VAN NATTA'S WORKERS' COMPENSATION REPORTER

VOLUME 43

(Pages 1615-2248)

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
HOMAR S. LOPEZ, Claimant
WCB Case No. C1-00150
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Bottini, et al., Claimant Attorneys
Gregory P. Lynch, Attorney
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Neidig and Westerband.

On June 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.

OAR 438-15-052 provides that, when a claim disposition agreement is approved, 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 the remaining proceeds. Under extraordinary circumstances, a fee may be approved in excess of those strictures. Id.

Here, the agreement provides for consideration in the amount of $25,000, out of which claimant's attorney is to receive $5,000 as her attorney fee. By our calculation, the proposed attorney fee exceeds the strictures of OAR 438-15-052 by $625. Moreover, the agreement does not indicate any extraordinary circumstances to justify the excessive fee.

Additionally, the agreement recites that claimant was provided the separate notice required by OAR 436-60-145(3) and that the notice is attached to the agreement and incorporated by reference as Appendix A. However, the separate notice requirement is in OAR 436-60-145(2), not (3). Moreover, Appendix A does not include the notice enclosure prescribed by the Director pursuant to OAR 436-60-145(2).

Finally, the agreement does not include original signatures by the parties. For these reasons, we find 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
DAVID D. BUCHANAN, Claimant
WCB Case No. 89-06843
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Popick & Merkel, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

On May 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. The proposed agreement purported to justify attorney fees which exceeded the strictures of OAR 438-15-052 with an explanation of extraordinary circumstances surrounding the claim. Because the extraordinary circumstances raised by the parties to justify larger attorney fees were not directly related to the obtaining or formulation of the proposed claim disposition agreement, on May 20, 1991, we set aside the proposed disposition.

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. Under extraordinary circumstances, a fee may be approved in excess of 25 percent of the proceeds. See OAR 438-15-052; Rollie Clark, 43 Van Natta 194 (1991).

On June 5, 1991, the Board received the parties' revised claim disposition agreement regarding this matter. As in the original agreement, the attorney fees exceed the amount allowed under OAR 438-15-052. The revised agreement provides that in consideration for the agreement the insurer will pay claimant and his attorney the total sum of $8,300. The agreement further specifies that "Claimant will accordingly receive $5,100 from the Claim Disposition, and claimant's attorney will receive a fee of $1,700 from the claim disposition, and a separate carrier paid fee of $1,500..." (See CDA page 3, lines 20-23). The agreement indicates that the fee is justified by counsel's services in pursuing and establishing claimant's right to compensation, obtaining benefits to be paid in this claim disposition and other benefits under the Workers' Compensation law, and by counsel's expenditure in excess of thirty five hours in attempting to establish claimant's right to compensation which currently remains pending before the Oregon Court of Appeals and the Workers' Compensation Board.

However, the revised claim disposition agreement does not address the concerns raised in our May 20, 1991 Order. The extraordinary circumstances raised by the parties to justify a larger attorney fee are not directly related to the obtaining or formulation of the proposed claim disposition agreement. The proposed claim disposition agreement is a separate and distinct agreement as compared to the prior Board and Court of Appeals proceedings. Further, the circumstances cited as extraordinary in this case were largely legal services for obtaining benefits which are being released by this agreement. Consequently, the Board finds that extraordinary circumstances do not exist to justify a fee greater than provided under normal circumstances. The agreement is, therefore, unreasonable as a matter of law and set aside. See ORS 656.236(2); Louis R. Anaya, 42 Van Natta 1843, 1844 (1990).

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
DONNA J. ENGLAND, Claimant
WCB Case No. 90-02863
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Charles J. Cheek (Saif), Defense Attorney

Reviewed by Board Members Crider and Neidig.

Claimant requests review of Referee Davis' order which affirmed a Determination Order award of 9 percent (28.8 degrees) unscheduled permanent disability for a neck injury. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

CONCLUSION AND REASONS

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

Because claimant became medically stationary before July 1, 1990, we apply the workers' compensation law in existence prior to its amendment by the Legislature on May 7, 1990. See Or Laws 1990 (Special Session), Ch. 2, Sec. 54(3).

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.

Citing to former OAR 436-35-290(2)(a), 436-35-300(2)(a) and 436-35-310(2)(a), the Referee did not rate claimant's age, education or adaptability in determining her unscheduled permanent disability. Claimant challenges the validity of those rules, arguing that they are outside the Director's delegated authority and contrary to former ORS 656.726(3)(f)(A), which authorizes the Director to adopt "standards for the evaluation of disabilities" and provides:

> "The criteria for evaluation of disabilities under ORS 656.214(5) shall be permanent impairment due to the industrial injury as modified by the factors of age, education and adaptability to perform a given job. The term 'education' shall include the development of an objective standard for evaluating a worker's skills, training and formal education."

We decline to declare the rules invalid. In this regard, former ORS 656.295(5) charges the Board, in part, as follows:

> "The board shall apply to the review of the claim such standards for the evaluation of disability as may be adopted by the director pursuant to ORS 656.726." (Emphasis supplied).

Although former ORS 656.295(5) requires that we apply the administrative rules in the rating of permanent disability, it further provides:

> "Nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present evidence to establish by clear and convincing evidence that the degree of permanent disability suffered by the claimant is more or less than the entitlement indicated by the standards adopted by the director under ORS 656.726."

If we were to conclude that it is highly probable that claimant's permanent disability resulting from her compensable neck injury is greater than that indicated by application of the "standards," then, rather than declaring the rules invalid, we would increase her award pursuant to our authority under former ORS 656.295(5). Henry L. Szweblik, 42 Van Natta 1847 (1990). However, we are not persuaded on this record that claimant suffers greater disability than that indicated by the "standards."

ORDER

The Referee's order dated November 30, 1990 is affirmed.

July 11, 1991 Cite as 43 Van Natta 1618 (1991)

In the Matter of the Compensation of
JEANETTE M. ROUSE, Claimant
WCB Case No. 90-14563
ORDER ON RECONSIDERATION
Royce, Swanson & Thomas, Claimant Attorneys
Schwabe, et al., Defense Attorneys

On June 19, 1991, we abated our May 24, 1991 Order on Review that affirmed a Referee's order that: (1) increased claimant's scheduled permanent disability award for the right arm from 5 percent (9.6 degrees) to 17 percent (32.64 degrees); and (2) directed the employer to pay claimant's increased scheduled permanent disability award at the rate of $305 per degree. This action was taken to consider the parties' stipulation which provides that claimant's increased scheduled permanent disability award will be paid at a rate of $145 per degree unless and until the "applicable rate" issue is "'finally determined' by the first Oregon Supreme Court case resolving the issue or by the first Court of Appeals decision followed by a Supreme Court denial of a writ of review." Stating that this stipulation will avoid needlessly repetitious and judicially uneconomic appeals, the parties seek approval of their agreement.

We recognize the parties' desire to resolve their dispute in a manner that will eliminate the need for a further appeal, as well as potentially reduce the financial and intellectual burden on the parties and the appellate forums. However, we consider the agreement to be contrary to law for several reasons.

Were we to accede to the parties' request, we would be approving a "conditional" stipulation that effectively places the dispute in a state of

"suspended animation" for an indeterminate period. Such a result would not be in accordance with the design of our legal system, which provides for finality in the decision making process. That is, once parties to a dispute have expended their appeals or have chosen not to pursue further administrative or judicial review, the resolution of their dispute is final and not subject to modification by a subsequent event.

In conclusion, we decline to approve the proposed stipulation. Accordingly, our prior orders are withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our May 24, 1991 order. The parties' rights of appeal shall begin from the date of this order.

IT IS SO ORDERED.

July 12, 1991 Cite as 43 Van Natta 1619 (1991)

In the Matter of the Compensation of
RICHARD P. BRADLEY, Claimant
Own Motion No. 88-0419M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE

Claimant requests review of the self-insured employer's October 4, 1989, Notice of Closure which closed his claim with an award of temporary disability benefits from March 13, 1989, through June 15, 1989. The employer declared claimant medically stationary as of August 15, 1989. Claimant contends that claim closure is premature and that, in any event, he is entitled to additional temporary disability benefits for the period from April 30 through December 31, 1988. Claimant also requests a penalty for the employer's allegedly unreasonable refusal to pay compensation. On March 27, 1991, the Board referred the issue to the Hearings Division for a fact-finding hearing and a recommendation.

By Own Motion Recommendation dated June 7, 1991, Referee Mills recommends that the employer be directed to pay claimant, for the period from April 30, 1988, through December 31, 1988, temporary partial disability benefits in the amount of 24 percent of claimant's weekly rate of temporary total disability benefits. We agree with the Referee's recommendation, with the following exception. Because claimant was temporarily totally disabled from work for the period from April 30 until May 15, 1988, he is entitled to the full weekly rate of temporary total disability benefits for that two-week period. Contrary to Referee Mills' Recommendation, we find nothing in the record establishing that any benefits have been paid for this period. From May 15 through December 31, 1988, however, claimant is entitled to receive temporary partial disability benefits in the amount of 24 percent of the weekly rate of temporary total disability benefits. The employer's Notice of Closure is modified accordingly.

By letter dated August 15, 1989, Dr. Grise wrote that he assumes claimant is medically stationary. There is no evidence to the contrary. Therefore, we find that claimant became medically stationary on August 15, 1989. Accordingly, the claim was not prematurely closed. As modified above, the employer's Notice of Closure is affirmed.

On the penalty issue, we find the employer did not have legitimate doubt of its liability for temporary total disability benefits for the period from April 30, 1988, to May 15, 1988, when claimant was totally disabled due to hospitalization relating to the compensable injury. The employer's refusal to pay those benefits amounted to an unreasonable refusal to pay compensation. See Peterson v. SAIF, 78 Or App 167, 172, rev den 301 Or 193 (1986). Accordingly, the employer is assessed a penalty equal to 25 percent of those amounts of

temporary total disability benefits due and owing from April 30, 1988, to May 15, 1988. See ORS 656.262(10)(a).

On the other hand, we find the employer had legitimate doubt of its liability for temporary partial disability benefits payable from May 15 through December 31, 1988. Because claimant returned to work as a sole proprietor on May 15, 1988, the employer was uncertain as to how claimant's wages should be calculated in order to determine the proper rate of temporary partial disability benefits. We found no statute, rule or case which prescribes the proper calculation of benefits under these circumstances. Therefore, the employer's uncertainty was reasonable and does not warrant assessment of a penalty.

IT IS SO ORDERED.

July 12, 1991 Cite as 43 Van Natta 1620 (1991)

In the Matter of the Compensation of
BARBARA J. CLAXTON, Claimant
WCB Case No. 89-23495
ORDER OF ABATEMENT
Douglas L. Minson, Claimant Attorney
Schwabe, et al., Defense Attorneys

The insurer requests reconsideration of our June 12, 1991 Order on Review.

In order to allow sufficient time to consider the motion, the above-noted Board order is abated and withdrawn. Claimant is requested to file a response to the motion within ten days. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

July 15, 1991 Cite as 43 Van Natta 1620 (1991)

In the Matter of the Compensation of
LYMAN K. HAMPTON, Claimant
WCB Case No. C1-01091
ORDER DENYING RECONSIDERATION
Emmons, et al., Claimant Attorneys
Brian L. Pocock, Defense Attorney

By order dated June 28, 1991, the Board disapproved the parties' claim disposition agreement because the agreement did not provide the present discount value of the proposed structured settlement. The Board reasoned that, without the present discount value, it could not determine whether the proposed attorney fee is within the strictures of OAR 438-15-052. By letter, the self-insured employer advises that the present value of the structured settlement would vary over time and, in any event, suggests that the attorney fee should be based on the total payout to claimant pursuant to the agreement. We view the self-insured employer's letter as a request for reconsideration of our order.

The agreement provides for a structured settlement whereby the employer agrees to pay claimant (presently 58 years of age?) $1,000 per month until the age of 65. Thus, if claimant survives to age 65, the settlement proceeds paid during the seven-year period would total $93,000. On the other hand, if claimant does not survive to age 65, he would receive proceeds totalling less than $93,000. In contrast, the proposed attorney fee of $11,175 is not contingent on

claimant's survival to age 65. Therefore, claimant's attorney would receive the entire attorney fee, even if claimant does not survive to receive the total potential proceeds of $93,000. Because the proposed attorney fee of $11,175 exceeds the strictures of OAR 438-15-052 for any amount of settlement proceeds below $93,000, this agreement is deemed unreasonable as a matter of law. ORS 656.236(1)(a); Louis R. Anaya, 42 Van Natta 1843, 1844 (1990).

