined him and diagnosed a possible tear of the meniscus. Claimant filed an aggravation claim related to his 1983 work injury at Bend Millworks.

Bend Millworks denied both compensability and responsibility. It moved to join Morelock and its insurer as necessary parties. On February 17, 1988, Morelock also denied

compensability and responsibility. On February 25, 1988, claimant's attorney sent a letter to the referee that had a copy of Morelock's denial attached to it. The letter said:

> "Now that I have received [the attached denial from Morelock], I am at a loss as to what claimant should be doing inasmuch as Morelock * * * is in this case based upon [Bend Millworks'] motion. Proceduraly [*sic*], I am in a quandary."

The referee never responded to the letter.

Morelock filed a response that denied that claimant had sustained a work-related accidental injury or occupational disease and denied that it was responsible. The response also said:

> "The amount of time required to present the employer's side of the case will be one hour. The employer demands copies of all medical reports and all other documents pertaining to this claim, whether or not claimant intends to rely on them *at hearing*." (Emphasis supplied.)

Morelock's attorney then wrote a letter to another referee, saying:

> "We enclose herewith copies of additional documents presumably relevant to the issues *raised by the Request for Hearing* filed with rgard [*sic*] to the referenced claim * * *." (Emphasis supplied.)

The Board issued a notice of hearing regarding the Bend Millworks and the Morelock claims, which said that the hearings in both cases had been consolidated. At the hearing, claimant's attorney orally requested a hearing regarding Morelock's denial letter. The referee issued an opinion and order in which he said that he had jurisdiction over the issues, because "claimant's February 25, 1988 letter constituted a Request for Hearing from the February 17, 1988 denial[.]" He upheld Bend Millwork's denial of claimant's aggravation claim,

> "[because] it was not until January 1987 that claimant's knee began to feel like jelly after numerous falls at work, [claimant had suffered a new injury as a result of] his numerous slips and falls at work with Morelock Wood Products which independently and materially contributed to his subsequent disability."

That opinion was based in part on Carlson's opinion that claimant had suffered a new injury rather than an aggravation of his 1983 injury.[1] The Board affirmed, concluding that claimant's February 25, 1988, letter constituted a request for hearing.

Morelock assigns error to the Board's determination that the February 25 letter was a request for a hearing under ORS 656.319(1). It argues that the issuance of an order of joinder does not eliminate the need for a claimant to file a request for hearing, that there was no request for a hearing and that there is not substantial evidence to support the Board's assignment of responsibility.

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[1] Carlson originally said that claimant had suffered an aggravation of his preexisting knee injury; however, he changed that opinion.

Under ORS 656.319(1), a referee has jurisdiction over a denial if a request for hearing is filed within 60 days after the denial was mailed, or within 180 days if good cause for the delay is shown. *See Giusti Wine Co. v. Adams,* 102 Or App 329, 332, 794 P2d 451 (1990). ORS 656.283(3) provides:

"A request for hearing may be made by any writing, signed by

or on behalf of the party and including the address of the party, *requesting the hearing, stating that a hearing is desired,* and mailed to the board." (Emphasis supplied.)

Although claimant did not expressly request a hearing in his February 25 letter, Morelock treated the letter as a request by indicating in the response that its denial was at issue and requesting production by claimant of medical records in preparation for hearing. It cannot now argue that there was no request.[2]

Morelock also asserts that the Board erred in assigning it responsibility for claimant's knee condition. Substantial evidence supports the Board's decision. ORS 656.298(6).

Affirmed.

[2] Claimant argues that he had good cause for making a delayed request for hearing under ORS 656.319(1). Given our conclusion that Morelock's response to claimant's letter was a recognition of a request for hearing, we do not address that argument.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Roger L. Snider, Claimant.

E.C.D., INC.
and Liberty Northwest Insurance Corporation,
Petitioners,

v.

Roger L. SNIDER,
Electronic Control Design
and Safeco Insurance Company,
Respondents.

(WCB Nos. 86-16046 and 87-01404; CA A64988)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 7, 1990.

Paul L. Roess, Portland, argued the cause for petitioners. With him on the brief was Acker, Underwood, Norwood & Hiefield, Portland.

Eveleen Henry, Eugene, argued the cause for respondent Roger L. Snider. With her on the brief were Karsten H. Rasmussen and Rasmussen & Henry, Eugene.

Paul Dakopolos, Salem, argued the cause for respondents Electronic Control Design and Safeco Insurance Company. On the brief were Susan G. Bischoff and Garrett, Seideman, Hemann & Robertson, P.C., Salem.

Before Richardson, Presiding Judge, and Joseph, Chief Judge, and Deits, Judge.

JOSEPH, C. J.

Petition for judicial review affirmed as to respondent Safeco; reversed and remanded for determination of Liberty Northwest Insurance Corporation's responsibility.

418 E.C.D., Inc. v. Snider

JOSEPH, C. J.

Liberty Northwest Insurance Corporation (Liberty), workers' compensation insurance carrier for employer E.C.D., Inc., seeks review of a decision of the Workers' Compensation Board's holding that it is responsible as a matter of law for claimant's low back condition. The only issue is whether Liberty is entitled to a factual determination of its responsibility for the claim.

Claimant injured his low back in 1985, when employer (then called Electronic Control Design) was insured by Safeco. In the course of resolving that claim, claimant and Safeco entered into a disputed claim settlement whereby, in exchange for payment of certain medical benefits and a lump sum, claimant agreed to give up any future rights he might have as to that claim.

Claimant injured his low back again in September, 1986, after Liberty had become the insurer for employer, which had become E.C.D., Inc. Liberty denied responsibility for the claim and asserted that Safeco was the responsible carrier; it requested the designation of a paying agent under ORS 656.307. Safeco denied compensability on the ground that it was barred by the disputed claim settlement. The denials were consolidated for hearing. Safeco moved to dismiss the request for hearing as to its denial; the referee granted the motion, which claimant did not oppose.[1] At the hearing between the parties, Liberty's attorney explained to the referee that Liberty was "not denying compensability, just responsibility."

The referee found that claimant had failed to establish that the September, 1986, incident independently contributed to his need for treatment or to his disability and held that Liberty was not responsible for the claim. On claimant's appeal, the Board reversed. It reasoned that, because Liberty had conceded compensability, the only issue at the hearing was responsibility. It said, further, that, when the only issue is responsibility, a claimant is entitled to compensation and the only issue is which insurer will pay. It held that, because Safeco had not remained in the proceeding, as required by

[1] Although Safeco is named as a respondent on review, no one challenges its dismissal from the hearing, and we therefore affirm the petition as to it.

Runft v. SAIF, 303 Or 493, 503, 739 P2d 12 (1987), Liberty could not contest responsibility alone and was responsible as a matter of law. The Board noted that Liberty could have argued that the claim was not compensable by Safeco by virtue of the disputed claim settlement. It did not decide whether, in fact, the September, 1986, injury independently contributed to claimant's condition so as to shift responsibility to Liberty.

The Board's reasoning is not persuasive. Safeco had been joined in the proceeding and was dismissed on its motion without objection from claimant. Liberty had satisfied its obligation under *Runft v. SAIF, supra.* It was not necessary for Liberty to contend that the claim was not compensable by Safeco in order to be able to make its argument concerning responsibility. The two issues are completely separate. Although, if Liberty prevails, the result is that claimant will receive no compensation, that is a consequence that he must be deemed to have accepted by having settled his rights as to Safeco. The Board should have made the determination whether the September, 1986, incident independently contributed to claimant's disability or his need for treatment and whether, as a fact, Liberty is responsible for the claim.

Petition for judicial review affirmed as to respondent Safeco; reversed and remanded for determination of Liberty Northwest Insurance Corporation's responsibility.

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458 February 6, 1991 No. 65

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Maria Alonzo, Claimant.

LIBERTY NORTHWEST INSURANCE CORPORATION and Agripac, Inc.,
Petitioners,

v.

Maria ALONZO,
Respondent.

(WCB 88-11045; CA A64186)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 19, 1990.

Stafford J. Hazelett, Portland, argued the cause and filed the brief for petitioners.

No appearance by respondent.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

WARREN, P. J.

Reversed and remanded for reconsideration.

WARREN, P. J.

Employer seeks review of a Workers' Compensation Board order denying an offset for overpayment of temporary disability benefits. We reverse and remand.

Claimant worked for employer as a seasonal worker. On October 10, 1987, she was struck on the back by a hydraulically operated door. Employer accepted her claim for that injury. She tried to return to work ten days later but was unable to do so because of her injury. She saw a chiropractor, who took her off work and began treating her for low back pain. The chiropractor treated claimant three times a week over the next four months, but her condition showed no improvement.

On February 22, 1988, claimant was examined by another chiropractor at employer's request. That chiropractor found that claimant's condition was normal and that there were no objective findings supporting claimant's subjective complaints. The chiropractor concluded that she was medically stationary and that further chiropractic treatments were not reasonable or necessary. Claimant had another examination on April 8, 1988, by an orthopedic surgeon, a neurologist and a chiropractor. The objective findings were again normal. Employer sent claimant a denial for ongoing chiropractic treatments on September 7, 1988. Claimant contested the denial and requested a hearing. On November 2, 1988, the referee affirmed the employer's denial and modified the award of temporary total disability, retroactively terminating it as of February 22, 1988. The referee made no mention of an offset for the overpayment.