We are authorized to prescribe a reasonable attorney fee for an attorney's services in negotiating a claim disposition on the worker's behalf. ORS 656.236(4). Pursuant to that authority, we adopted OAR 438-15-052, which prescribes strictures for attorney fees relating to claims disposition. In order to apply the rule, it is necessary to determine the value of the settlement proceeds. Where the parties enter a structured settlement in which the settlement proceeds are to be paid out over a specified period of time, we require the present value of the settlement as of the date the parties execute the agreement. Without that value, it is impossible to determine whether the proposed attorney fee is within the strictures of OAR 438-15-052.

Accordingly, the self-insured employer's request for reconsideration is denied.

IT IS SO ORDERED.

In the Matter of the Compensationof
JAMES W. ENGSTROM, Claimant
WCB Case Nos. 90-13992, 90-06343 & 90-13991
ORDER ON REVIEW
Bennett & Durham, Claimant Attorneys
Jim Dodge (Saif), Defense Attorney
Scheminske & Lyons, Defense Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Crider.

Continental Loss Adjusting Services requests review of those portions of Referee Neal's order that: (1) found that claimant's claim was timely filed; (2) set aside its denial of claimant's occupational disease claim for bilateral hearing loss; and (3) upheld SAIF Corporation's and AIAC's "de facto" denials of claimant's occupational disease claim for the same condition. On review, the issues are timeliness and responsibility.

We affirm and adopt the order of the Referee as supplemented.

Under the last injurious exposure rule claimant does not have the burden of proving medical causation as to a particular employer. He need only prove that the employment environment was of the type that could have contributed to the hearing loss. Claimant credibly testified that he experienced daily ringing in his ears while working for Continental's insured. Moreover, Dr. Lipman testified that an individual experiencing "ringing ears" probably has been exposed to loud noise effecting the inner ear. He further indicated that such an effect could be potentially injurious. Thus, we conclude that claimant suffered exposure to conditions which could have caused hearing loss during the time that Continental was on the risk. Inkley v. Forest Fiber Products Co., 288 Or 337 (1980).

In order for Continental, as the last Oregon employer where working conditions existed that could have caused the hearing loss, to shift responsibility to an earlier employer where working conditions could have caused the disease, it must establish that the conditions at the earlier employer were the sole cause or that it was impossible for conditions at Continental's insured to have caused the disease. Because Continental has not met its burden, it is responsible. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370 (1984).

Continental requested review of the Referee's order awarding compensation. We have found that the award should not be disallowed or reduced. Hence, claimant's attorney is entitled to an assessed fee. ORS 656.382(2). After considering claimant's statement of services, as well as 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 $1,000, to be paid by Continental Loss Adjusting Services. 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 December 6, 1990 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by Continental Loss Adjusting Services.

July 17, 1991 Cite as 43 Van Natta 1622 (1991)

In the Matter of the Compensation of
STEVEN C. HATFIELD, Claimant
WCB Case No. C1-01208
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Neidig & Westerband.

On June 6, 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 $40,000 by the SAIF Corporation, claimant released his rights to future workers' compensation benefits, except medical services, for his compensable injury.

Although the agreement reflects that claimant has certified that he has "read this document and discussed it with legal counsel," claimant is unrepresented. On June 10, 1991, the Board received a "notice of claim for lien for attorney fees" from claimant's former counsel, Christine Jensen. Counsel's petition states that Jensen represented claimant from January 26, 1987 through May 15, 1991.

Counsel also states in her petition that substantial work was performed on this claim in order to achieve a "full and final settlement of claimant's compensable claim." In addition, at the time claimant terminated their attorney-client relationship, negotiations were underway to resolve this claim by claim disposition agreement for consideration of $20,000. Therefore, pursuant to ORS 87.445 and 87.450 counsel claims a lien to that extent on any future benefits payable to claimant as a result of a claim disposition agreement or disputed claim settlement.

On June 26, 1991, the Board requested the parties to respond to counsel's petition within 14 days. The Board also requested that counsel provide to the

Board a copy of the Attorney Retention Agreement for review. In response, counsel has provided the Board with the requested agreement. In addition, SAIF has indicated by letter that it takes no position with regard to this dispute. The Board has received no written response from claimant within the aforementioned 14 day period.

Upon review of counsel's petition, the Board finds that at the time the attorney-client relationship was terminated on May 15, 1991, counsel was engaged in negotiations to settle the claim for $20,000. These efforts consisted of conferences with claimant, and several letters to SAIF. Apparently, these efforts eventually culminated in the CDA which was executed by claimant and SAIF on June 3, 1991 for $40,000. We note that claimant has not attempted to rebut counsel's assertions.

Accordingly, counsel's petition for attorney fees is granted to the extent that counsel would have received an attorney fee if the Board had approved a CDA for $20,000. Therefore, counsel is entitled to an attorney fee in accordance with OAR 438-15-052 based upon settlement proceeds of $20,000.

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 of $3,875, payable directly to claimant's former counsel, Christine Jensen by the SAIF Corporation is approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
LORA L. SCHULTZ (DANIELS), Claimant
WCB Case Nos. 90-07841, 90-05313, 90-10199 & 90-11506
ORDER ON RECONSIDERATION
Karen M. Werner, Claimant Attorney
Nelson, et al., Defense Attorneys
Alan Ludwig (Saif), Defense Attorney

On June 5, 1991, we issued an Order of Abatement in this matter stating that we had decided to reconsider our Order on Review in the above-captioned case, issued May 29, 1991. In our initial order, we set aside the SAIF Corporation's denial of claimant's injury claim for left carpal tunnel syndrome. In reaching this decision, we concluded that the 1990 amendments to the Workers' Compensation Law were not applicable to this case. We did so because a hearing in the matter was convened prior to July 1, 1990. See Oregon Laws 1990 (Special Session), Chapter 2, Section 54, paragraphs (1) & (2). On reconsideration, SAIF contends that the new law applies because the hearing request was not filed until after May 1, 1990. Id. Claimant has filed a response to SAIF's motion.

We agree with SAIF's contention that a hearing request was not filed in this matter prior to May 1, 1990. The issue before us on review is SAIF's denial of claimant's claim for left carpal tunnel syndrome resulting from a January 27, 1990 injury and/or work activity with SAIF's insured. A hearing request on this claim was not filed until May 11, 1990.

Claimant had previously filed a request for hearing on April 11, 1990, listing SAIF as the insurer. However, that request referenced an incorrect injury date of January 27, 1989, and a claim number for an unrelated 1988 low

back injury with Liberty Northwest Insurance Corporation. Furthermore, the specification of issues submitted with the April 1990 request carried the same Liberty Northwest claim number and listed Liberty Northwest as the insurer. Moreover, claimant did not challenge the Board's processing of the April 1990 hearing request under the 1988 injury claim with Liberty Northwest. Finally, the hearing request on the 1988 claim was subsequently dismissed, and claimant has not challenged that dismissal.

Under these circumstances, we conclude that a hearing request on SAIF's denial was not filed with the Board until after May 1, 1990. This case should, therefore, be analyzed under the new law. Nevertheless, this does not effect the ultimate decision reached in our May 29, 1991 Order on Review. Under both the old and new law, claimant can establish a compensable claim by proving that the January 27, 1990 injury materially contributed to the onset of her left carpal tunnel syndrome. Compare former and current ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). In our May 29, 1991 order, we concluded that claimant had satisfied that burden of proof. We adhere to that decision.

Accordingly, on reconsideration, as corrected and supplemented herein, we adhere to and republish our May 29, 1991 order, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

July 18, 1991 Cite as 43 Van Natta 1624 (1991)

In the Matter of the Compensation of
RUSSELL D. THOMPSON, Applicant
WCB Case No. CV-91008
CRIME VICTIM ORDER
Thomas E. Ewing, Assistant Attorney General

Reviewed by Board Members Westerband and Neidig.

Russell Thompson (hereafter referred to as "applicant"), has requested Board review of the Department of Justice's March 7, 1990 Order on Reconsideration. By its order, the Department denied applicant's claim for compensation as a victim of a crime under ORS 147.005 to 147.375. The Department based its denial on applicant's substantial contribution to his injury through the provocation of his assailant.

Following our receipt of the request for Board review, applicant was advised that he was entitled to present his case to a hearing officer. To exercise his right to a hearing, applicant was instructed to notify the Board within 15 days from the date the Department mailed him a copy of its record. The Department mailed a copy of its record to applicant on April 30, 1991. Having received no hearing request within the requisite time period, we have conducted our review based solely on the record. OAR 438-82-030(2). The standard for our review under the Act is de novo, based on the entire record. ORS 147.155(5); Jill M. Gabriel, 35 Van Natta 1224, 1226 (1983). Based on our de novo review of the record, we make the following findings and conclusions.

FINDINGS OF FACT

On May 18, 1989, the Department received applicant's May 15, 1989 claim for compensation as a victim of a crime. According to the application, the crime occurred on April 2, 1989, when, while operating his vehicle down a city street, another vehicle drove alongside him and the occupants of that vehicle

insulted applicant and his girlfriend. While attempting to elude the vehicle, applicant became enraged and threw a can of beer at the other vehicle. Eventually, applicant stopped his car and confronted the occupants outside of their car. A physical confrontation ensued, resulting in applicant's injuries and a two-day hospitalization. He sustained two lacerations to the back of his head, hemorrhaging, and a concussion.

In answer to the question on his application as to whether he had cooperated to apprehend and prosecute his assailants, applicant responded "yes." In response to applicant's claim for benefits, the Department conducted an investigation. Police reports of the incident were requested, as well as applicant's voluntary statement.

On May 30, 1989, the Department received initial incident reports from the Springfield Police Department. The investigating officer reported that applicant had thrown a beer can into the other vehicle when the occupants of that vehicle had "flipped him off." The physical confrontation occurred after applicant stopped to see if his car was damaged after the occupants in the other vehicle had thrown the beer can back at him. Applicant could neither provide a description of his assailants nor recall where the incident had occurred. He acknowledged that he had consumed "5 or 6" beers during the evening, but did not recall how much time it had taken him to consume them.

The police reports also included a statement from Tracy Stryffeler, who was a passenger in applicant's car. She recalled that the other car had been "tailgating" them. As the other vehicle pulled alongside applicant's car, he had "flipped them off." When the passenger in the other vehicle had leaned out of the window towards him, applicant threw a "full beer can" at the passenger who "returned fire" striking applicant's car. After applicant stopped to check for any damage, the fight ensued. Stryffeler admitted that applicant "had had a lot to drink" that night, but would not comment concerning whether he was intoxicated.

Investigating officers who were called to the scene were advised by applicant that he did not wish to file a report. Upon applicant's departure from the hospital, he was recontacted concerning his intentions. Applicant remained undecided. Seeking a copy of Ms. Stryffeler's statement, applicant stated that his attorney might be able to settle the matter in court. Based on these representations, the case was suspended.

On June 12, 1989, the Department received applicant's voluntary statement. Applicant explained that the other vehicle had been following his vehicle "right on my bumper." When he came to a stop sign he told them "if we were any closer, we could make love." Thereafter, the occupants in the other vehicle yelled obscenities at applicant and his girlfriend. As the chase continued and the verbal exchanges escalated, applicant eventually got mad and threw a can of beer at them. After they threw two cans of beer at his car, he stopped to check for damage. Thereafter, he was struck from behind by a weapon, which he believes was a "black jack."

On December 19, 1989, the Department issued its Findings of Fact, Conclusions and Order. The Department found that applicant had provoked his assailants, thereby contributing to his injuries. Furthermore, the Department concluded that applicant had failed to fully cooperate to apprehend and prosecute his assailants. Inasmuch as applicant had not satisfied ORS 147.015(3), (5), and 147.125(3), the Department denied his application for benefits.

On January 22, 1990, the Department received applicant's request for reconsideration of its denial. Noting that the Department had apparently not

received the police reports developed subsequent to his departure from the hospital, applicant contended that he had cooperated with law enforcement officials. Furthermore, regardless of what he had said or done to his assailants, applicant argued that the assault upon him was not warranted. Recommending that the Department obtain the later police reports, applicant sought reconsideration of the prior order and acceptance of his claim.

Thereafter, the Department obtained a supplemental police report. The report indicated that, on May 13, 1989, applicant had told the police that he was "almost positive" that he had seen his assailants at a residence near Ms. Stryffeler's home. When reminded that he had previously been unable to describe his assailants, he responded that seeing them had "triggered his memory." The investigating officer noted that applicant had recently learned that to receive victim assistance a suspect must be identified.

The investigating officer contacted the individual (Mr. Miller), who applicant asserted was the driver of the other vehicle. Miller recalled knowing an individual named "Russell Thompson" while in junior high school, but otherwise was not familiar with one. Miller did not know Ms. Stryffeler. Unable to recall his whereabouts on the night in question, Miller claimed that he did not drive because he was medically prohibited from doing so by his epilepsy. Miller consented to having his picture taken because "he had nothing to hide."

Miller's picture was shown to applicant and Stryffeler along with five other photos. Stryffeler was unable to identify any of the six photos. After some hesitation, applicant picked Miller's picture and was "98% sure" it was a picture of the driver of the other vehicle.

The investigating officer contacted the other suspect applicant had mentioned. (Mr. Wells). Unfamiliar with either applicant or Stryffeler, Wells claimed he was home with his girlfriend on the night in question. Wells also consented to a photo. When the photo was shown to Stryffeler with five other pictures, she chose another photo. ("80% sure.") Applicant stated that none of the photos were his assailant.

The officer completed this additional investigation on May 29, 1989. At that time, the officer returned the case to suspended status "until further leads develop."

Following further consideration, on March 7, 1990, the Department found that applicant did cooperate with law enforcement officials. However, the Department continued to find that applicant provoked his assailants, thereby contributing to his injury. Consequently, the Department determined that there was no basis for reversing its prior decision to deny the claim.

The Department's March 7, 1990 Order on Reconsideration notified applicant that he could request Board review of the decision. To do so, applicant was advised that the request "must be made within 60 days of this date."

On April 23, 1991, the Board received applicant's request for Board review of the Department's March 7, 1990 Order on Reconsideration. Contending that he was only trying to escape his assailants because he was in fear for his life, applicant argued that he had not provoked them.

CONCLUSIONS OF LAW AND OPINION

To begin, applicant has not requested Board review of the Department's March 7, 1990 Order on Reconsideration within 60 days as directed by the order. Yet, we are aware of no authority for setting this limitation on requesting

Board review. In fact, ORS 147.155 sets no time limitation for appealing a Department order. Rather, the statute merely provides that any applicant who disagrees with the Department's decision "may appeal to the board." ORS 147.155(1). Under such circumstances, we proceed with our review of the Department's order.

In determining the amount of compensation to which an applicant is entitled under the Act, the Department shall determine the degree or extent to which the victim's acts or conduct provoked or contributed to the injuries or death of the victim. ORS 147.125(3). An applicant is entitled to an award under the Act, if, among other requirements, the death or injury to the victim was not substantially attributable to the wrongful act of the victim or substantial provocation of the assailant of the victim. ORS 147.015(5).

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

Considering applicant's admitted consumption of a significant amount of alcohol during the evening in question, as well as his documented instances of diminished memory, we primarily draw from the observations offered by Ms. Stryffeler, applicant's passenger, in reaching our conclusions. After conducting our review, we find that, at each stage of this unfortunate episode, applicant engaged in conduct which substantially contributed to the escalation of emotions and confrontational actions.

For example, when applicant believed that the other vehicle was following his car too closely, he told the occupants in the other vehicle that "if we were any closer, we could make love." Thereafter, as the other vehicle gave chase and the verbal exchanges continued, applicant again escalated the tensions by throwing a beer can at the vehicle. Finally, rather than extricating himself from the situation, applicant eventually stopped his vehicle, thereby permitting the occupants in the other vehicle to continue the confrontation.

In reaching this conclusion, we wish to emphasize that we do not condone the conduct exemplified by the assailants. Their acts of violence are deplorable and, if identified, we trust that they will be punished to the fullest extent of the law. However, in order to receive benefits as a victim of a crime under the Act, applicant's injury must not be substantially attributable to his own wrongful act or his substantial provocation of his assailant. We conclude that the aforementioned described conduct constitutes such acts or provocation. Consequently, we hold that applicant's claim does not satisfy the statutory requirements for receiving benefits under the Act.

In conclusion, we recognize the physical trauma and financial burden this incident has caused applicant. Yet, to recover benefits as a victim of a crime under the Act, the Legislature has mandated that several specific prerequisites must be satisfied. As detailed above, all of these statutory requirements have not been met. Accordingly, applicant's claim for benefits must be denied.

ORDER

The December 20, 1989 Findings of Fact, Conclusions and Order of the Department of Justice, as reconsidered March 7, 1990, is affirmed.

In the Matter of the Compensation of
CANDY S. WOOD, Claimant
WCB Case No. 90-13811
ORDER ON RECONSIDERATION
Welch, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

On July 5, 1991, we withdrew our June 12, 1991 Order on Review, which affirmed and adopted the Referee's order that declined to award claimant an attorney fee under ORS 656.386 for his counsel's services in obtaining the rescission of an injury claim denial prior to hearing. We took this action to reconsider our order in light of Senate Bill 540, which amended ORS 656.386 to allow a carrier-paid fee if an attorney is instrumental in obtaining compensation for a claimant prior to hearing. In response to our order, the insurer has replied that it has no objection to an order granting the $625 attorney fee award that claimant sought at the hearings level.

On June 19, 1991, the Governor signed Senate Bill 540 A-Engrossed, which amends ORS 656.386(1) to provide that "[i]f an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held, a reasonable attorney fee shall be allowed." Section 1. Section 3 further states that the amendments "apply to all claims for which an order relating to the issue on which attorney fees are sought has not become final on or before the effective date of this 1991 Act, regardless of the date of injury." The Act took effect on its passage. Section 4.

Here, since this matter has not become final, the amendments to ORS 656.386(1) are applicable. Therefore, considering claimant's counsel's efforts in submitting a hearing request concerning the insurer's denial and in light of the insurer's aforementioned concession, we conclude that claimant's attorney was instrumental in obtaining compensation for claimant through the rescission of the insurer's denial prior to the scheduled hearing. Consequently, we hold that claimant is entitled to an insurer-paid attorney fee under revised ORS 656.386(1).

After considering the factors set forth in OAR 438-15-010(4) and in view of the parties' stipulations as documented by the Referee's order, we conclude that a reasonable attorney fee concerning the rescission of the insurer's denial is $625, 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), the complexity of the issue, and the value of the interest involved.

Accordingly, on reconsideration, we reverse the Referee's November 27, 1990 order. Claimant's attorney is awarded $625, to be paid by the insurer.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICK D. ALEXANDER, Claimant
WCB Case Nos. 90-05727 & 90-05650
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Nelson, et al., Defense Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board Members Westerband and Crider.

Liberty Northwest Insurance Company requests review of those portions of Referee T. Lavere Johnson's order which: (1) set aside its denial of compensability and responsibility for claimant's low back condition; and (2) upheld the self-insured employer's denial of the same condition. Claimant cross requests review of that portion of the Referee's order which dismissed with prejudice as untimely claimant's hearing request concerning the self-insured employer's denial. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the findings of the Referee with the following correction and supplementation. On page 2 of his order, the Referee found that on August 17, 1987, claimant was employed by Norpac Foods and compensably injured his low back. The Referee presumably intended to say, and we find, that the injury occurred on August 17, 1983.

At the time of claimant's 1983 injury, and at all times material thereafter, claimant had a preexisting low back structural abnormality which was not itself disabling, but which made him more susceptible to having recurrent low back problems such as the lumbosacral strain that he suffered in 1983 when working as a laborer for Norpac. The lumbosacral strain claimant suffered at Norpac completely resolved in 1984, by which time he was restored to his pre-injury status. While performing heavy manual labor for Mega Log, Liberty Northwest's insured, in 1989, claimant experienced the gradual onset of severe low back pain, which was diagnosed as lumbosacral strain. Claimant's work activities at Mega Log were the major contributing cause of claimant's lumbosacral strain condition and need for medical treatment. Claimant was first treated for the condition in July 1989. Time loss was first authorized on November 29, 1989.

CONCLUSIONS OF LAW AND OPINION

The ultimate question is which employer, Norpac or Mega Logs is responsible for claimant's condition. The Referee concluded that Mega Log is responsible because claimant's work activities at Mega Log independently contributed to a "worsening" of claimant's symptoms and back condition. We agree that Liberty Northwest is the responsible carrier.

The parties do not dispute that responsibility is to be initially assigned to Norpac, as the last carrier against whom claimant had an accepted claim for a low back injury. In order to shift responsibility to Liberty Northwest, Norpac was required to establish that claimant's subsequent employment at Mega Logs independently contributed to a worsening of his low back condition. See Boise Cascade v. Starbuck, 296 Or 238 (1984); Stevens Equipment Co. v. American Fabricators, 106 Or App 354 (1991). The medical evidence establishes that claimant's work activities at Mega Log did not "worsen" claimant's back condition in the usual sense, but contributed independently to the causation of an entirely new condition. The condition Norpac accepted in 1983 was a lumbosacral strain. Claimant's treating physicians opined, and we have found, that the 1983 strain condition was completely resolved in 1984, meaning that claimant had

fully recovered and was restored to his pre-injury status long before he began working for Mega Log. Thus, the evidence establishes that the low back pain claimant experienced at work for Mega Log was not an exacerbation of claimant's 1983 accepted injury for which Norpac could be held responsible on an aggravation theory. Therefore, claimant's condition is either compensable as a new injury or occupational disease or it is not a compensable condition at all.

Claimant's pain symptomology while working at Mega Log in 1989 was gradual in onset and is to be analyzed as an occupational disease. Valtinson v. SAIF, 56 Or App 184 (1982). The threshold problem is to identify specifically the occupational disease from which claimant suffers, if any. The medical reports from Dr. Clibborn, claimant's treating physician, and the medical evidence as a whole clearly show that claimant's preexisting back abnormality is not the occupational disease. Dr. Clibborn diagnosed lumbosacral strain, which is the occupational disease. In contrast, the preexisting abnormality is a developmental structural problem which simply made claimant more susceptible to having the kind of back strain that Dr. Clibborn diagnosed, and which claimant has had in the past. See Tucker v. Liberty Mutual Ins. Co., 87 Or App 607 (1987) (claimant's structural foot deformity is not the occupational disease, but rather is a developmental structural problem which makes claimant more susceptible to chronic foot strain, which is the occupational disease).

The medical evidence also establishes that claimant's work activities at Mega Log were the major contributing cause of claimant's back strain condition and need for medical treatment. Therefore, claimant's lumbosacral strain condition (as opposed to the underlying structural abnormality) is compensable. Aetna Casualty Co. and St. Vincent Hospital v. Donna E. Aschbacher, 107 Or App 494 (1991). The strain became disabling in November 1989. Claimant's last employment was Liberty Northwest's insured. Therefore, Liberty Northwest is responsible. Bracke v. Baza'r, 293 Or 239 (1982). For these reasons alone, we affirm the Referee's order setting aside Liberty Northwest's denial and upholding the denial by Norpac.

As an additional basis for upholding Norpac's denial, the Referee also dismissed claimant's hearing request for being untimely and because claimant allegedly failed to establish good cause for the untimeliness. Claimant does not deny that the hearing request was untimely filed. Instead, claimant contends that he established good cause for the late filing. However, given our disposition of this case, we need not reach that issue.

Attorney Fees

Liberty Northwest requested review. We have concluded that claimant's compensation should not be disallowed. Therefore, claimant's attorney is entitled to an assessed fee. 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 $850 is a reasonable assessed fee for claimant's efforts on Board review, to be paid by Liberty Northwest. 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 presented, and the value of the interest involved.