Both parties appealed to the Board, and the Board affirmed the referee's order. The Board did not rule on employer's request to recover an overpayment, because the issue was not raised at the hearing. Employer contends both that the issue was raised in the pleadings and that, even if recovery of an overpayment was not raised, the Board could consider the overpayment request on its *de novo* review.

The record shows that employer raised the offset issue in its responses to issues before the hearing, requesting a return of an overpayment of $614.45. On remand, the Board is to determine whether employer is in fact entitled to an offset.

We need not decide if the Board could have decided the issue on *de novo* review under ORS 656.295(5) and (6) had the question not been raised below.

Reversed and remanded for reconsideration.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Forrest W. Bell, Claimant.
LIBERTY NORTHWEST
INSURANCE CORPORATION
and American Steel,
Petitioners,
v.
OREGON STEEL MILLS,
American Industries, Industrial Indemnity,
and Forrest W. Bell,
Respondents.
(88-08021, 88-08022, 88-08023,
88-08024; CA A64210)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 5, 1990.

Stafford J. Hazelett, Portland, argued the cause and filed the brief for petitioners.

John E. Snarskis, Portland, argued the cause and filed the brief for respondents Industrial Indemnity Company and American Industries.

Patric J. Doherty, Portland, waived appearance for respondent Oregon Steel Mills.

No appearance for respondent Forrest W. Bell.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

BUTTLER, P. J.

Affirmed.

BUTTLER, P. J.

American Steel seeks review of a decision of the Workers' Compensation Board affirming the decision of a referee, acting as an arbitrator pursuant to ORS 656.307, as amended by Oregon Laws 1987, chapter 713, section 5, holding that it is responsible for claimant's compensable cervical and shoulder injury.

Claimant injured his cervical spine in 1978 while working for Gilmore Steel, the predecessor to Oregon Steel Mills. His claim was accepted. Claimant again injured his cervical spine in May, 1982, while working for American Industries, and Industrial Indemnity, as American Industries' workers' compensation carrier, was assigned responsibility for the claim. On April 14, 1987, while working for American Steel, claimant sustained an injury to his neck and to his shoulder, and his claim was accepted as nondisabling. He continued to experience pain, and doctors later diagnosed a cervical disc herniation. He filed another claim; all three

employers denied responsibility, but conceded compensability. The Department of Insurance and Finance issued an order under ORS 656.307 designating a paying agent and referred the matter to an arbitrator.

The substance of the arbitrator's decision reads:

> "There is much conflicting medical evidence in the record. In consideration of the totality thereof and the lay testimony offered at the hearing, I find claimant's accepted compensable industrial injury of April 14, 1987, independently and materially contributed to cause claimant's current condition and disability and his need for treatment. I note somewhat parenthetically that the immediately above finding was reached after nearly finding I was unconvinced that any one employment was the more likely cause of claimant's disability, certainly the latter three of which were employments that may have caused it.
>
> *"CONCLUSIONS AND OPINION*
>
> "The Facts above reflect I was persuaded that claimant's disability was caused by successive work-related exposures and that the employment and injury of April 14, 1987, is the most likely cause of his disability. Therefore, liability must be placed upon American Steel/Liberty."

The Board and this court review the arbitrator's decision pursuant to ORS 656.307(2), for errors of law:

> "Review of the determination of the arbitrator by the board and by the Court of Appeals is limited to questions of law and is not thereafter subject to review by any other court or administrative body."

American Steel contends, relying on *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988), that the arbitrator's decision contains insufficient findings to determine whether the arbitrator applied the correct legal standard in shifting responsibility to American Steel when the weight of the medical evidence related claimant's condition to his 1982 injury, for which American Industries was responsible. The order is sufficient to permit our limited review under ORS 656.307(2).

Given the existence of multiple, accepted injuries to the cervical spine and the arbitrator's finding that the most recent accepted compensable injury in 1987 independently and materially contributed to cause claimant's current condition and disability and his need for treatment, the arbitrator applied the correct law in assigning responsibility to American Steel, claimant's employer at the time of that injury. *See Industrial Indemnity Co. v. Kearns*, 70 Or App 583, 690 P2d 1068 (1984); *see also Smith v. Ed's Pancake House*, 27 Or App 361, 556 P2d 158 (1976). We do not review the arbitrator's findings, as petitioner would have us do, to determine whether they are supported by substantial evidence.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Rick R. Pittman, Claimant.
NORTH AMERICAN VAN LINES,
and Crawford & Company,
Petitioners,
v.
Rick R. PITTMAN,
Lile International Company
and Liberty Northwest Insurance Company,
Respondents.
(88-13437; 88-08119; CA A65197)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 5, 1990.

Margaret H. Leek Leiberan, Portland, argued the cause for petitioners. With her on the brief were Leiberan & Gazeley, Portland, and Schuyler T. Wallace, Portland.

Stafford J. Hazelett, Portland, argued the cause and filed the brief for respondents Lile International Co. and Liberty Northwest Insurance Company.

Douglas S. Swanson, Portland, argued the cause for respondent Rick R. Pittman. With him on the brief were Geoffrey G. Wren and Royce, Swanson & Thomas, Portland.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

PER CURIAM

Affirmed.

PER CURIAM

North American Van Lines seeks review of a decision of the Workers' Compensation Board affirming the referee's decision that claimant was its employee, and not an independent contractor, when he was injured on September 18, 1987.

The Board, in affirming the referee, made these unchallenged findings:

> "[C]laimant was carrying out the duties of his job that were required under the contract with [Lile] International Company, which was the exclusive agent for North American Van Lines. The only reason the claimant was in Portland was at the direction of [Lile] International Company to bring the trailer there for repair. The mechanical problems with the trailer had necessitated the maintenance repairs on the tractor. The fact that [Lile] International Company owned the trailer and that claimant owned the tractor has very little relevance because claimant was obligated under his employment contract to perform maintenance duties involving the tractor and trailer regardless of ownership. The maintenance duties were required by the contract between claimant and

> [Lile] International Company and also by the contract between North American Van Lines and [Lile] International Company. The maintenance of the tractor and trailer is obviously to prevent accidents and to maintain timetables which ultimately are for the benefit of North American Van Lines. Here the claimant was a party to an express contract of hire for remuneration and was subject to the direction and control of his employer."

Additionally, the Board found, and North American Van Lines does not contest, that, in its denial of the claim, it acknowledged that it was claimant's employer. Those findings are based on substantial evidence in the record and support the Board's conclusion that claimant was North American Van Lines' employee.

Affirmed.

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16 February 20, 1991 No. 107

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Robert R. Elder, Claimant.

Robert R. ELDER,
Petitioner,

v.

ROSBORO LUMBER COMPANY and Liberty Northwest Insurance Corporation,
Respondents.

(87-15657; CA A64093)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 2, 1990.

James L. Edmunson, Eugene, argued the cause and filed the brief for petitioner.

David O. Wilson, Employers Defense Counsel, Eugene, argued the cause and filed the brief for respondents.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

BUTTLER, P. J.

Affirmed.

18 Elder v. Rosboro Lumber Co.

BUTTLER, P. J.

Claimant seeks review of a decision of the Workers' Compensation Board reversing the referee's decision that he is permanently and totally disabled.

Claimant has a seizure disorder as a result of brain surgery in 1982. Neither the disorder nor the surgery was job-related. In 1984, he suffered a compensable injury to his left knee and shoulder. In March, 1986, the parties stipulated to an award of 50 percent scheduled permanent partial disability for his knee and 5 percent for his shoulder. Employer later

reopened the claim to provide vocational services. Training went well until February, 1987, when claimant experienced a seizure that left him significantly impaired on his left side. The training program was terminated because of claimant's inability to perform.

The Board concluded that, in determining the extent of claimant's permanent disability for purposes of workers' compensation, the disabling effects of the seizure that occurred after, and was not related to, the November, 1984, compensable injury should not be considered, because they did not exist at the time of the injury. It held that claimant had failed to prove that he was permanently and totally disabled.

ORS 656.206 defines permanent total disability to mean "the loss, including *preexisting disability,* of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation." A disability is preexisting if it predates the injury. *Searles v. Johnston Cement,* 101 Or App 589, 792 P2d 449, *rev den* 310 Or 393 (1990); *Fowler v. SAIF,* 82 Or App 604, 729 P2d 9 (1986), *rev den* 303 Or 74 (1987); *Arndt v. National Appliance Co.,* 74 Or App 20, 701 P2d 474 (1985); *Emmons v. SAIF,* 34 Or App 603, 579 P2d 305 (1978).

Claimant would have us hold that, because he had a condition that was symptomatic but not disabling before the injury, that condition is a preexisting disability; therefore, he contends, a post-injury increase in disability resulting from a worsening of that condition should be considered in determining whether he is permanently and totally disabled. However,

the statute refers to preexisting *disability,* not preexisting condition. The disabling effects, if any, of claimant's seizure condition that preexisted the injury must be taken into account in determining whether he is permanently and totally disabled. However, any disability that developed as a result of the condition after the injury, but not as a result of the employment, may not be considered. *See Searles v. Johnston Cement, supra.*

In *Waremart, Inc. v. White,* 85 Or App 122, 735 P2d 1262 (1987), we held that the worker's noncompensable, preexisting neurological condition, which became symptomatic after the compensable injury, should be considered in determining whether she was permanently and totally disabled. There, however, the preexisting condition prevented the claimant from recovering from the physical effects of her compensable injury. The preexisting condition and the compensable condition were so intertwined that it was impossible to separate the two in determining the extent of disability. 85 Or App at 126 n 3; *see also Aquillon v. CNA Insurance,* 60 Or App 231, 653 P2d 264 (1982), *rev den* 294 Or 460 (1983).