ORDER

The Referee's order dated October 17, 1990 is affirmed. For services on Board review, claimant's counsel is awarded $850, to be paid by Liberty Northwest.

In the Matter of the Compensation of
SHANNON L. MATHEWS, Claimant
WCB Case Nos. 89-07445 & 90-00544
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

The insurer requests reconsideration of our June 21, 1991 Order on Review that affirmed and adopted the order of the Referee with supplementation. Specifically, the insurer requests that we reconsider our order in light of the recent Board decision in Harry E. Forrester, 43 Van Natta 1480 (1991). Additionally, the insurer requests that we reconsider and reduce our award of assessed attorney fees.

Because claimant requested a hearing before May 1, 1990, and hearing was held before July 1, 1990, former ORS 656.262(10) applies. See Ida M. Walker, 43 Van Natta 1402 (1991). The Board analyzed the penalty-related attorney fee in the matter of Harry E. Forrester, supra, pursuant to amended ORS 656.262(10). Accordingly, a similar analysis is not appropriate to the present case.

Additionally, we conclude that the assessed attorney fee issue raised by the insurer's request for reconsideration was adequately considered and addressed in our prior order.

Accordingly, our June 21, 1991 order is abated and withdrawn. As supplemented herein, we republish our June 21, 1991 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
HENRY M. PARNELL, Claimant
WCB Case No. C1-00231
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Malagon, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Crider & Neidig.

Previously, on March 25, 1991, we approved the parties Claim Disposition Agreement. Pursuant to that agreement, in consideration of the payment of $42,500 by EBI Companies, claimant released his rights to future workers' compensation benefits, except medical services, for his compensable injury.

We received the insurer's April 9, 1991 letter seeking reconsideration and rescission of the CDA, or in the alternative requesting reformation of the CDA. The purpose of this request was to rectify the parties' failure to obtain the Director's approval for reimbursement from the Handicapped Workers' Reserve (HWR). However, inasmuch as we found that the insurer had requested abatement of the order after 10 days had passed since approval, we denied the motion for reconsideration in accordance with OAR 438-09-035(1).

Since our March 25, 1991 approval order issued, the Board has been made aware that the claim being disposed of was granted Handicapped Worker Reserve relief prior to the execution of the agreement by the parties. Thus, the Director or his designated representative was a necessary party to the agreement. See ORS 656.236(6). The agreement which was approved did not provide for the Director's approval and was not approved by him.

ORS 656.628(7) provides that any settlement of an HWR qualified claim is void, unless approved by the Director:

> "(7) Notwithstanding any other provision of law:
>
> (a) After a determination has been made by the director that an employer will receive reimbursement from the Handicapped Workers Reserve, any settlement of the claim by the parties is void unless made with the written approval of the director."

The director has defined the term "settlement" to include a claim disposition agreement. See OAR 436-40-005(10).

Thus, because the parties have attempted to settle a HWR qualified claim without the Director's approval, we find that the agreement entered into by the parties was "void." See ORS 656.628(7). It therefore follows that the Board's March 25, 1991 approval order was without authority, and is invalid as well.

On July 11, 1991, we received a revised CDA. This agreement contains the same terms and provisions of the prior submission. In addition, it has been approved by the Director's representative approving reimbursement of the claim from the Handicapped Workers' Reserve Fund. We find this agreement is in compliance with the applicable administrative rules and statutes. See ORS 656.236(6); 656.628(7)(a). 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.

In the Matter of the Compensation
BETTY J. CURTISS, Claimant
WCB Case No. 84-04967
ORDER ON REVIEW
Richard O. Nesting, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Neidig and Crider.

The self-insured employer requests review of Referee Mills' order that: (1) granted claimant permanent total disability, whereas prior Determination Orders had awarded her a total of 30 percent (96 degrees) unscheduled permanent disability for a low back injury; and (2) found that claimant was permanently and totally disabled as of October 1985. In its brief, the employer contends that, if the Referee erred in finding claimant permanently totally disabled as of October 1985, an offset of temporary disability benefits for the period of November 3, 1987 through June 20, 1988, should be authorized. On review, the issues are permanent total disability and offset. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact, with the exception of the final sentence in the second to last paragraph and the last paragraph.

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

The Referee concluded that claimant was permanently totally disabled. We agree.

In order to prove entitlement to permanent total disability benefits, claimant must prove that she is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a). 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 her nonmedical disabilities renders a work search futile, SAIF v. Scholl, 92 Or App 594, 597 (1988), she must also establish that she has made reasonable efforts to obtain regular gainful employment. ORS 656.206(3). Moreover, even if a work search would be futile, she must further establish that, but for the compensable injury, she would have returned to work. SAIF v. Stephen, 308 Or 41, 47-48 (1989).

In July 1986, claimant's treating neurologist, Dr. Berkeley, opined that claimant was permanently and totally disabled on October 4, 1985, when he saw her at the request of Dr. Cherry. Dr. Berkeley noted that claimant was unable to walk for any particular distance and was required to use a cane. Claimant had constant pain in the low back and legs and she suffered from severe muscle spasms. Claimant was unable to bend, lift, twist or do any housework. Dr. Berkeley opined that claimant had remained permanently and totally disabled with no changes.

In November 1989, Dr. Berkeley reiterated that claimant remained "fully disabled as before." He noted claimant's low back and left leg problems, in addition to muscular spasms and pain in the groin area. He reported that claimant was unable to sleep and had to get up to walk around every two hours.

In November 1989, the Orthopaedic Consultants examined claimant and diagnosed degenerative disc disease and postoperative status "lumbar laminotomy and foraminotomy x 2 with residuals." The Consultants also diagnosed chronic mechanical low back pain, chronic left S1 radiculopathy, exogenous obesity and psychological factors impeding recovery. The Consultants concluded that, from a physical standpoint, claimant was capable of performing sedentary work.

In March 1990, Dr. Berkeley reported that claimant's present condition was related to her industrial accident. He noted that claimant had difficulty sitting or standing for prolonged periods of time. She also had difficulty coping with housework and had to be constantly helped by her husband. In light of claimant's disabilities, Dr. Berkeley concluded that claimant was incapable of performing any type of work "even if sedentary," because of her persisting pain.

Finally, Dr. Berkeley reported that, during the nine years he had known claimant, he had never observed psychological factors impeding her recovery. He stated that claimant's complaints "were always related to some organic condition."

In April 1990, Dr. Parvaresh, psychiatrist, examined claimant for the third time. He diagnosed "psychological factors affecting physical condition." Dr. Parvaresh reported that claimant did not have major depression and did not have ongoing psychiatric impairment as it related to her ability to work. He concluded that claimant did not have ongoing psychiatric problems other than the underlying problems diagnosed as psychological factors affecting physical condition.

In June 1990, Dr. Tinker, psychologist, examined claimant and reported that she presented with a depressed mood and appropriate affect. He stated that claimant's depression was manifested by crying spells, social withdrawal, irritability, fatigue, sleep and appetite disturbance. Dr. Tinker noted that a recent MMPI administered by Dr. Parvaresh indicated that claimant had shown some improvement with regard to her depressed state. He also noted that an initial Beck Depression Inventory score placed claimant within the range of extremely severe depression, however, her most recent score was within the moderate to severe range of depression. Finally, Dr. Tinker concluded that claimant was severely depressed and anxious in reaction to the residuals of her job injury. He reported that, from a psychological standpoint, claimant did not appear capable of gainful employment.

Under the circumstances, we conclude that claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation, due to her 1979 compensable injury and its psychological sequelae. In reaching this conclusion, we rely upon the opinion of Dr. Berkeley. Dr. Berkeley, as claimant's treating neurologist for a nine year period, 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).

We are also convinced that claimant's psychological condition is related to her impairment. Although Dr. Parvaresh reported that claimant had improved and did not have major depression, he initially believed claimant was depressed, although he was not sure "that the depression was entirely related to her back pain, even though obviously chronic disability contributes to it." We do not find Dr. Parvaresh's recent opinion to be persuasive as he has not stated that claimant's depression had resolved and he emphasized that claimant was in much better spirits than during her visit in 1986, as demonstrated by no overt tearfulness, and claimant's ability to be congenial, smile and relate reasonably well.

On the other hand, Dr. Tinker reported that, during both visits, claimant presented with a depressed mood and affect. He noted that her depression was manifested by crying spells and other symptoms. Dr. Tinker did not disagree with Dr. Parvaresh's assessment that claimant's depression had improved. Nevertheless, he concluded that claimant was severely depressed, although, because of her optimistic demeanor and coping styles of denial and repression, she appeared less depressed than she in fact was.

We conclude that Dr. Tinker's opinion is consistent with the record and is supported by the medical evidence, including Dr. Parvaresh's earlier opinion and the most recent test results. Accordingly, we find Dr. Tinker's opinion persuasive in respect to claimant's psychological condition and her ability to obtain employment.

Finally, we are persuaded that claimant's compensable physical and psychological conditions preclude vocational retraining and make a work search futile. Claimant has expressed a willingness to return to work within her physical capabilities. Her inability to complete a training program was a result of a serious fall, rather than an unwillingness to cooperate with vocational services. Therefore, we are persuaded that, but for the compensable injury and its psychological sequelae, claimant would have been willing to seek regular gainful employment.

Assuming arguendo that claimant is not permanently and totally disabled from a medical standpoint, we would nevertheless conclude that she is permanently and totally disabled under the "odd-lot" doctrine. See Wilson v. Weyerhaeuser, 30 Or App 403 (1988). Claimant is 56 years of age and her work history is limited to that of a homemaker and a bakery helper. Although claimant began vocational retraining, it was interrupted by an injury. In addition, the vocational testimony indicated that, even though claimant might be able to obtain work at home doing telephone sales, she would not be able to hold such a job unless she could be productive. Dr. Berkeley's opinion indicates that claimant could not physically perform even sedentary work.

We, therefore, conclude that claimant's age, aptitude and lack of training, combined with her physical and psychological conditions, render her permanently totally disabled under the "odd-lot" doctrine.

Effective Date of Permanent Total Disability

The Referee concluded that claimant was permanently totally disabled since at least October 1985. On review, the employer contends that, because an order postponing action on own motion instructed the Referee to rate permanent disability based on claimant's condition at the time of the hearing, the Referee erred by awarding permanent total disability from any date other than that of the hearing. We disagree.

Although the Referee was directed to rate permanent disability based on claimant's condition at the time of hearing, he was not precluded from finding that claimant had proven entitlement to permanent total disability from an earlier date. Claimant is entitled to permanent disability benefits from the earliest date on which disability is proved to have existed. V.W. Johnson & Sons v. Johnson, 103 Or App 355 (1990).

Here, we have found that claimant is permanently totally disabled on a medical basis, as supported by the evidence regarding her physical and psychological conditions. Dr. Tinker testified that his review of the medical record indicated that claimant's onset of depression following her compensable injury occurred in the early to mid-1980's. Dr. Tinker noted claimant's symptoms of depression in 1983 and 1984.

Claimant's last award of compensation was a March 24, 1980 Determination Order that awarded an additional 5 percent unscheduled permanent disability. Claimant's treating physician, Dr. Berkeley, reported that claimant was permanently totally disabled as of October 1985. Because claimant's psychological condition existed before that time, we conclude that, as of October 1985, claimant was permanently and totally disabled. We, therefore, affirm the Referee on the issue of effective date of permanent total disability.

Offset

Because we have affirmed the Referee on the issue of effective date of permanent total disability, the issue of offset is moot.

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 $1,200, 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 significant complexity of the issues and the value of the interest involved.

ORDER

The Referee's order dated August 31, 1990 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,200, to be paid by the self-insured employer.

July 22, 1991 Cite as 43 Van Natta 1636 (1991)

In the Matter of the Compensation of
KENNETH V. HAMBRICK, Claimant
WCB Case No. 89-10273
THIRD ORDER ON RECONSIDERATION
Malagon, et al. Claimant Attorneys
Brian Pocock, Defense Attorney

The self-insured employer requests reconsideration of our April 12, 1991 Order on Review and June 6, 1991 Order on Reconsideration. Specifically, the employer disagrees with that portion of our order that awarded claimant's counsel an approved fee at the hearings level, notwithstanding claimant's failure to request such a fee until Board level. The employer contends that it has complied by paying claimant's compensation as ordered by the Referee and, therefore, it should not now be required to pay claimant's counsel an attorney fee.