Here, there is no claim that the preexisting condition interfered with claimant's physical recovery. The Board correctly held that the post-injury increase in disability caused by claimant's preexisting condition is not to be considered in determining whether he is permanently and totally disabled. His disability is to be evaluated as of the date immediately

preceding the worsening of his noncompensable seizure disorder. *Emmons v. SAIF, supra.*

However, a more difficult question arises because, solely as a result of his compensable injury, claimant had to be retrained in order to obtain gainful employment. In *Gettman v. SAIF,* 289 Or 609, 619 P2d 473 (1980), the Board had reduced the referee's award of permanent total disability because of the claimant's potential for retraining. The Supreme Court reversed, holding that the claimant's disability had to be evaluated as of the date of the hearing, without regard for his potential for retraining. Here, claimant was in the process of being retrained when his post-injury seizure rendered him unable to continue. Before that seizure occurred, claimant's rehabilitation consultant reported that he foresaw no barriers to continued employment after the training program was completed. In evaluating the extent of

claimant's disability, the Board assumed that, but for the intervening noncompensable disability, claimant would have completed the rehabilitation program and would have been employable.

We conclude that the Board was correct. To find claimant permanently and totally disabled because his noncompensable disability prevents his retraining would run head-on into the rule that noncompensable post-injury disabilities may not be considered in determining whether a claimant is permanently and totally disabled. We do not believe that either the Supreme Court in *Gettman* or the legislature intended claimant's proposed result. In *Gettman,* the claimant, who was 59, had been denied vocational assistance because of his age. The court was not faced with the circumstances here, where a post-injury noncompensable disability prevents retraining. Holding an employer responsible for permanent total disability in such a situation would be an unwarranted extension of the holding in *Gettman.* If claimant had been unable to complete his training as a result of a noncompensable automobile accident, surely employer should not bear the cost of the combined total disability. Neither should it here. *See Nyre v. F & R Leasing,* 106 Or App 74, ___ P2d ___ (1991).

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Keith L. Jegglie, Claimant.

FRERES LUMBER CO.,
Petitioner - Cross-Respondent,

v.

Keith L. JEGGLIE,
Respondent - Cross-Petitioner,

and

GREEN VENEER, INC.,
and Liberty Northwest Insurance,
Respondents - Cross-Respondents.

(87-10847 and 86-17048; CA A62643)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 28, 1990.

Jerald P. Keene, Portland, argued the cause for petitioner - cross-respondent. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Karen M. Werner, Eugene, argued the cause for respondent - cross-petitioner. With her on the brief were Richard T. Kropp and Emmons, Kropp, Kryger, Alexander & Egan, P.C., Albany.

Jerry K. Brown, McMinnville, argued the cause for respondents - cross-respondents. With him on the briefs were Cummins, Brown, Goodman, Fish & Peterson, P.C., McMinnville.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

ROSSMAN, J.

Affirmed on petition and on cross-petition.

ROSSMAN, J.

Freres Lumber Co. (Freres), a self-insured employer, petitions for review of a decision of the Workers' Compensation Board, holding it responsible for claimant's bilateral carpal tunnel syndrome. It assigns error to the Board's determination that claimant established good cause under ORS 656.319(1) for filing a late request for hearing after Freres denied his claim. Claimant cross-petitions, making arguments that are contingent on our reversal on the petition.

In 1984, while working for Green Veneer, claimant filed a claim for a bilateral carpal tunnel syndrome. Green Veneer accepted the claim, which was closed without an award of permanent disability. Claimant requested a hearing. On January 27, 1986, a referee awarded him 10 percent scheduled disability for each wrist.

In January, 1986, claimant began working for Freres. His symptoms worsened, and, in October, 1986, Dr. Hubbard recommended that he have surgery. Green Veneer denied the request for authorization for the surgery and also denied claimant's aggravation and medical treatment claims, contending that he had suffered a new injury or occupational disease at Freres. Green Veneer filed a motion requesting the designation of a paying agent under ORS 656.307, which was denied, because claimant had not filed a claim against Freres.

Subsequently, the Workers' Compensation Department advised that Freres' receipt of information from Green Veneer constituted notice of the claim. Freres knew by January 20, 1987, that claimant was represented by an attorney, but, when it denied the claim on February 12, 1987, it did not notify the attorney. Claimant's attorney did not have actual notice of the denial until July 14, 1987, and on that date he filed a request for hearing. Because the request was filed more than 60 but less than 180 days after the denial, the referee had jurisdiction over the request only if claimant established good cause for the delay. ORS 656.319(1)(b).

In holding that claimant had good cause for filing a late request for hearing, the referee relied in part on ORS 656.331, which provides that, if an injured worker is represented by an attorney and the attorney has given written notice of such representation, the insurer "shall not contact

the worker without giving prior or simultaneous written notice to the worker's attorney if the contact affects the denial, reduction or termination of the worker's benefits." The referee found that it was reasonable, in the light of the statute and "under the circumstances," for claimant to leave the legal pursuit of his claim to his attorney, noting that the attorney had been representing him against Green Veneer since December, 1986.

The Board affirmed and adopted the referee's order, and commented:

> "Recently, the Court of Appeals in *Cowart v. SAIF*, 94 Or App 288[, 765 P2d 226] (1988), held that a claimant who failed to file a timely hearing request on the basis that he thought the insurer had sent the denial letter to his attorney, when in fact it had not, constituted excusable neglect. [94 Or App] at 291. Concluding that excusable neglect is good cause under ORS 656.319(1)(b), the court held that claimant had established good cause for the untimely filing. *Id.*
>
> "Similarly, in the instant case, claimant's untimely filing was based on his inaccurate belief that Freres had sent a copy of its denial to his attorney. As in *Cowart, supra,* this constitutes excusable neglect which is good cause for an untimely request for hearing."

Freres contends that *Cowart* is distinguishable and that the Board should not have relied on it. We agree that *Cowart* is different from this case. There, the claimant's attorney had asked the insurer to mail him all documents related to the claim, and the insurer's actions had misled the claimant into believing that the insurer would notify his attorney of any significant matters concerning the claim. The Board found

that the claimant had failed to seek a hearing because he had advised his attorney to act on his behalf and had assumed, when he received a copy of SAIF's denial, that his attorney had also received a copy and had taken action as instructed. In fact, SAIF had not sent a copy of the denial to the claimant's attorney. We held that those facts constituted excusable neglect and good cause as a matter of law. *Cowart v. SAIF*, 94 Or App at 291.

Although the evidence in this case is different, it support's the Board's finding that, as in *Cowart*, claimant reasonably left the legal pursuit of his claim to his attorney. The evidence also supports the Board's finding that claimant's attorney did not have actual knowledge of the denial until July, 1987. We conclude that the Board's determination that those circumstances constitute good cause is consistent with ORS 656.319(1)(b) and the cases decided thereunder.

Because we affirm on the petition, we affirm on the cross-petition without discussion.

Affirmed on petition and on cross-petition.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

ACCIDENT PREVENTION DIVISION,
Respondent,
v.
ROSEBURG FOREST PRODUCTS,
Petitioner.

(SH-89107; CA A62768)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 8, 1990.

Kimberly D. Wallan, Medford, argued the cause for petitioner. With her on the brief was Cowling & Heysell, Medford.

Richard D. Wasserman, Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

DE MUNIZ, J.

Affirmed.

DE MUNIZ, J.

Employer seeks review of an order under the Oregon Safe Employment Act, ORS 654.001 to ORS 654.259; ORS 654.991, that affirmed a citation issued to it for violation of OAR 437-40-030(1). We affirm.

The citation arose from the on the job death of Pur-

cell at employer's complex in Dillard. In January, 1989, labor unions struck employer. Supervisory personnel, including Purcell, were assigned to fill in for striking workers. Purcell and two other supervisors, Horner and Dwight, worked together loading lumber on a forklift. On the afternoon of February 2, while Purcell was setting blocks, a load of lumber toppled from the forklift, crushing him.

The referee found that Purcell, Horner and Dwight had experience in the work that they were performing and were familiar with company safety procedures. She also found that Purcell had previously trained and supervised forklift drivers and block setters, had provided safety instruction and had made certain that safety procedures were followed. He knew that a block setter should never get between a moving vehicle and a load and that a forklift load is not to be set down until the driver can see the block setter. The referee found that those were company policies and also the general practices in the industry.

The referee found that, during the strike, the three men worked by "consensus" and that, on two occasions before the fatal accident, Purcell had moved toward the forklift before it had stopped. On one of those occasions, Horner had warned Purcell that that was unsafe.

OAR 437-40-030(1) provides:

> "The employer shall see that workers are properly instructed and supervised in the safe operation of any machinery, tools, equipment, process, or practice which they are authorized to use or apply. This rule shall not be construed to require a supervisor on every part of an operation nor to prohibit workers from working alone."