In our first order on reconsideration, we concluded that claimant was entitled to an approved fee for services provided at the hearings level even though the Referee failed to approve a fee out of compensation and claimant did not request such a fee until reconsideration at Board level. We ordered the employer to pay the fee. We relied upon a Board case which held that, where a Referee erred by not awarding claimant's counsel an approved fee, the error may be corrected at Board level. Teresa R. Harmon, 42 Van Natta 1 (1990).

In Harmon, we concluded that, because our review is de novo and the administrative rules provide that the Referee shall approve a fee of 25 percent of the increased compensation, we may award claimant's counsel a fee in a case in which the Referee failed to do so. See OAR 438-15-040(1); 656.386(2). Additionally, we declined to speculate whether or not the insurer had paid the compensation ordered by the Referee. We concluded that even if such a finding could be made from the record, we would nonetheless be required to address the Referee's error. Teresa R. Harmon, 42 Van Natta at 2. We further held that if the employer had paid claimant the full award, the employer must nonetheless pay an additional amount as a fee. Teresa R. Harmon, 42 Van Natta 237 (1990).

On reconsideration, the employer argues that it has complied with the Referee's order and has paid the compensation due claimant. The employer contends that claimant's counsel had an obligation to request reconsideration from the Referee's order which failed to approve a fee, and because the issue was not raised, claimant's counsel should seek his fee from claimant, rather than from the employer.

While claimant's attorney is entitled to a fee, in the absence of a Referee's order approving a fee and directing it to be paid to the attorney, the

employer may not be required to pay an additional amount as a fee. The employer's argument has merit. We have held that an insurer is under no obligation to reimburse claimant's attorney for a misdirected attorney fee. Mohammad Zarifi, 42 Van Natta 670 (1990). In Zarifi, the insurer paid the entire compensation fee to claimant but claimant did not pay his attorney. We nevertheless concluded that the insurer was not required to reimburse claimant's attorney. The Board had not ordered direct payment of the fee to the attorney and there was no evidence that claimant consented to such direct payment.

We conclude that the rationale expressed in Zarifi conflicts with the Harmon case, in which the Referee never did order payment of an out-of-compensation fee. We conclude that if the insurer has no duty to pay an out-of-compensation attorney fee directly to claimant's counsel in a case in which the Referee has approved such a fee, it follows that, in a case such as the present one (i.e., where no fee was ever approved by the Referee), the employer similarly has no duty to pay the fee directly to claimant's attorney. Moreover, if the employer has already paid the compensation as ordered, we conclude that it would be inequitable to require the employer to now pay a fee as a result of the Referee's error and claimant's failure to timely request correction of the error. Therefore, to the extent that it is inconsistent with the Zarifi case, we disavow our holding in Harmon.

Accordingly, the employer's request for reconsideration is granted and our prior orders are withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our April 12, 1991 order and our June 6, 1991 and June 26, 1991 orders on reconsideration, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

July 22, 1991 Cite as 43 Van Natta 1637 (1991)

In the Matter of the Compensation of
WILLIAM J. HARRISON, Claimant
WCB Case No. 89-20610
ORDER ON RECONSIDERATION
Welch, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

On June 14, 1991, we abated our May 29, 1991 Order on Review that affirmed a Referee's order that: (1) declined to postpone the hearing pending appeal of claimant's medical services claim under the Longshore and Harbor Workers' Compensation Act; and (2) set aside the self-insured employer's denial of claimant's occupational disease claim for a left knee condition. We abated our order to allow further consideration in light of the Court of Appeals' decision in Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991). Having reviewed the compensability issue in view of the court's recent decision, we proceed with our reconsideration.

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 was apparently working for the self-insured employer at the time of the February 9, 1990 hearing. Therefore, the last work exposure which could have contributed to his knee condition occurred on that date. Accordingly, the occupational disease law effective between January 1, 1988 and July 1, 1990 before its amendment is applicable. See Johnson, supra, at 146-48; Donna E. Aschbacher, 41 Van Natta 1242 (1989).

Claimant's work as a plumber involved repetitive bending, stooping, crawling, kneeling, walking and climbings stairs. Considering these activities, we conclude that his claim is for a condition resulting from a "series of traumatic events or occurrences" under former ORS 656.802(1)(c). To establish that his condition is compensable under subsection (1)(c), claimant must prove that these traumatic events at work were the major contributing cause of a worsening of his preexisting knee condition. Aetna Casualty Co. v. Aschbacher, supra. Major contributing cause means an activity or exposure, or combination of activities or exposures, which contribute more to the onset or worsening than all other activities or exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); Dethlefs v. Hyster Co., 295 Or 309-310 (1983).

In our May 19, 1991 order, we determined that the claim was compensable, due to claimant's worsened symptoms, based on the opinion of Dr. La Gosse, long-time treating physician. Upon reconsideration, we continue to find La Gosse's opinion concerning causation to be persuasive, for the reasons stated in our prior order.

During the years that La Gosse treated claimant for knee problems, he repeatedly opined that claimant's work activities aggravated his knee symptoms. However, he also opined that claimant's "condition would have been essentially the same even had he engaged in a more sedentary or less strenuous form of gainful occupation" and that claimant's history since 1978 "represents a natural progressive degenerative arthritis." (Ex. 51, emphasis added). Therefore, we conclude that claimant has not carried his burden of proving that his work activities with the employer were the major contributing cause of his worsened left knee condition. Consequently, that portion of the Referee's order which set aside the employer's denial is reversed. The employer's denial is reinstated and upheld.

Claimant's attorney is not entitled to a fee for his services at hearing or on review because the compensation awarded at hearing is disallowed and he did not successfully defend against the employer's appeal. See ORS 656.386(1) & ORS 656.382(2).

Accordingly, our prior order is withdrawn. On reconsideration, as supplemented and amended herein, we adhere to and republish our May 29, 1991 order effective this date, except for those portions pertaining to compensability and attorney fees. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
NICOLASA MARTINEZ, Claimant
WCB Case No. 90-12293
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Crider.

Claimant requests review of Referee Holtan's order that: (1) awarded claimant's attorney 50 percent of a penalty under ORS 656.262(10) for the self-insured employer's untimely payment of medical services; and (2) declined to award claimant an attorney fee under ORS 656.382(1) for the same conduct. On

review, claimant contends that she is entitled to a carrier-paid attorney fee pursuant to ORS 656.382(1). We affirm.

FINDINGS OF FACT

On April 4, 1990, the Board affirmed and adopted a Referee's December 5, 1988 order that set aside the employer's denial of claimant's medical services claim for her low back condition. This claim pertained to chiropractic treatments provided by Dr. Romanick. The Board's order was not appealed within 30 days from its issuance.

The employer did not pay the disputed chiropractic bills within 60 days of the Board's order. On June 11, 1990, the Board received claimant's hearing request, which raised the issues of medical services, penalties and attorney fees. The employer paid the medical bills on July 6, 1990.

Prior to the scheduled hearing, the parties entered into an "Interim Partial Stipulation and Order of Dismissal." Pursuant to the stipulation, the employer agreed that $1,289.91 in medical bills were untimely paid. Consequently, the employer agreed to pay a penalty equal to 25 percent of that amount, i.e., $322.47.

In accordance with the stipulation, claimant agreed to accept the aforementioned penalty on the condition that she could seek entitlement to a carrier-paid attorney fee under ORS 656.382(1). In the event that the Referee did not grant her such an attorney fee, claimant agreed that her attorney would receive one-half of her penalty, i.e., $161.24. Thereafter, the Referee approved the interim stipulation and accepted written arguments regarding claimant's entitlement to an attorney fee under ORS 656.382(1).

CONCLUSIONS OF LAW

Relying upon ORS 656.262(10), the Referee held that claimant's attorney was entitled to one-half of the amount "then due" at the time of the employer's unreasonable conduct. Reasoning that the aforementioned statute was directly on point, the Referee concluded that claimant was not entitled to a separate attorney fee under ORS 656.382(1) for the same unreasonable conduct. We agree.

Claimant requested a hearing in this case after May 1, 1990. The hearing was convened after July 1, 1990. Neither party contends that the former law is controlling. Therefore, the amendments to ORS 656.802 apply. Or Laws 1990 (Special Session), ch 2, 54; see Ida M. Walker, 43 Van Natta 1402 (1991).

Claimant contends that ORS 656.382(1) provides a separate route for an attorney fee award distinct from ORS 656.262(10), particularly when the carrier has not timely complied with an unappealed Board order. ORS 656.382(1) does warrant an attorney fee under some circumstances in which none may be awarded under ORS 656.262(10). However, under the circumstances presented in this case, it does not.

Former ORS 656.262(10) authorized the assessment of an attorney fee under ORS 656.382(1) if a carrier unreasonably refuses to pay compensation. However, the legislature amended ORS 656.262(10) during its 1990 Special Session. See Or Laws 1990 (Special Session), Ch. 2, 15. In place of the language authorizing the assessment of an attorney fee under ORS 656.382(1), ORS 656.262(10)(a) provides that, if the worker is represented by an attorney, the attorney shall receive one-half the penalty "in lieu of an attorney fee." Accordingly, claimant's attorney is awarded one-half of the penalty assessed by the Referee's order, in lieu of an attorney fee.

We are mindful that the legislature has not repealed ORS 656.382(1), which authorizes the assessment of an attorney fee if a carrier refuses to pay compensation due under a Board order or otherwise unreasonably resists the payment of compensation. We decline to assess an attorney fee in this case, however, because the factual basis asserted in support of the fee -- the employer's refusal to pay medical bills found compensable under an unappealed Board order -- is identical to the factual basis for which a penalty is assessable under ORS 656.262(10)(a). Moreover, there are amounts "then due" upon which to assess a penalty under ORS 656.262(10). Under such circumstances, the simultaneous assessment of an attorney fee under ORS 656.382(1) would contravene the legislative intent expressed in ORS 656.262(10)(a) that claimant's attorney receive one-half the penalty, "in lieu of an attorney fee."

In reaching this conclusion, we wish to emphasize that ORS 656.382(1) was not impliedly repealed by the recent amendments to ORS 656.262(10). When appropriate, an attorney fee may still be assessed under ORS 656.382(1). For example, if a carrier engages in conduct which constitutes unreasonable resistance to the payment of compensation but either does not violate ORS 656.262(10) or there are no amounts then due upon which to assess a penalty, claimant's attorney would not be entitled to an amount under ORS 656.262(10) but would be entitled to an attorney fee under ORS 656.382(1) for such unreasonable resistance. In other words, we do not consider ORS 656.382(1) to have been displaced by the recent amendments to ORS 656.262(10).

In conclusion, for the reasons discussed above, we conclude that claimant is not entitled to an attorney fee under ORS 656.382(1). Accordingly, we affirm the order of the Referee.

ORDER

The Referee's order dated December 13, 1990 is affirmed.

In the Matter of the Compensation of
JAMES E. PERFECT, Claimant
WCB Case No. 89-18999
ORDER ON RECONSIDERATION
Dahn & Morrison, Claimant Attorneys
Jerome Larkin (Saif), Defense Attorney

Claimant requests reconsideration of our June 25, 1991 Order on Review. In that order, we concluded that the record was not improperly, incompletely or otherwise insufficiently developed absent claimant's newly submitted statements from Drs. Fraback and Gray. We also concluded that the Referee correctly declined to grant claimant permanent and total disability and affirmed and adopted the Referee's order.

On reconsideration, claimant argues: (1) our order incorrectly states that claimant's attorney did not request a continuance; (2) our order addresses Mr. Sanders' testimony as reliable when he did not testify; and (3) the modified job created by the employer was not within claimant's physical capacity.

In our initial Order on Review, we declined to remand for admission of the newly submitted statements in part because, although claimant's attorney initially requested a continuance, after the Referee stated that she would consider the disputed hearsay testimony only as to the basis of the expert's opinion and not as substantive evidence, claimant's attorney did not thereafter move for a continuance. Assuming claimant's failure to reassert his request for

continuance was not a withdrawal of that request, we would still decline to remand. The failure to reassert the request for continuance was only one of several grounds for our ruling. We adhere to that ruling based on the alternative grounds discussed in our Order on Review.