The referee held:

> "The decedent was not properly supervised because of the labor dispute. No one was in charge, among the three skilled and experienced workers. For most purposes, they did not

> need a supervisor, because they all knew what to do and how to do it. However, a supervisor who is on the site frequently provides a different perspective, a sort of third-party view of the situation. In this case, a supervisor would most likely have noticed that Mr. Purcell was rushing the loads and trying too hard, and disciplined him effectively. His co-workers and fellow managers simply were not in a position to both supervise and keep working. The company did not designate anyone to be the supervisor of the team, with responsibility for safety, and the consensus approach was inadequate.
>
> "* * * I conclude that this was at least the third such dangerous incident, and that there may well have been more which were not officially noted or reported. This is the sort of pattern which a supervisor would be expected to notice and stop. I believe that, absent the strike, this is what Roseburg Lumber's supervisors do."

Our review is only for errors of law. ORS 183.482(8)(a). Employer contends that the referee's order is inconsistent with the rule quoted above, because it essentially imposes a requirement that a supervisor be present at all times

on every part of an operation. Although the rule does not require full-time supervision of every part of an operation, the first sentence recognizes that, in some instances, there will need to be a supervisor for a safe operation. The referee's order recognizes the distinction.

The referee found that, in general, the three men did not require supervision, but that the nature of loading and moving a forklift was such that it could not be done safely without supervision. Requiring a supervisor for that procedure would not require a supervisor for "every part" of employer's sawmill operation at Dillard. The referee's holding is not inconsistent with the rule.

Employer next argues that the referee failed to make findings to support the conclusion that a "serious violation" occurred. To establish a serious violation, there must be a finding (1) that the violation presented a substantial probability of death or serious physical harm and (2) that the employer knew, or with reasonable diligence should have

known, of the violation. OAR 437-01-015(55)(a)(A).[1] The violation was failing to provide adequate supervision. The referee's findings support the conclusion that that violation was serious:

> "When someone is within the zone of danger of a forklift, particularly when there is ice and snow on the ground and on the loads, there is a substantial probability that death or serious physical harm will result if the load or the machine shifts. As provided in OAR 437-01-140(1), it is reasonably predictable, given the heavy loads carried on this forklift, that serious physical harm or death would result."

Employer argues that it could not be held to have knowledge of the violation, because there was no evidence that it knew, or should have known, that Purcell would walk between a stationary load and a moving vehicle. However, we agree with respondent that that argument misses the point. Employer's violation, as noted above, was the failure to supervise; it did not involve knowledge of what Purcell would or would not do. Although the referee did not make an explicit finding about employer's knowledge, the findings provide a rational basis to support the inference that employer knew of the failure. *See City of Roseburg v. Roseburg City Firefighters,* 292 Or 266, 272, 639 P2d 90 (1981). The referee found that employer did not assure that Purcell was supervised and did not designate a supervisor for the team. Implicit in those findings is that employer knew that there was no supervisor.

Affirmed.

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[1] OAR 437-01-015(55)(a)(A) defines a serious violation as

"[a] violation in which there is a substantial probability that death or serious physical harm could result from a condition which exists, or from one or more practices, means, methods, operations or processes which have been adopted or are in use in a place of employment unless the employer did not, and could not with the exercise of reasonable diligence, know of the presence of the violation[.]"

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Marlin H. Nyre, Claimant.

Marlin H. NYRE,
Petitioner,

v.

F & R LEASING
and EBI Companies,
Respondents.

(88-06220; CA A63770)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 27, 1990.

Karen Werner, Eugene, argued the cause for petitioner. On the brief were Michael R. Stebbins and Stebbins & Coffey, North Bend.

Priscilla M. Taylor, Portland, argued the cause for respondents. With her on the brief was Williams, Zografos & Peck, Portland.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

DE MUNIZ, J.

Affirmed.

DE MUNIZ, J.

Claimant seeks review of a decision of the Workers' Compensation Board that reduced his award of 100% permanent partial disability for a low back injury to 65% permanent partial disability.

The findings of the referee, not expressly altered by the Board's decision, are that, as a result of his compensable injury, claimant needs retraining and that he cannot be retrained because of his *non*compensable cervical condition, which came about after the injury. Reasoning that he was required to rate disability as of the date of the hearing, the referee concluded that, because claimant could not work without retraining, he was entitled to 100% permanent partial disability. Claimant did not seek permanent total disability. In reducing the award to 65%, the Board said that it had "not considered any impairment claimant has sustained as a result of his noncompensable cervical condition."

Claimant asserts that the Board mistakenly assumed that the referee had considered the noncompensable cervical condition in evaluating disability. He asserts that the referee's opinion simply reflects the fact that he is currently unemployable without retraining as a result of his compensable low back injury. *Gettman v. SAIF,* 289 Or 609, 614, 616 P2d 473 (1980).

A claimant is entitled to benefits only for disability caused by the injury. Subsequent, noncompensable conditions are not considered. *Emmons v. SAIF*, 34 Or App 603, 579 P2d 305 (1978). We stated in *Emmons* that, when a subsequent non-compensable injury intervenes, the claimant's loss of earning capacity is to be determined as of the date immediately preceding the noncompensable injury. 34 Or App at 605. Here, that means disregarding claimant's cervical condition *and its effect on his ability to be retrained* and evaluating his disability as of the date immediately preceding the date when his noncompensable cervical condition became disabling. *See Elder v. Rosboro Lumber*, 106 Or App 16, ___ P2d ___ (1991); *Emmons v. SAIF, supra.*

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Theodore L. Nomeland, Claimant.

Theodore L. NOMELAND,
Petitioner,

v.

The CITY OF PORTLAND,
Bureau of Risk Management,
Respondent.

(88-01084; CA A63771)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 27, 1990.

Charles Robinowitz, Portland, argued the cause and filed the brief for petitioner.

David L. Jorling, Deputy City Attorney, Portland, argued the cause and filed the brief for respondent.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

DE MUNIZ, J.

Affirmed.

DE MUNIZ, J.

Claimant seeks review of an order of the Workers' Compensation Board that reversed the referee and allowed employer to offset claimant's preexisting hearing loss in determining his scheduled permanent disability.

Claimant suffered a compensable hearing loss while working for employer. The parties have stipulated that claimant also had a significant hearing loss before his employment, as established by an audiogram. The only question on review is how to treat claimant's documented, preemployment hear-

ing loss in calculating the extent of his disability. The Board held that claimant was entitled to benefits only for the incremental loss caused by the employment and that his preemployment hearing loss should be deducted from his total loss in determining the amount of the award. We affirm.

Hearing loss is a scheduled disability. It is subject to the provisions of ORS 656.214(2):

> "When permanent partial disability results from an injury, the criteria for the rating of disability shall be the permanent loss of use or function of the injured member *due to the industrial injury.*
>
> "* * * * *
>
> "(g) For partial or complete loss of hearing in both ears, that proportion of 192 degrees *which the combined binaural hearing loss bears to normal combined binaural hearing.*"[1] (Emphasis supplied.)

Claimant contends that, when applied to a case such as this, where a portion of the claimant's total hearing loss is not caused by the employment, the statute requires that, when calculating benefits due to loss of hearing, the entire hearing loss, including preexisting disability, is considered. We disagree.

Subsection (2) bases the rating of disability on loss of use or function "due to the injury." Subparagraph (2)(g),

which sets out the specific formula for the calculation of binaural hearing loss, would appear, in and of itself, to require that claimant be compensated for loss based on a comparison of his present total hearing loss with normal hearing, irrespective of any preexisting loss. We conclude, however, that the requirement stated in subsection (2), that the loss be "due to the industrial injury," must be read to apply to subparagraph (2)(g) and that the comparison required under that subparagraph must be made only between the claimant's hearing loss *due to the industrial injury* and normal hearing. The administrative rule, OAR 436-30-360(2), which is applicable in this case, is consistent with that reading:

> "Compensation for work-related hearing loss, whether diagnosed as an occupational disease or acoustic trauma, will be offset by pre-existing hearing loss *if previously compensated, presbycusis, or if supporting evidence such as base-line or pre-exposure audiograms are provided.*" (Emphasis supplied.)

We are satisfied that the Board correctly applied the statute and the rule to allow an offset of claimant's preexisting hearing loss, unless, as claimant contends, such an application is precluded by statute or case law.

ORS 656.222 provides:

> "Should a further accident occur *to a worker who is receiving compensation for a temporary disability, or who has been*

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[1] *Compare* ORS 656.214(5):

"In all cases of injury resulting in permanent partial disability, other than those described in subsections (2) to (4) of this section, the criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury."

> *paid or awarded compensation for a permanent disability,* the award of compensation for such further accident shall be made with regard to the combined effect of the injuries of the worker and past receipt of money for such disabilities." (Emphasis supplied.)

That section permits an offset against an award of compensation when the claimant has received a previous award for permanent disability under the Oregon workers' compensation system. *American Bldg. Maint. v. McLees,* 296 Or 772, 679 P2d 1361 (1984). Claimant contends that the statute requires, by implication, that, if there has been no previous award of compensation for a disability, there can be no offset. Although we agree with the general premise, it must be applied in what appears to be the implicit context of the statute: The previous disability must have been compensable. ORS 656.222 simply has no significance with respect to previous noncompensable

disabilities and should not be read to imply anything with respect to such disabilities. It does not prohibit employer from offsetting claimant's preemployment disability in calculating claimant's award.

Claimant contends that the Board's decision is in conflict with the general principle that, in cases of successive, incremental injuries, liability for the entire disability is assigned to the last employer. *Bracke v. Baza'r, Inc.,* 293 Or 239, 646 P2d 1330 (1982). However, that rule applies to successive *employment-related* disabilities. It is not applied, in the context of partial disability, to hold an employer responsible for a non-work-related disability that pre-existed the injury. *See Barrett v. D & H Drywall,* 300 Or 325, 328, 709 P2d 1083 (1985), *on reconsideration* 300 Or 553, 715 P2d 90 (1986). We have held that, when injuries are so distinct that it is possible to segregate them in terms of causation, responsibility for the injuries can and will be apportioned between or among the employers. *Cascade Corporation v. Rose,* 92 Or App 663, 759 P2d 1127 (1988). Similarly, when it is possible, as here, to segregate a claimant's disability that preexisted his employment from that caused by the employment, the employer is responsible only for the disability caused by the employment.

Claimant's final contention is that this result conflicts with the maxim that the employer takes the worker as it finds him. *Bracke v. Baza'r, Inc., supra.* As applied in the context of unscheduled permanent disability, that maxim means that, if a compensable injury causes a previously asymptomatic condition to become symptomatic and, if those symptoms produce a loss of earning capacity, then that loss of earning capacity is "due to" the injury and is considered in evaluating unscheduled permanent disability. *See Barrett v. D & H Drywall, supra; Weller v. Union Carbide,* 288 Or 27, 602 P2d 259 (1979). In the context of scheduled permanent partial disability, which is measured by the permanent loss of use or function of the injured member *due to the industrial injury,* ORS 656.214(2), the maxim requires that, if the claimant has a predisposition to suffer a disability, and the injury, combined with that predisposition, causes a loss of use or function,

the loss of use or function is due to the injury and is compensable. The rule is not applied, in the context of partial disability, to impose liability on the employer for disability or loss of use or function that preexisted the employment. *See Barrett v. D & H Drywall, supra,* at 555.

We conclude that the Board correctly held that claimant's preexisting hearing loss, as determined by a pre-employment audiogram, should be offset from claimant's total hearing loss in determining the benefits to which he is entitled.

Affirmed.

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98 February 27, 1991 No. 122

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Laura Basl, Claimant.

GREEN THUMB, INC.,
Petitioner,

v.

Laura BASL,
Respondent.

(87-17697; CA A63841)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 22, 1990.

Margaret H. Leek Leiberan, Portland, argued the cause and filed the brief for petitioner.

Karen M. Werner, Eugene, argued the cause and filed the brief for respondent.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

WARREN, P. J.

Reversed and remanded.

WARREN, 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 prospective medical benefits. We reverse and remand.

Claimant is a 68-year old woman with a history of low back problems. In 1975, she had fusion surgery on her lower back and received chiropractic treatments. In May, 1984, she began working for employer, and she injured her back on January 23, 1986. She filed a claim for a lower back strain on February 18, 1986. Her chiropractor diagnosed a severe lumbar sprain and treated her three times a week from January to September, 1986. The treatments were reduced to twice a week for the next year and a half, until two or three months before the hearing. At the time of the hearing in March, 1988, claimant was receiving one treatment a week.

In July, 1987, claimant was examined by another chiropractor at employer's request. That chiropractor concluded that claimant's 1986 injury was "superimposed upon previous lumbar surgery and degenerative spine" and that there were no indications of recent fracture, luxation or bony pathology. The chiropractor also found no objective indications of permanent impairment as a result of her work-connected injury. The chiropractor concluded that claimant's treatment was related to her history of lower back complaints and was unrelated to her work injury.

Relying on that examination, employer issued a denial on November 5, 1987:

> "We have carefully reviewed your claim filed for injury on January 23, 1986. After carefully reviewing new medical reports in your file, it has been determined that your *current need for treatment* is related to your longstanding past history of lower back complaints and *presently unrelated* to your industrial injury. For this reason, we must respectfully deny *your current need for chiropractic treatment.*" (Emphasis supplied.)

The record does not show that there were then any outstanding medical bills or that the claim went to closure.

After a hearing, the referee overturned the denial and held that chiropractic care was reasonable and necessary for

treating the injury. Employer then requested review by the Workers' Compensation Board, which affirmed on different grounds. It held that, because there was no evidence of outstanding unpaid billings for chiropractic treatments, employer's denial was a denial of future treatments and was therefore invalid under *Evanite Fiber Corp. v. Striplin,* 99 Or App 353, 781 P2d 1262 (1989). The Board did not reach the question of whether claimant's chiropractic treatments were reasonable and necessary for her industrial injury.

Employer contends that the Board erred in holding that a valid denial requires evidence of pending unpaid medical bills. It argues that *Evanite Fiber Corp. v. Striplin, supra,* recognizes denials for a claimant's current claimed *need,* as well as for a specific medical benefits claim. Claimant contends that employer's denial was invalid for two reasons: First, it denied ongoing medical care before claim closure; and, second, the denial was prospective, because there was no evidence of any unpaid medical bills.

We review for errors of law. ORS 183.482(8); ORS 656.298(6). Initially, we note that claimant's assertion that an employer cannot deny a request for ongoing care before claim closure is not correct. An employer can deny a request for payment, either because the treatment is not related to the industrial injury or because it is not reasonable and necessary. ORS 656.245(1). Claim closure is appropriate when a claimant is medically stationary, meaning that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). An employer is not compelled to pay for unnecessary treatment just because the claimant has received that treatment over time and is not yet medically stationary. ORS 656.245(1);

Evanite Fiber Corp. v. Striplin, supra; Stratis v. Georgia-Pacific Corp., 94 Or App 781, 767 P2d 934, *on reconsideration* 96 Or App 706, 773 P2d 821, *rev den* 308 Or 331 (1989).

The issue is whether employer's denial is effective for a current claimed need for a particular medical treatment. In *Evanite Fiber Corp. v. Striplin, supra,* the insurer sent the claimant a letter that denied "all *further* chiropractic care in that it is not reasonable, necessary, or attributable to our industrial injury." 99 Or App at 355. (Emphasis in original.) In holding the denial invalid, we said:

> "An employer has authority to deny a *current claimed need for medical services, or specific claims* as the claimant presents them, if the medical services are not reasonable and necessary and attributable to the compensable injury. * * * However, an employer may not deny its *future responsibility for payment of benefits* relating to a previously accepted claim, unless it follows the statutory procedure for claim closure." (Emphasis supplied.) 99 Or App at 356.

The denial in this case is not a prospective denial; it denies a *current need* for chiropractic treatment, without precluding benefits for any *future need.* Once a claimant's current need has been denied, the claimant is barred only from reimbursement for that particular service. However, the claimant could make a later claim for medical services of the same kind, if the condition has changed and the request is supported by new facts that could not have been discovered earlier. *Liberty Northwest Ins. Corp. v. Bird,* 99 Or App 560, 564, 783 P2d 33 (1989); *Argonaut Ins. Co. v. Rush,* 98 Or App 730, 780 P2d 748 (1989). The claimant may also seek additional services to treat the compensable injury.

The distinction between *Evanite Fiber Corp. v. Striplin, supra,* and this case is narrow: *Evanite* denied "all *further* chiropractic care" (emphasis supplied); in this case employer denied that there was a "*current* need for chiropractic care." (Emphasis supplied). *Evanite* allows denials for specific unpaid services *or* for a current claimed need. Because the denial in this case denied benefits for a "current need" and does not preclude future benefits, we hold that the denial is not impermissibly prospective.

On remand, the Board must determine whether claimant's claimed need for chiropractic care is reasonable and necessary.

Reversed and remanded.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Brenda M. Huntley, Claimant.
INTERNATIONAL PAPER COMPANY,
Petitioner,
v.
Brenda M. HUNTLEY,
Respondent.
(WCB No. 88-11369; CA A64041)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 14, 1990.

Paul L. Roess, Portland, argued the cause for petitioner. With him on the brief was Acker, Underwood, Norwood & Hiefield, Portland.

Karen M. Werner, Eugene, argued the cause and filed the brief for respondent.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

WARREN, P. J.

Affirmed.

WARREN, P. J.

Employer seeks review of a Workers' Compensation Board order that required it to pay temporary disability, penalties and attorney fees under ORS 656.262(10). We affirm.

Claimant began working for employer on November 17, 1986, as a tree grader. At that time, she was re-entering the work force after having taken several years off to care for her family. She understood that the job was seasonal. She stopped working January 7, 1987, because of a cervical strain and carpal tunnel syndrome. She would have been laid off anyway on March 4, 1987. On July 15, 1988, a referee held that her conditions were compensable. Employer, however, paid no compensation after April 15, 1987. Claimant sought and received penalties and attorney fees for unreasonable failure to pay compensation; employer was also ordered to pay temporary disability benefits.

Employer's theory is that claimant was not a worker entitled to compensation, because she lost no wages after March 4, 1987, when she would have been laid off. Those who have withdrawn from the work force are not entitled to disability benefits, because benefits are intended to replace lost income. *Dawkins v. Pacific Motor Trucking,* 308 Or 254, 778 P2d 497 (1989). The Board correctly held that employer must continue to pay temporary disability benefits, even after claimant would have been laid off, because no statutory basis for terminating payments existed. After she would have been

laid off, claimant continued to meet all the requirements to receive compensation: She was not working, she had not been released for work and her claim had not been closed. ORS 656.268. The power to terminate compensation payment depends on statutory authority. Here, there was none.