Claimant's remaining arguments were adequately addressed in our initial Order on Review.

Accordingly, our June 25, 1991 Order on Review is abated and withdrawn. As supplemented herein, we republish our June 25, 1991 Order on Review in its entirety. The parties rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

July 22, 1991 Cite as 43 Van Natta 1641 (1991)

In the Matter of the Compensation of
JOHN C. SCHILTHUIS, Claimant
WCB Case No. 89-25021
ORDER ON RECONSIDERATION
Garlock, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

The insurer has requested reconsideration of our June 24, 1991 Order on Review. Specifically, the insurer notes that the Order paragraph inadvertently awarded claimant 3.84 degrees for 2 percent scheduled permanent partial disability of both the right and left wrists rather than 3.0 degrees. On reconsideration, we agree with the insurer's assessment.

Accordingly, our June 24, 1991 order is abated and withdrawn. On reconsideration, the Order paragraph is modified to award 2 percent (3.0) degrees scheduled permanent disability for loss of use or function of each wrist/forearm. As corrected herein, we adhere to and republish our June 24, 1991 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

July 23, 1991 Cite as 43 Van Natta 1641 (1991)

In the Matter of the Compensation of
MARTIN COELHO, Claimant
WCB Case No. C1-01388
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Gatti, et al., Claimant Attorneys
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Niedig and Westerband.

On July 2, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration 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.

On July 16, 1991, we received a letter from claimant. This letter states that claimant disapproves of the agreement. Yet, the letter also suggests that

claimant desires the Board to accept the agreement. Moreover, claimant indicates that he desires consideration of $15,000 in settlement of the claim. However, we note that the proposed agreement has a stated consideration of $8,000. Although claimant is represented by counsel, there is no indication that his counsel or the insurer's counsel has received a copy of this letter. Therefore, a copy of the letter is provided to the respective counsels along with this order.

Under such circumstances (particularly since claimant has expressed dissatisfaction with the agreement and desires a settlement much larger than the present proposed disposition), we interpret claimant's letter as a request that the disposition be disapproved. See ORS 656.236(1)(c). Inasmuch as this disapproval request has been made within 30 days of the submission of the disposition to the Board, the request is granted. See OAR 438-09-025(2).

Should the parties disagree with this decision, they are reminded that reconsideration may be requested under OAR 438-09-035. However, to be considered, a motion for reconsideration must be filed with the Board within 10 days from the mailing date of this order and must specifically state the reason reconsideration is sought. See OAR 438-09-035(1), (2).

Because the proposed disposition has been disapproved, the SAIF Corporaton shall recommence payment of any 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
TERRI A. FERGUSON, Claimant
WCB Case No. 90-14135
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband, Neidig and Crider.

Claimant requests review of Referee Menashe's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a bilateral shoulder condition. On review, the sole issue is compensability.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated June 21, 1990 is affirmed.

Board Member Crider concurring.

I agree with the Referee's conclusion that claimant has established that work activities were a material cause of a worsening of the symptoms of her bilateral shoulder rotator cuff calcific tendinitis but has failed to establish that those activities were the major cause of the onset or worsening of the condition.

Claimant contends that the 1990 amendments to the Workers' Compensation law do not apply to this case because the claim, and the medical services

therefore, were incurred prior to the effective date of the Act. In an earlier case, I indicated my agreement with the view that the Act was not intended to be retroactively applied. The majority of the Board disagreed. See Ida M. Walker, 43 Van Natta 1402 (1991).

In this case, however, claimant can prevail under neither the old law nor the new law. See Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991). Therefore, the outcome of this case does not turn on the retroactivity question.

July 23, 1991 Cite as 43 Van Natta 1643 (1991)

In the Matter of the Compensation of
JACK J. FORD, Claimant
WCB Case No. 90-11658
ORDER ON REVIEW (REMANDING)
Olson, et al., Claimant Attorneys
Robert J. Jackson (Saif), Defense Attorney

Reviewed by Board Members Westerband and Neidig.

The SAIF Corporation requests review of Referee Brown's order that dismissed claimant's hearing request without prejudice. We remand.

FINDINGS OF FACT

On April 25, 1990, a Determination Order issued which: (1) granted temporary disability; (2) did not grant permanent disability; and (3) found claimant's left knee condition to be medically stationary on February 14, 1990.

On May 30, 1990, claimant requested a hearing and specified the issues as: (1) appeal of the April 25, 1990 Determination Order and (2) scheduled permanent partial disability.

On June 15, 1990, SAIF sent claimant a letter by certified mail. Noting that it had received information indicating that claimant wished to reopen his claim because of an alleged worsening of his condition, SAIF denied the request. On June 22, 1990, claimant supplemented his hearing request by adding as an issue the June 15, 1990 denial.

On August 1, 1990, a hearing was scheduled to take place at Coos Bay on October 9, 1990. The case was assigned WCB Case No. 90-11658.

On July 25, 1990, claimant was examined by Dr. Bert, his treating physician. In a chart note (Ex. 14a), Bert stated that claimant was "not yet stationary." Such a statement was the first indication from Bert questioning whether the claim should have been closed. (Exs. 14, 17). A copy of this chart note was provided to SAIF. (Ex. 14a). On September 28, 1990, a copy of Exhibit 14a was mailed to claimant's attorney. (Tr. 6). Claimant's attorney attempted to contact Dr. Bert and discovered that he was on vacation or out of town since September 28, 1990, and would not return until October 15, 1990. (Tr. 5).

At the October 9, 1990 hearing, claimant's attorney explained his inability to pursue the premature closure issue due to Dr. Bert's absence and requested a continuance to submit a report from Dr. Bert when he returned. SAIF's counsel opposed the motion, contending that there had been no showing of due diligence because the chart note which questioned whether claimant was medically stationary was dated July 25, 1990. The Referee denied the continuance, stating

that a number of witnesses were ready to testify. Claimant's attorney then withdrew claimant's hearing request.

The Referee dismissed claimant's hearing request without prejudice. SAIF's attorney opposed the dismissal without prejudice, arguing that it should be with prejudice.

On October 19, 1990, claimant requested another hearing and specified the issues as: (1) an appeal of the April 15, 1990 Determination Order; (2) scheduled permanent partial disability; and (3) premature closure.

This second hearing is currently pending and was ultimately set for July 31, 1991 at Coos Bay. It is assigned to Referee Gruber under WCB Case No. 90-19806.

CONCLUSIONS OF LAW AND OPINION

SAIF argues that the Referee erred in granting the dismissal without prejudice. On the facts of this case, SAIF distinguishes Julie Mayfield, 42 Van Natta 871 (1990), and Peter M. Grocki, 40 Van Natta 777 (1988), in which we found that those Referees did not abuse their discretion in granting a dismissal without prejudice.

We need not address the issue of whether the dismissal should have been granted with or without prejudice because we conclude that the Referee abused his discretion in denying claimant's initial request for a continuance in this case. We reach such a conclusion because it was the denial of a continuance that put this case in its present posture.

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). We review for abuse of discretion. See Mark G. Smith, 43 Van Natta 315 (1991).

At hearing, claimant's attorney stated that the first evidence he received that supported the issue of premature closure was Dr. Bert's July 25, 1990 chart note which he received on or about September 28, 1990. Dr. Bert's previous reports indicated that claimant was medically stationary. (Exs. 14, 17). This July chart note stated that claimant "is not yet stationary." Claimant's attorney attempted to contact Dr. Bert and discovered that Bert was out of town on vacation since September 28 and until October 15, 1990. Claimant's attorney argued that he had established due diligence in pursuing the premature closure issue as soon as he had any evidence as to its existence.

In response, SAIF's counsel did not contest claimant's attorney's representation concerning the receipt of Dr. Bert's chart note. Rather, arguing that the chart note was dated in July 1990, SAIF's counsel contended that there had been no showing of due diligence to justify a continuance of the hearing.

The Referee implicitly found that claimant's attorney had not exercised due diligence by insisting that the hearing would close that day and denying the requested continuance. We vacate the Referee's order and remand for hearing.

On de novo review, we find that claimant's attorney's unrebutted statements establish that the circumstances surrounding the requested continuance were extraordinary and beyond the control of the requesting party. See Elizabeth A. Lawrence, 42 Van Natta 848, 850 (1990). Furthermore, we find that completion of the record could not have been accomplished with due diligence. OAR 438-06-091(4); 438-06-081(4). By the time claimant's attorney received

Exhibit 14a, which notified him that premature closure was a possible issue, Dr. Bert was unavailable and remained unavailable until six days after the date of the hearing.

Under these circumstances, we conclude that any response from Dr. Bert concerning the premature closure issue was unobtainable with due diligence prior to the hearing. We also find that the Referee abused his discretion in denying claimant's request for a continuance to submit a report from Dr. Bert upon his return. The hearing could have proceeded with the testimony of the witnesses who were present to testify, with the record remaining open for the limited purpose of permitting the submission of a report concerning the premature closure issue from Dr. Bert and granting SAIF the opportunity to submit a report in rebuttal or a deposition from Dr. Bert.

Presumably, such evidence has subsequently been developed since WCB Case No. 90-19806 (which involves the identical issues raised in this matter, including the premature closure issue) is currently pending at the Hearings Division. Inasmuch as WCB Case No. 90-19806 is scheduled for July 31, 1991 before Referee Gruber in Coos Bay and because the issues are identical, we remand this case to Referee Gruber for consolidation. Following a hearing and the closure of the record, Referee Gruber shall issue a final, appealable order addressing the issues raised in these consolidation cases.

ORDER

The Referee's order dated October 17, 1990 is vacated. This matter is remanded to Referee Gruber for consolidation with WCB Case No. 90-19806 and further proceedings consistent with this order.

July 23, 1991 Cite as 43 Van Natta 1645 (1991)

In the Matter of the Compensation of
ROGER B. LINDSAY, Claimant
WCB Case No. C1-01454
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Welch, et al., Claimant Attorneys
Nelson, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

On July 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 438-15-052 provides that, when a claim disposition agreement is approved, the Board may approve an attorney fee in an amount up to 25 percent of the first $12,500 of the agreement proceeds plus 10 percent of the remaining proceeds. Under extraordinary circumstances, an attorney fee exceeding those strictures may be approved. Id.

Here, the agreement provides for a structured settlement whereby the insurer agrees to pay claimant and his attorney the following consideration: (1) $250 payable monthly for 24 months guaranteed; (2) $17,325 payable in lump sum when claimant attains the age of 65 years, one month; and (3) $4,675 payable in lump sum to claimant's attorney as an attorney fee when the agreement is

approved. The agreement further provides that, if claimant does not survive to receive the above payments, they shall be paid to his estate.

Thus, when the terms of the agreement have been fully performed, claimant or his estate would receive settlement proceeds totalling $28,000. Out of that amount of consideration, claimant's attorney would receive an attorney fee of $4,675. However, unlike the amounts payable to claimant, the attorney fee would be paid when the agreement is approved. In order to determine whether the attorney fee is within the strictures of OAR 438-15-052, we must determine the value of the structured settlement proceeds. Because the structured settlement proceeds are to be paid over an extended period of time while the attorney fee is to be paid when the claim disposition agreement is approved, we require the present discounted value of the settlement as of the date the parties executed the agreement. See, e.g., Lyman K. Hampton, 43 Van Natta 1620 (1991).

The agreement does not provide the present discounted value of the settlement. It is reasonable to presume, however, that the present discounted value would be less than the total payout of $28,000. Because the proposed attorney fee of $4,675 exceeds the strictures of OAR 438-15-052 for any amount of settlement proceeds below $28,000 and no extraordinary circumstances have been advanced to justify such a fee, this agreement is deemed 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.

July 23, 1991 Cite as 43 Van Natta 1646 (1991)

In the Matter of the Compensation of
HOMAR S. LOPEZ, Claimant
WCB Case No. C1-00150
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT
Bottini, et al., Claimant Attorneys
Gregory P. Lynch, Attorney
Dennis Martin (Saif), Defense Attorney

Claimant requests reconsideration of the Board's July 1, 1991 Order Disapproving Claim Disposition Agreement. The agreement was disapproved because: (1) the proposed attorney fee was excessive; (2) the notice enclosure was not attached to the agreement as referenced in the agreement; and (3) the agreement did not include original signatures by the parties.

In his motion for reconsideration, claimant states that the proposed attorney fee is for his counsel's services in negotiating both the claim disposition and settlement of a third-party claim. Moreover, claimant submits a copy of the notice enclosure, and represents that this document was previously provided to claimant, but that during the process of "changing hands" was inadvertently misplaced. In addition, claimant advises that the agreement with the parties' original signatures was lost while being routed from the Department of Insurance and Finance to the Board. These representations are unrebutted. We

find that claimant's explanations regarding the notice requirement and lack of original signatures sufficiently addresses the Board's prior concerns.

OAR 438-09-035(3) provides that reconsideration of a final order issued pursuant to ORS 656.236 shall be limited to the record before the Board at the time its final order was mailed and that no additional information will be considered. We find that claimant submits new information that there were extraordinary circumstances justifying an attorney fee exceeding the strictures of OAR 438-15-052. That information was not before the Board at the time the disapproval order was issued. Moreover, the new information concerning extraordinary circumstances contradicts the provision in the agreement that the proposed attorney fee does not exceed the strictures of OAR 438-15-052. (See CDA page 2, lines 24-26 through page 3, lines 1-22). Consequently, even if we were to consider this new information regarding the proposed attorney fee, we would not disturb our prior conclusion.

However, claimant's counsel alteratively states that "If the Board feels this fee is not justified, we request you substitute the amount you deem appropriate in order to finally allow client his recovery." Inasmuch as claimant's counsel has indicated his willingness to accept a reduced fee, we conclude that claimant's counsel is entitled to an attorney fee in accordance with OAR 438-15-052. Such a conclusion is also in accordance with the aforementioned provision that claimant's attorney fee should not exceed the strictures of OAR 438-15-052. Since the proceeds of the disposition equal $25,000, claimant's counsel's attorney fee should not exceed $4,375. See OAR 438-15-052.

Accordingly, claimant's motion for reconsideration is granted, and our prior order withdrawn. On reconsideration, we find that the agreement is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. We further find no 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. Our signatures upon this order shall constitute our approval of the parties' disposition subject to one exception. Rather than the attorney fee proposed in the parties' agreement, an attorney fee payable to claimant's attorney of $4,375 is approved.

IT IS SO ORDERED.

July 24, 1991 Cite as 43 Van Natta 1647 (1991)

In the Matter of the Compensation of
PEGGY D. McCLEARY, Claimant
WCB Case No. 89-05192
ORDER ON RECONSIDERATION
Patrick Lavis, Claimant Attorney
Kenneth Russell (Saif), Defense Attorney

Claimant requests reconsideration of our June 24, 1991 Order on Review in which we upheld the SAIF Corporation's denial of her claim for Raynaud's Syndrome. On reconsideration, claimant argues that her Raynaud's Syndrome is compensable based on the holding in Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498 (1990), on remand, 43 Van Natta 922 (1991). We disagree.

In Vorderstrasse, the claimant established that work activities were the major contributing cause of the onset of symptoms diagnosed as Raynaud's Syndrome. The claim was found to be compensable because the medical evidence established that the claimant's symptoms were the disease. In the present case,

claimant must prove that work activities caused a pathological worsening of her preexisting Raynaud's Syndrome. The medical evidence in the record before us does not establish a pathological worsening, as distinct from a symptomatic increase. We cannot use the medical evidence submitted in the Vorderstrasse case to support compensability in the present case.

Accordingly, our June 24, 1991 Order on Review is abated and withdrawn. As supplemented herein, we republish our June 24, 1991 Order on Review in its entirety. The parties rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

July 24, 1991 Cite as 43 Van Natta 1648 (1991)

In the Matter of the Compensation of
LINDA J. HUGHES SMITH, Claimant
WCB Case Nos. 89-26261 & 88-11457
ORDER OF ABATEMENT
Olson, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Claimant requests reconsideration of our June 28, 1991 order that reversed a Referee's order which increased claimant's unscheduled permanent disability award for a low back injury from 23 percent (73.6 degrees), as awarded by a Determination Order, to 60 percent (192 degrees). Specifically, claimant contends that the appropriate legal standard was incompletely stated, thus the Board misapplied the law to the facts of this case.

Before addressing the motion, we request a response from SAIF within 10 days from the date of this order. Consequently, our June 28, 1991 order is abated and withdrawn. At the conclusion of the aforementioned period, we shall take this matter under advisement.

IT IS SO ORDERED.

July 24, 1991 Cite as 43 Van Natta 1648 (1991)

In the Matter of the Compensation of
STEVEN W. SMITH, Claimant
Own Motion No. 91-0106M
OWN MOTION ORDER ON RECONSIDERATION
James W. Powers, Claimant Attorney
SAIF Legal Department, Defense Attorney

By Own Motion Order dated June 28, 1991, the Board reopened claimant's claim for the payment of temporary disability benefits. Claimant now requests the assessment of a penalty and attorney fee for the SAIF Corporation's allegedly unreasonable delay in processing his own motion request. We dismiss.

Though not specified, the apparent basis for claimant's request is ORS 656.262(10), which provides that, if an insurer unreasonably delays the payment of compensation, the insurer shall be liable for an additional amount up to 25 percent of the amounts of compensation then due. However, effective July 1, 1990, ORS 656.262(10)(a) provides in relevant part:

> "Notwithstanding any other provision of this chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount described in this subsection. * * * * If the worker is represented by an attorney, the worker shall be paid one-half the additional amount and the worker's attorney shall be paid one-half the additional amount, in lieu of an attorney fee."

Here, claimant seeks an attorney fee, presumably under ORS 656.382(1), in addition to the penalty. We nevertheless find that we lack jurisdiction of claimant's request. ORS 656.262(10)(a) provides that, if a penalty is assessed and claimant is represented, the Director shall award one-half of the penalty to the attorney, in lieu of a fee. That provision therefore contemplates that a worker seeking a penalty may be represented by an attorney before the Director. If the Director's jurisdiction could be avoided by merely requesting an attorney fee under ORS 656.382(1) in addition to the penalty, the aforementioned statutory provision would be rendered superfluous. We decline to read the statute accordingly. We conclude that the Director has exclusive jurisdiction of claimant's request pursuant to ORS 656.262(10)(a). See Darrell D. Tuttle, 43 Van Natta 1210 (1991).

Accordingly, claimant's request for a penalty and attorney fee is dismissed for lack of jurisdiction. The request should be directed to the Director.

IT IS SO ORDERED.

July 24, 1991 Cite as 43 Van Natta 1649 (1991)

In the Matter of the Compensation of
FRANCISCO VILLAGRANA, Claimant
Own Motion No. 90-0077M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Nichols & Bogardus, Claimant Attorneys
Bottini & Bottini, Defense Attorneys

The self-insured employer requests reconsideration of our June 27, 1991, Own Motion Order Reviewing Carrier Closure which set aside its claim closure as premature, awarded additional temporary disability benefits and assessed a penalty for the employer's unreasonable refusal to pay compensation. Claimant has not responded to the motion.

The employer contends that OAR 438-12-035(2) authorized the termination of temporary disability benefits pursuant to the Director's rules in OAR 436, Division 30. The employer further contends that it properly terminated temporary disability benefits in accordance with the provisions of OAR 436-30-036. We disagree.

When we exercise our own motion authority and reopen a claim for the payment of temporary disability benefits, those benefits must be paid in accordance with OAR 438-12-035. OAR 438-12-035(2) provides: "Temporary total disability compensation shall continue to be paid under the relevant statutory provisions and regulations established by the Director for all other claims until termination of such benefits is authorized by the terms of ORS 656.268." Thus, the Director's regulations are expressly applicable to the payment, not the termination, of temporary total disability benefits. In other words, the employer is required to pay benefits at the rate and in the manner prescribed by the

Director's regulations for all other claims; however, the termination of such benefits must be authorized by ORS 656.268. Accordingly, the employer's termination of benefits in accordance with OAR 436-30-036 was improper. Moreover, inasmuch as the processing of own motion claims is not governed by ORS 656.262, the employer's reliance on ORS 656.262(4) is similarly misplaced.

ORS 656.268(3) authorizes the termination of temporary total disability benefits when one of the following events first occurs: (1) the worker returns to regular or modified employment; (2) the attending physician gives the worker a written release to return to regular employment; and (3) the attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment. Thereafter, temporary partial disability benefits must be paid if claimant is temporarily and partially disabled. See OAR 438-12-035(3).

There is no evidence that claimant returned to, or was released for, regular work before closure of his claim in April, 1991. Therefore, claimant was entitled to temporary disability benefits through the date of claim closure.

The employer further contends that, by enrolling as a full-time student in June, 1990, claimant withdrew from the work force, thereby permitting the termination of further temporary disability benefits. The employer attempts to distinguish this case from Weyerhaeuser Co. v. Kepford, 100 Or App 410, 414-15 (1990), on the basis that Kepford involved a retired worker. We find the distinction immaterial. In Kepford, the court held that, if a worker is in the work force when he became disabled by the worsening of the compensable injury and therefore qualifies for temporary disability benefits, he is entitled to receive those benefits until termination is authorized, even though he subsequently withdrew from the work force. Accordingly, claimant's enrollment as a full-time student did not justify the termination of temporary disability benefits.

Finally, we are persuaded that claimant's contentions regarding the penalty and medically stationary issues were adequately addressed in our previous order.

Accordingly, our June 27, 1991, order is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our June 27, 1991, order in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD L. ZIEMER, Claimant
WCB Case No. 91-00712
ORDER OF DISMISSAL (REMANDING)
Frank J. Susak, Claimant Attorney
Thomas Castle (Saif), Defense Attorney

Claimant has requested Board review of Referee Knapp's order dated May 24, 1991. We have reviewed the request to determine whether we have jurisdiction to consider it. We conclude that jurisdiction rests with the Hearings Division.

FINDINGS OF FACT

Referee Knapp's Opinion and Order issued May 24, 1991. On June 21, 1991, Referee Knapp issued an Order of Abatement to consider claimant's request for

reconsideration. That same day, June 21, 1991, claimant mailed by certified mail his request for Board review of the Referee's May 24, 1991 order to the Board.

CONCLUSIONS OF LAW

Where simultaneous acts affect the vesting of jurisdiction in this forum, in the interest of administrative economy and substantial justice, we will give effect to the act that results in the resolution of the controversy at the lowest possible level. James D. Whitney, 37 Van Natta 1463 (1985).

Here, the Referee's May 24, 1991 order was abated on June 21, 1991. That same day, claimant filed his request for Board review of the Referee's May 24, 1991 order. See OAR 439-05-046(1)(b). Since the Referee abated his order simultaneously with claimant's request for Board review, we shall give effect to the Order of Abatement. Accordingly, the request for Board review is dismissed as premature. This matter is remanded to Referee Knapp for further consideration.

IT IS SO ORDERED.

July 26, 1991 Cite as 43 Van Natta 1651 (1991)

In the Matter of the Compensation of
JOYCE SIEGERT, Claimant
WCB Case No. 90-22654
ORDER DENYING RECONSIDERATION
Carrol J. Smith (Saif), Defense Attorney

Claimant's former attorney requests reconsideration of our June 28, 1991 order that dismissed his request for review of a Referee's order that had dismissed claimant's hearing request seeking a carrier-paid attorney fee for allegedly unreasonable resistance to the payment of compensation and had declined to award an attorney fee for the aforementioned conduct. We took such an action because claimant had terminated her relationship with the attorney prior to the convening of the hearing which had been requested on her behalf. We reasoned that the attorney lacked the authority to proceed further on claimant's hearing request or to request Board review of the Referee's dismissal order.

Claimant's former attorney asks that we address the question of his entitlement to a reasonable fee payable from claimant's compensation for his efforts in obtaining compensation prior to the hearing. We deny the request. Inasmuch as we have previously held that claimant's former attorney lacked authority to proceed further on claimant's hearing request or to request Board review of the Referee's order, it follows that we lack authority to consider any issue raised by the attorney's appeal.