Employer also argues that the Board erred in imposing penalties and attorney fees under ORS 656.262(10), which provides:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

An employer's refusal to pay is not unreasonable if it has a legitimate doubt about its liability. *Castle & Cook, Inc. v. Porras,* 103 Or App 65, 796 P2d 662 (1990). Employer contends that it had a legitimate doubt, because it relied on the advice of counsel. We disagree. Employer's attorney is its agent, and employer, as principal, cannot hide behind the incorrect advice of its agent. *Free v. Wilmar J. Helric Co.,* 70 Or App 40, 688 P2d 117 (1984), *rev den* 298 Or 553 (1985).

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Deborah L. Pearson, Claimant.

INTERNATIONAL PAPER COMPANY,
Petitioner,

v.

Deborah L. PEARSON,
Respondent.

(WCB 87-06095; CA A65174)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 28, 1991.

Paul L. Roess, Portland, argued the cause for petitioner. With him on the brief was Acker, Underwood, Norwood & Hiefield, Portland.

James L. Edmunson, Eugene, argued the cause and filed the brief for respondent.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

WARREN, P. J.

Affirmed.

WARREN, P. J.

Employer seeks reiew of a Workers' Compensation Board order that held employer responsible for certain medical services. The parties do not argue that the findings were not supported by substantial evidence. We review for errors of law. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988). We affirm.

Claimant was compensably injured on March 21, 1983. On October 26, 1983, while on her way to her doctor's office for treatment of the compensable injury, she was involved in an automobile accident, which traumatized the same body parts that had been injured in the industrial accident. In October, 1985, claimant's attorney submitted medical bills to employer for payment. Employer denied responsibility for them, asserting that they were "the direct result of the motor vehicle accident * * *." Claimant requested a hearing. The parties entered into a disputed claim settlement, which provided, in part:

"[T]he parties do hereby stipulate and agree as follows:

"* * * * *

"III

"That a bona fide dispute exists with regard to the compensability of and the responsibility for the billings submitted [on] October 29, 1985 * * *; that all of the issues raised and raisable by the Request for Hearing and the Supplemental Request for Hearing should be settled on the basis of a bona fide dispute by a lump sum payment * * *; that claimant fully understands that said bona fide dispute and compromise is in full and final settlement of any contention that the billings submitted [on] October 29, 1985 are compensable, * * * and that liability for the billings submitted [on] October 29, 1985 is expressly denied by International Paper Company.

"IV

"That claimant's Request for Hearing and Supplemental Request for Hearing (and all issues raised thereby, and which could have been raised thereby) shall be, and the same hereby are dismissed with prejudice, and the written denial of * * * International Paper Company[] of February 20, 1986 shall be, and the same hereby is, affirmed and approved."

"V

"Claimant represents, and it is fully understood and agreed, * * * that all of the billings submitted [on] October 29, 1985 were solely occasioned by the motor vehicle accident of October 26, 1983."

After the settlement, claimant submitted additional medical services billings to employer. Employer denied responsibility, claiming that they were for services not "substantially dissimilar" to the services previously denied and compromised by the disputed claim settlement. After a hearing on the denial, the referee concluded that there was no evidence that the treatments for which claimant sought pay-

ment were for "non-automobile-related injuries" and affirmed the denial. On review, the Board reversed, rejecting employer's claim that the doctrine of *res judicata* precluded claimant from litigating the issue of whether the treatments were related to the compensable injury. It also found that the treatments were compensable because they were "materially related to injuries claimant sustained in the October, 1983, automobile accident."[1] Employer seeks review, claiming error in the Board's failure to apply *res judicata* to preclude this claim for medical services.[2]

Neither party disputes that it may not relitigate issues resolved by the disputed claim settlement. *See Proctor v. SAIF,* 68 Or App 333, 681 P2d 161 (1984). The issue comes down to what, precisely, was resolved by the settlement. Employer asserts that the settlement resolved that "[t]he *condition* for which chiropractic services [were] rendered in 1986 was determined to have been solely occasioned by the automobile accident * * *." (Emphasis in original.) We disagree with that characterization. The dispute that was resolved was whether certain medical services were compensable. The settlement did *not* resolve whether the *condition* for which the

medical services were provided was compensable. Claimant could not relitigate the responsibility for particular medical services that were the subject of the billings resolved by the settlement; however, because the settlement said nothing about the compensability of the underlying condition, resolution of the question of whether the earlier medical bills were payable is unrelated to whether further medical services for the same condition precipitated by the automobile accident are employee's responsibility. There was no such determination in the settlement agreement, and the Board acted correctly by considering and deciding whether the later medical services, which it found were related to the automobile accident, were compensable.

Affirmed.

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[1] *Fenton v. SAIF,* 87 Or App 78, 83, 741 P2d 517, *rev den* 304 Or 311 (1987), held that, when a worker is injured in an accident during a trip to see a physician for treatment of a compensable injury, the new injury also is compensable.

[2] Employer asserts that the case should be remanded to the Board for a determination of whether the billings were related to the condition caused by the automobile accident. However, the Board made that finding in its original order. On reconsideration, the Board adhered to and republished its order, as supplemented. There is nothing in the order on reconsideration that would negate the Board's earlier finding that the medical services were related to the automobile accident.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Phyllis I. Dupape, Claimant.

SAFEWAY STORES, INC.,
Petitioner,

v.

Phyllis I. DUPAPE,
Respondent.

(87-18387; CA A63496)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 22, 1990.

Kenneth L. Kleinsmith, Portland, argued the cause for petitioner. With him on the brief was Meyers & Radler, Portland. Steven L. Piucci, Portland, argued the cause for respondent. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.

Affirmed.

RIGGS, J.

Employer seeks review of a decision of the Workers' Compensation Board affirming the referee's decision that employer's denial of claimant's out-of-state medical services should be set aside.[1] We affirm.

Claimant suffered a compensable injury on February 16, 1987, while employed by Safeway Stores, Inc., in Tigard, Oregon. Employer accepted the claim as a nondisabling injury, and claimant underwent treatment for back pain with a physiatrist in Oregon. In late April, 1987, she resigned her job and moved to Kent, Washington. When she told employer about the move, she was not informed that prior approval would be required for treatment by out-of-state doctors. In May, 1987, she received treatment for continuing back pain from Dr. Richard Neiman at the Kent Medical Center in Washington. She did not notice any improvement from Neiman's prescription of medicine and sought treatment from Dr. Chan, a chiropractor. She continued treatment with him until November, 1987.

Employer paid the expenses associated with Chan's treatment until November 19, 1987, when employer's agent wrote a letter denying liability for any future billings from Chan, because claimant had not obtained prior approval for

[1] The Board issued an order on reconsideration that republished its first order in its entirety and supplemented it with an award of $750 for services rendered on review by claimant's attorney.

her treatments. The letter suggested two medical doctors and a chiropractor in the area whose treatment would be approved. On January 10, 1988, claimant was examined, but not treated, by Dr. Singer, the chiropractor suggested in the letter. Claimant found Singer's office location extremely inconvenient and returned to Chan. Employer does not dispute that treatment by Chan was reasonable and necessary for claimant's compensable injury or that Chan's medical reports had been received by employer without objection.

The Board concluded that, because employer had not shown that claimant's out-of-state chiropractor would be unlikely to cooperate with reporting requirements, the denial of medical expenses should be set aside. Employer argues that the Board erred as a matter of law, because an employer has a

statutory right to veto treatment by an out-of-state doctor and is not required to give a reason for the veto.

We review the Board's decision to determine whether its action is inconsistent with an agency rule or otherwise violates a constitutional or statutory provision. ORS 656.298(6); ORS 183.482(8). We give "some deference" to the Board's interpretation of statutes and administrative rules relating to its field. *Mershon v. Oregonian Publishing*, 96 Or App 223, 225-226, 772 P2d 440, *rev den* 308 Or 315 (1989).

ORS 656.245(3) gives workers the right to choose an attending physician "within the State of Oregon." Those words "suggest an intention to differentiate between in-state and out-of-state physicians insofar as the worker's freedom of choice is concerned." *Reynaga v. Northwest Farm Bureau*, 300 Or 255, 259, 709 P2d 1071 (1985). Although it is silent as to the reason for that differentiation, the statute does not deny the worker a choice of treatments. *Reynaga v. Northwest Farm Bureau, supra*, 300 Or at 262. Although the state and employers have an interest in assuring the full cooperation of out-of-state doctors, that interest "would be satisfied by granting insurers a right to veto individual doctors who have demonstrated that they are unlikely to fully cooperate with reporting requirements." *Reynaga v. Northwest Farm Bureau, supra*, 300 Or at 259; *Day v. S & S Pizza Co.*, 77 Or App 711, 716, 714 P2d 275 (1986).

Employer relies on OAR 436-60-050(5) to support its veto of claimant's treatment by Chan. That rule provides:

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

On its face, the rule imposes no restrictions on an insurer's right to object to a claimant's choice of an out-of-state physician. However,

> "the insurer's power to veto [a] claimant's choice of an out-of-state physician under ORS 656.245(3) is not unlimited. That power does not limit claimant's right to receive medical services under 656.245(1), wherever she is." *Day v. S & S Pizza Co., supra*, 77 Or App at 716.

The Board concluded that employers have only a limited right to veto a claimant's choice of an out-of-state physician, and that the only adequate basis for a veto is when the out-of-state doctor would be unlikely to comply with the workers' compensation reporting requirements. That conclusion is not inconsistent with the wording or purpose of ORS 656.245(3). In the face of a statute silent on the point, the Board is free to interpret the statute to provide for reasonable administration of claims. It did so here. Neither is its conclusion inconsistent with OAR 436-60-050(5), which, in the light of *Reynaga v. Northwest Farm Bureau, supra,* and *Day v. S & S Pizza Co., supra,* must be interpreted as giving an employer only a limited right to object to a claimant's choice of physician.

We conclude that the Board is entitled to require that employer state a reason for its objection and to require that the reason be related to a concern that the out-of-state doctor will not comply with Oregon's reporting requirements or other cognizable purposes of the statute or rules. Therefore, we affirm the Board's decision setting aside employer's denial of claimant's choice of the out-of-state physician.

Affirmed.

No. 137 February 27, 1991 169

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Robert J. Saling, Claimant.

SOUTHWEST FOREST INDUSTRIES,
Petitioner,

v.

Robert J. SALING,
Respondent.

(WCB Nos. 86-15197, 85-13694; CA A62996)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 25, 1991.

Adam T. Stamper, Medford, argued the cause for petitioner. On the brief were Kimberly D. Wallan and Cowling & Heysell, Medford.

Karen M. Werner, Eugene, argued the cause and filed the brief for respondent.

Before Warren, Presiding Judge, and Joseph, Chief Judge, and Edmonds, Judge.

PER CURIAM

Affirmed.

PER CURIAM

In this workers' compensation case, we affirm the order of the Board reversing the referee's order. We write only because the Board's order is so unclear that we need to illuminate for the parties how we read it.

Although claimant suffered a compensable injury in 1975, by the time of the 1985 and 1986 work incidents giving rise to this case he was suffering only from conditions not related to the 1975 claim. Therefore, according to the Board, the referee erred in treating the case as involving whether there was an aggravation *or* a new injury; the only issue on the facts is whether the 1985 and the 1986 incidents caused a new injury. So viewed, as we believe the Board did view it, the evidence is that the incidents exacerbated the preexisting, non-compensable conditions to the point that those conditions became disabling and required medical services. Therefore, claimant suffered a compensable injury.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Dena L. Barnett, Claimant.

Dena L. BARNETT,
Petitioner,

v.

LIBERTY NORTHWEST
INSURANCE CORPORATION
and California Shellfish Co., Inc.,
Respondents.

(WCB 88-22382; CA A64959)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 28, 1991.

Benton Flaxel, North Bend, argued the cause for petitioner. With him on the brief was Flaxel, Todd & Nylander, North Bend.

Stafford J. Hazelett, Portland, argued the cause and filed the brief for respondents.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

PER CURIAM

Reversed and remanded for reconsideration.

PER CURIAM

Claimant seeks review of the Workers' Compensation Board's calculation of temporary total disability benefits (TTD). We reverse and remand.

Claimant contends that the Board improperly failed to consider extended gaps in her work time during the 26 weeks before her injury. Under *former* OAR 436-60-020(7)(c), TTD for a worker who is employed varying hours and shifts is calculated on her average weekly earnings for the 26 weeks just before the disability, unless there are "extended gaps" in that period when the claimant was not working. On remand, the Board should determine whether the breaks in claimant's work qualify as "extended gaps" under *former* OAR 436-60-020(7) for the purposes of computing TTD.

Reversed and remanded for reconsideration.

218 March 6, 1991 No. 150

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Marjorie Janisch, Claimant.

Marjorie JANISCH,
Petitioner,
v.
LANE CO. S-D #45
and SAIF Corp.,
Respondents.

(88-11489; CA A63384)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 2, 1990.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Dale C. Johnson and Malagon, Moore & Johnson, Eugene.

Katherine H. Waldo, Assistant Attorney General, Salem, argued the cause for respondents. With her on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

BUTTLER, P. J.

Reversed and remanded for reconsideration.

BUTTLER, P. J.

Claimant seeks review of an order of the Workers' Compensation Board affirming the decision of the referee that she is not permanently and totally disabled. Because the Board's opinion contains an inconsistency, we reverse it and remand for reconsideration.

The Board adopted the referee's finding that claimant is not totally disabled because of physical impairment alone, but because of a combination of medical and non-medical factors, she is totally disabled. It found that claimant cannot sell her services in a competitive labor market, because "she is simply too old, too unskilled, and has too many physical limitations." The Board then held that, because claimant had made only two job contacts, she had not satisfied the requirement of ORS 656.206(3) that she make a reasonable attempt to obtain regular, gainful employment. For that reason, it concluded that claimant had not established entitlement to permanent total disability benefits. Instead, it awarded her benefits for 100 percent permanent partial disability. The Board made no finding concerning claimant's willingness to work.

The Board's finding that claimant cannot sell her services in a competitive labor market appears to be inconsistent with its finding that she had not made a reasonable

attempt to seek work. She is excused from the requirement that she seek work if it would be futile for her to do so. *Butcher v. SAIF,* 45 Or App 313, 608 P2d 575 (1980). Even if it would be futile to seek work, however, claimant must show her willingness to work. *SAIF v. Stephen,* 308 Or 41, 48, 774 P2d 1103 (1990). We remand for the Board to reconcile the apparent inconsistency and, if necessary, to address the question of whether claimant has demonstrated a willingness to work.

Reversed and remanded for reconsideration.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Dave G. Owen, Claimant,
and
In the Matter of the Complying Status of
Charles W. and Minerva A. Blain,
dba Wesco Trucking, Employer.

Charles W. BLAIN
and Minerva A. Blain,
dba Wesco Trucking,
Petitioners,
v.
Dave G. OWEN
and SAIF Corporation,
Respondents.

(86-09303; CA A63073)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 24, 1990.

Leeroy O. Ehlers, Pendleton, argued the cause and filed the brief for petitioners.

David L. Runner, Assistant Attorney General, Salem, argued the cause for respondent SAIF Corporation. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

No appearance for respondent Dave G. Owen, Hermiston.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

DE MUNIZ, J.

Affirmed as to employer's non-complying status; otherwise reversed and remanded for proceedings not inconsistent with this opinion.

DE MUNIZ, J.

Employer seeks review of an order of the Workers' Compensation Board holding that it is a subject employer, that it did not file a request for hearing regarding the compen-

sability of the claim and that, even if it did file a request, it was untimely.

Claimant drove a truck owned by employer in its agricultural trucking business. In September, 1985, while the truck was in a repair shop for repair of a hydraulic lift cylinder, claimant sustained fractured ribs when the cab fell on him. He filed a claim in April, 1986.

On May 22, 1986, the Workers' Compensation Department issued an order declaring employer to be a noncomplying employer. ORS 656.052(2). The department received a letter from employer on June 9, 1986, that reads:

> "In regard to injury of [claimant]. [Claimant] was not employed by [employer.] We furnished [a] truck for [claimant] on a percentage basis. [Employer] furnished maintenance on [the] truck [and] took it to [the] shop to be fixed. [Claimant] was not working for [employer] when he got hurt. [Claimant] *was acting on his own.* [The injury occurred] on Sunday and *he* had *no business even being at [the] shop* where [the] truck was being fixed. He was supposed to take care of his own insurance and income tax when working." (Emphasis in original.)

SAIF sent claimant a notice of claim acceptance dated July 2, 1986. The Board received the June 9 letter on July 7, 1986, after the department had forwarded it. On July 9, 1986, SAIF sent employer a notice that it had accepted the claim and that employer had 60 days to request a hearing on compensability. On August 30, 1987, the Board received another letter from employer's attorney, dated August 27, 1987:

> "As you may recall, this matter was scheduled for a hearing in Pendleton on February 10, 1987. At that time it developed that there may have been some procedural problems in how the case came before the Hearings Division.
>
> "* * * * *
>
> "It would be requested that this matter be rescheduled for a hearing on any contested issues. As far as the employer is concerned, the issues would be whether the employer was required to provide workers' compensation coverage to the

> claimant, and if so, whether the claimant suffered a compensable injury."

A hearing was held on whether employer was a noncomplying employer and on compensability. The referee concluded that, at the time of the injury, claimant was a subject worker and employer was a subject employer. He found that employer's June 9 letter to the department was filed before acceptance of the claim. Citing *Barr v. EBI Companies*, 88 Or App 132, 744 P2d 582 (1987), he concluded that employer's letter was ineffective as a request for a hearing on compensability. Accordingly, he did not decide the issue of compensability.

The Board affirmed the referee on his determination that claimant was a subject worker and that employer was a subject employer. It concluded that employer "failed to request a hearing regarding the notice of acceptance" and also stated:

> "Even if the [June 9 letter] received by the Board on July 7, 1986 is regarded as raising the issue of compensability of claimant's injury, it was filed two days before the claim had been accepted and was therefore * * * ineffective and void [as a request for a hearing on compensability]. *See Barr v. EBI Companies*[, *supra*]."

The Board did not reach the issue of compensability, because there was "no timely request for hearing." Accordingly, it affirmed the referee.

Employer argues that claimant was not a subject worker and that employer was not a subject employer, because claimant was not acting under a contract, received no remuneration and was not acting under the direction and control of employer when he attempted to repair the truck on the date of the injury. Employer confuses the issues of whether claimant was a subject worker and employer was a subject employer, *see* ORS 656.023; ORS 656.027, with the issue of whether claimant was acting within the course of his employment when he was injured, which relates to compensability of the claim. *See* ORS 656.005(7)(a).

There was substantial evidence to support the referee's findings, which were adopted by the Board, that employer hired claimant to drive its truck. He "was paid 25

percent of the gross of the truck during the harvest season," and employer exercised its right to direct and control claimant in various aspects of his work. Therefore, claimant was a "worker" as defined in ORS 656.005(27), and employer was an "employer," as defined in ORS 656.005(13), regardless of whether claimant was acting in the course of his employment when he was injured.

Employer contends that "the issue of the compensability of the claim was adequately raised by [its June 9 letter] as well as the further statement of issues contained in [its attorney's] letter of August 27, 1987." ORS 656.283(3) provides the requirements for an effective request for hearing:

> "A request for hearing may be made by any writing, signed by or on behalf of the party and including the address of the party, *requesting the hearing, stating that a hearing is desired,* and mailed to the board." (Emphasis supplied.)

The August letter from employer's attorney to the Board, which expressly stated that a hearing was desired on compensability, met the statutory requirements for a request for hearing. We need not address whether the June letter was also adequate.

The remaining question is whether the August letter was timely. It was received by the Board more than a year after SAIF's acceptance of the claim. SAIF concedes that "no statute or rule expressly limits the time within which a noncomplying employer may request a hearing under ORS 656.283 after SAIF's acceptance of a claim." ORS 656.283(1) provides that, "[s]ubject to subsection (2) of this section and ORS 656.319, any party or the director may *at any time*

request a hearing on any question concerning a claim."[1] (Emphasis supplied.) However, SAIF contends that, by analogy to the time within which a claimant may request a hearing on an insurer or self-insured employer's denial of a claim for compensation under ORS 656.262(8), we should impose a 60-

day time limitation, because failure to do so would "run afoul of important policies of the Workers' Compensation Law as enunciated in *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027 (1983)."

In *Bauman*, SAIF accepted a claim and subsequently paid medical benefits for a three-year period. "It was only after claimant attempted to reopen his claim for aggravation that SAIF suddenly reversed its decision and denied compensability for the original claim." 295 Or at 793. The court focused its analysis on ORS 656.262, which, in subsection (6), "gives the insurer or self-insured employer 60 days after notice of the claim in which to accept or deny the claim." 295 Or at 793.

Employer did not accept the claim here. It was SAIF's statutory responsibility to accept or deny the claim, because employer was a noncomplying employer. ORS 656.054(1); *Clark v. Linn*, 98 Or App 393, 397, 779 P2d 203 (1989). Nonetheless, SAIF was not employer's agent. *Bauman* does not apply to the controversy presently existing between employer and SAIF. Employer's right to challenge compensability of the claim does not originate from ORS 656.262, but from ORS 656.283(1). *Clark v. Linn, supra.* The unambiguous language of that section allowed employer to request a hearing on compensability "at any time." *See Satterfield v. Satterfield*, 292 Or 780, 782, 643 P2d 336 (1982). We cannot insert a time limitation; only the legislature can do that. The Board erred in concluding that it could not consider compensability.

Affirmed as to employer's non-complying status; otherwise reversed and remanded for proceedings not inconsistent with this opinion.

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[1] ORS 656.283(2) applies to a request for hearing by a worker "dissatisfied with an action of the insurer or self-insured employer regarding vocational assistance." ORS 656.319 provides a time limitation for requests for a hearing on "objections by a claimant to denial of a claim for compensation under ORS 656.262," "objections to a determination or notice of closure under ORS 656.268" and "objection by a claimant to a notice of refusal to close a claim under ORS 656.268(3)." ORS 656.319(1), (4) and (5).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
John L. Wyncoop, Claimant.
DELTA/MCLEAN TRUCKING,
Petitioner,
v.
John L. WYNCOOP,
Sessler, Inc.
and Liberty Northwest Insurance Corporation,
Respondents.
(WCB 88-09286, 88-10107, 88-09285,
88-10108; CA A64300)

Judicial Review from Workers' Compensation Board Arbitrator.

Argued and submitted November 14, 1990.

Marianne Bottini, Portland, argued the cause for petitioner. With her on the brief was Bottini & Bottini, Portland.

Bruce D. Smith, Medford, waived appearance for respondent John L. Wyncoop.

Stafford J. Hazelett, Portland, argued the cause and filed the brief for respondents Sessler, Inc. and Liberty Northwest Insurance.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.

Affirmed.

RIGGS, J.

The issue in this case is which of two employers, Delta/McLean Trucking (Delta) or Sessler, Inc., is responsible for claimant's current back condition. Delta seeks review of a decision of a Workers' Compensation Board referee, who was acting as an arbitrator pursuant to ORS 656.307, determining that it is responsible. We affirm.

Claimant, age 54, has suffered from a noncompensable low back impairment since the 1950's. He also has congenital and developmental back problems. Claimant's first workers' compensation claim for a back injury was in 1979, which was closed with no permanent disability award. He injured his back again in 1980 and received a 20 percent unscheduled disability award. In 1984, he strained his back while he was employed as a truck driver by Delta. The claim was accepted and was eventually closed in March, 1985, with no additional permanent disability awarded. Claimant continued to have low back symptoms and impairment, and his

claim against Delta was reopened in October, 1985. The claim was closed by a January, 1987, determination order, which awarded him 15 percent unscheduled permanent partial disability. His varyingly severe symptoms persisted through 1987.

In November, 1987, claimant began working as a truck driver for Sessler. On February 19, 1988, he fell and was injured. Dr. Hearns, his physician, reported that he complained of "low back pain and muscle spasms, left hip, dorsal and neck pain." Hearns wrote that claimant sustained an "acute post-traumatic musculoskeletal injury involving the lumbar, dorsal and cervical spine and associated soft tissue." In April, Delta refused to reopen the 1984 claim on the basis that the February, 1988, incident at Sessler had independently contributed to claimant's back condition. On May 10, 1988, Sessler accepted compensability and responsibility for the specific conditions of "cervicodorsal sprain/strain and muscle tension headaches." On May 27, 1988, Sessler denied responsibility for claimant's lumbar condition on the ground that the

1988 incident did not materially worsen the pre-existing condition.[1]

The arbitrator set aside Delta's denial and concluded that an aggravation of the 1984 injury had occurred and that the 1988 incident did not independently contribute to claimant's disability. He found that claimant

> "slipped and fell, which resulted in another strain and a temporary increase in the same symptoms he had experienced for several years, but did not significantly affect his underlying condition. * * * The incident * * * was just another episode in a long pattern of variably severe symptoms. The claimant's testimony describes symptoms as in the same place and of the same quality, only more severe, as he had experienced for several years. * * * There is no medical opinion that reflects a change in the nature of the disabling condition."

Citing *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 675 P2d 1044 (1984), the arbitrator concluded that Delta could not shift responsibility to Sessler, the second employer, because Delta failed to prove that claimant had sustained a new injury that independently contributed to his disabling condition. The Board adopted the arbitrator's order and affirmed.

Delta argues that the arbitrator improperly assigned the burden of proof to it. It also contends that he applied the incorrect legal standard when he concluded that Delta, as the

---

[1] Delta also argues that, because Sessler accepted claimant's 1988 claim,

"which included a specification of low back condition on the claim form, and * * * did not attempt a 'partial denial' until 60 days after the claim was filed, they [*sic*] are barred as a matter of law under *Bauman v. SAIF*, 295 Or 788, 670 P2d 1077 (1982), from denying their [*sic*] responsibility."

Delta is incorrect. Sessler only accepted claimant's claim for headaches and neck injuries; it never accepted his low back condition claim. Therefore, it is irrelevant that its express partial denial of that condition was not issued until more than 60 days after the claim was filed.

1984 employer, had the burden of proving that the 1988 incident was a new injury that independently contributed to claimant's low back condition. Relying on *Industrial Indemnity v. Kearns*, 70 Or App 583, 690 P2d 1068 (1984), and *Linda L. Wise*, 42 Van Natta 115 (1990), Delta argues that there is a rebuttable presumption that Sessler, as the later employer, is responsible, unless Sessler can prove that the 1988 incident, which occurred during its employment, did not independently contribute to claimant's condition.

We review for errors of law. ORS 656.307(2). Delta's reliance on the presumption in *Kearns* is misplaced. As the last employer against whom claimant had an accepted claim for a low back injury, Delta is presumptively responsible. In order to avoid responsibility for the 1988 incident, it had the burden of establishing that claimant's subsequent employment[2] independently contributed to his low back condition. Whether claimant suffered an aggravation or a new injury is a question of fact. *Boise Cascade Corp. v. Starbuck, supra*, 296 Or at 244-45. The arbitrator determined that the evidence supported the finding that claimant's present low back condition is an aggravation of his 1984 injury. We conclude, therefore, that it was not an error of law for the arbitrator to conclude that Delta remained the responsible insurer, because it had failed to meet its burden of proving that the 1988 incident independently contributed to claimant's condition. *See Stevens Equipment Co. v. American Fabricators*, 106 Or App 354, ___ P2d ___ (1991).

Affirmed.

---

[2] In *Kearns*, we said:

"Unlike the 'last injurious exposure rule,' under which the last employer would be liable if the work environment 'could have' caused the disability, the 'last injury rule' requires proof that the traumatic accident 'contributed independently' to claimant's disability, even though the contribution be slight. It is not sufficient to show that the last injury 'could have' contributed to claimant's disability." 70 Or App at 587.

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