Accordingly, the motion for reconsideration is denied. The parties' rights of appeal shall continue to run from the date of our June 28, 1991 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RUDOLPH D. SODERGREN, Claimant
WCB Case No. 90-18722
ORDER OF DISMISSAL
Rick Dawson (Saif), Defense Attorney

Claimant has requested review of Referee Thye's order dated May 28, 1991. The SAIF Corporation has moved for dismissal, contending that the request is untimely. The motion is granted.

FINDINGS OF FACT

The Referee's order issued May 28, 1991. On June 28, 1991, claimant mailed a request for review of the order to the Board. The request, which was dated June 27, 1991, was mailed by certified mail. There was no certification or any other indication on the request that copies had been provided to the other parties to the proceeding.

On July 8, 1991, the Board mailed a computer-generated letter to the parties acknowledging the request.

CONCLUSIONS OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

If filing of a request for Board review of a Referee's order is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing. OAR 438-05-046(1)(b). If the request is actually received by the Board after the date for filing, it shall be presumed that the mailing was untimely unless the filing party establishes that the mailing was timely. Id.

Here, the 30th day after the Referee's May 28, 1991 order was June 27, 1991. Claimant's request for Board review was dated June 27, 1991. Yet, his request for Board review was not filed until June 28, 1991, the date his request was mailed by certified mail to the Board. See ORS 656.289(3); 656.295(2); OAR 438-05-046(1)(b). Consequently, we lack jurisdiction to review the Referee's order which has become final by operation of law. See ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, supra.

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

Accordingly, the request for Board review is dismissed.

In the Matter of the Compensation of
HUBERT W. BARKER, Claimant
WCB Case No. 87-00261
ORDER ON REMAND
Malagon, et al., Claimant Attorneys
Ronald Pomeroy (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Barker v. Farmers Packing Company, 107 Or App 376 (1991). The court has concluded that there was substantial evidence to support our prior findings in Hubert W. Barker, 42 Van Natta 961 (1990), that claimant refused an offer of an available job that was within his physical abilities and that he had not made a reasonable effort to find work. Considering the latter finding, the court determined that a conclusion that claimant was not entitled to permanent total disability benefits was required. However, the court held that there was no substantial evidence to support our statement that claimant had a "documented history of functional overlay." Reasoning that such an erroneous finding could have influenced our decision, the court has reversed and remanded for reconsideration.

In accordance with the court's instructions, we have proceeded to reconsider this matter. After completing our reconsideration, subject to the following exception, we continue to adhere to our prior findings and conclusions that claimant is not entitled to permanent total disability benefits. In conducting this reconsideration, we expressly do not adhere to our prior erroneous finding that claimant has a "documented history of functional overlay." Furthermore, we wish to emphasize that our prior erroneous finding that claimant has a "documented history of functional overlay" has not influenced our decision. Accordingly, as supplemented and clarified herein, we adhere to and republish our April 27, 1990 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
EUGENIA D. HINSDALE, Claimant
WCB Case No. 90-14973
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Carol Taaffe (Saif), Defense Attorney

Reviewed by Board Members Neidig and Crider.

The SAIF Corporation requests review of those portions of Referee Leahy's order which: (1) set aside its partial denial of claimant's claim for Lyme disease; and (2) found that claimant's claim was prematurely closed. In her brief, claimant contends that if the denial was proper and she is medically stationary, the case should be remanded to determine extent of permanent disability. On review, the issues are compensability, premature closure, remand, and extent of unscheduled permanent disability. We reverse and deny the remand request.

FINDINGS OF FACT

We adopt the first two paragraphs of the Referee's "Findings of Fact" and make the following additional findings.

On July 19, 1988, following her initial emergency room visit, claimant was seen by her family physician, Dr. Naito. Her body, with the exception of her face and the palms of her hands, was covered by a diffuse rash. There were confluent areas measuring 10 centimeters square. The rash caused itchiness. Dr. Naito diagnosed a dermitis, likely allergic in nature. He referred claimant to Dr. Kingery, a dermatologist.

Dr. Kingery performed a titer for Lyme disease. It was borderline, neither ruling out nor confirming existence of the disease. A subsequent repeat titer, taken August 1, 1988, revealed no increase in antibodies such as would occur if claimant suffered from Lyme disease. He diagnosed erythema multiforme, a temporary rash accompanied by headaches.

The rash persisted for three or four weeks. By late July, claimant was still experiencing achiness in her knees. She continued to feel tired. The remaining flu-like symptoms, however, receded.

In January 1989, claimant returned to Dr. Naito complaining of chronic fatigue and joint pain. She was still concerned that she might have Lyme disease. Dr. Naito referred her to Dr. Brem, a rheumatologist.

Dr. Brem's examination identified degenerative disc disease and facet arthritis, capable of causing neck ache and pain. He diagnosed an affective disease.

Meanwhile, claimant also sought treatment from Dr. Bryant, an infectious disease specialist at Oregon Health Sciences University. Dr. Bryant found nothing to support the existence of Lyme disease. Nonetheless, at the patient's urging and because the tests for Lyme disease do permit rare false negatives, he treated her as if she had the disease.

At hearing, claimant continued to report chronic fatigue.

On October 10, 1988, SAIF accepted an insect bite on the right ankle as a disabling injury.

By letter dated May 29, 1990, SAIF denied Lyme disease.

On August 2, 1990, a Determination Order issued awarding temporary total disability compensation from July 7 to July 24, 1988 and awarding no permanent disability compensation.

CONCLUSIONS OF LAW AND OPINION

Partial Denial of Compensability of Lyme Disease

The Referee concluded that SAIF's denial of Lyme disease was premature and set it aside. SAIF argues that the denial was a proper partial denial of a condition unrelated to the compensable injury. We agree with SAIF's contention.

SAIF accepted claimant's claim for "insect bite, right ankle." Subsequent testing suggested that claimant <u>might possibly</u> have contracted Lyme disease from the bite. However, there is no medical evidence in the record proving it likely that claimant had the disease. To the contrary, in a letter to claimant summarizing her complaints and the physician's tests and treatments, Dr. Bryant, claimant's treating physician, stated "although we looked quite carefully for a number of possible insect associated diseases we were never able to find one that we could conclusively state would account for your underlying and persistent complaints." (Ex. 21-1).

Dr. Kingery, who had examined claimant in 1988, stated that claimant had no clinical or laboratory evidence of Lyme disease, although he conceded that the tests for Lyme disease were not reliable. (Ex. 22). In April 1989, Dr. Morita examined claimant. He felt that there was no objective medical evidence to substantiate Lyme disease. (Ex. 8-3).

The uncontroverted evidence in the record shows that claimant did not have Lyme disease. Accordingly, we conclude that SAIF appropriately issued a partial denial of Lyme disease.

Premature Closure

SAIF argues that the Referee improperly concluded that claimant's claim was prematurely closed by the August 2, 1990 Determination Order. We agree.

A claim may not be closed until a claimant is medically stationary, i.e., no further material improvement in the compensable condition would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17). The Referee relied in part on the final letters of Dr. Bryant and Dr. Kingery as support for his conclusion. In his letter to claimant, Dr. Bryant stated that, although there had been no diagnosis, claimant's claim with SAIF should be kept open for attempts to exclude other possible diagnostic causes of her complaints. We have previously held, however, that a need for additional diagnostic measures does not preclude medical stationary status. See Kenneth W. Myers, 41 Van Natta 1375 (1989). Only if further work-up is likely to lead to improvement in a compensable condition, does need for it support a finding that a worker is not medically stationary.

Dr. Kingery followed claimant during July and August 1988. In a letter to claimant in November 1990 in which he summarized his diagnosis and treatment of claimant, he stated that his concluding diagnosis was an erythema reaction of the erythema multiforme type. He felt that there was a connection between claimant's initial reaction and the insect bite, but he offered no opinion on the compensability of her condition or on whether she was medically stationary at the time of claim closure.

The proponderance of the evidence establishes that claimant's complaints as of claim closure are not related to the compensable insect bite. Hence, assuming there was a need to further treat those conditions, the claim was not prematurely closed. In April 1989, Dr. Naito, claimant's treating physician, questioned whether her continuing complaints were related to the insect bite.

Claimant saw Dr. Morita for an independent medical examination in April 1989. He did not think the insect bite caused Lyme disease and he found no permanent sequelae resulting from the reaction to the insect bite. He, also, diagnosed hypothyroidism, untreated, and arthralgias, no specific etiology. (Ex. 8).

Dr. Brem saw claimant on referral almost six months after claim closure. At that time her complaints were of stiffness, achiness and chronic fatigue. The rash was no longer present. Dr. Brem stated that claimant had chronic fatigue syndrome which he thought was an affective disease. He did not relate claimant's current complaints to her insect bite. (Ex. 13-2).

Dr. Bryant is the only physician who recommended keeping claimant's claim open, and that was only for further diagnostic testing. Whether he anticipated any further improvement in claimant's condition from treatment or the passage of time was not indicated. Moreover, the medical evidence does not establish a causal connection between claimant's current complaints and her compensable

insect bite. Therefore, claimant has not proven by a preponderance of the evidence that her claim was prematurely closed by Determination Order in August 1990.

Extent of Permanent Disability

In the event that we find, as we have, that claimant's claim was not prematurely closed, claimant requests that we remand the case to the Hearings Division for a determination of extent of permanent disability. We may remand a case for further evidence if we determine that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

Here, we conclude that the record has not been improperly, incompletely or otherwise insufficiently developed and proceed to our determination of the extent of unscheduled permanent disability.

Dr. Bryant is the only physician who was willing to even entertain the possibility that claimant's complaints were related to her insect bite. Although he thought it possible that her condition was work-related, he did not opine that work relation was probable.

We are not persuaded that claimant's complaints are related to her compensable injury. Rather, we are convinced by the reports of Drs. Morita, Naito and Brem, all of whom find claimant's current condition unrelated to her insect bite. Accordingly, because we find that claimant's compensable insect bite did not result in permanent impairment, she is not entitled to a permanent disability award. Former OAR 436-35-280(1).

ORDER

The Referee's order dated January 7, 1991 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Determination Order is reinstated and affirmed. The Referee's award of an assessed attorney fee of $2,000 is reversed.

July 29, 1991 Cite as 43 Van Natta 1656 (1991)

In the Matter of the Compensation of
RANDOLPH A. KRIEGER, Claimant
WCB Case No. 89-03927
ORDER ON RECONSIDERATION
Vick & Gutzler, Claimant Attorneys
Gary T. Wallmark (Saif), Defense Attorney

The SAIF Corporation has requested reconsideration of our February 22, 1991 Order on Review which set aside its denial of medical services and reversed that portion of a Referee's order that upheld its aggravation denial. In order to allow claimant sufficient time to respond to SAIF's motion, we abated our order. Subsequently, the Board requested additional briefing of issues raised by SAIF's request and claimant's response. Having received the parties' supplemental briefs, we now proceed with our review.

FINDINGS OF FACT

We adopt the "Findings of Fact" set forth in our prior Order on Review with the following supplementation.

On February 9, 1990, SAIF issued a denial of authorization for cervical surgery. Claimant requested a hearing challenging that denial. Claimant's hearing request was assigned WCB Case No. 90-04176. On October 3, 1990, by Stipulation and Order for Disputed Claim Settlement of Partial Denial (DCS), the parties agreed to settle their dispute regarding the contested surgery. In return for the payment of $5,000, claimant agreed to withdraw his hearing request challenging SAIF's February 9, 1990 denial. SAIF's denial was to remain in full force and effect. The surgery denied by SAIF on February 9, 1990 is the same surgery for the same condition as was litigated by the parties at the prior hearing.

The parties subsequently submitted a Claim Disposition Agreement (CDA) to the Board for approval. That agreement referenced claimant's August 19, 1987 date of injury and provided that the parties had agreed to settle claimant's claim for compensation and payments of any kind due to or claimed for the past, the present, and the future, except compensable medical services, for the sum of $15,000. According to the terms of the agreement, "compensation and payments of any kind due or claimed" included temporary disability and aggravation rights per ORS 656.273. The parties' agreement was approved by Board order dated November 19, 1990.

CONTENTIONS

SAIF contends that the medical services issue addressed in our February 22, 1991 order had been previously resolved by the parties pursuant to the October 3, 1990 DCS. In addition, SAIF contends that the aggravation issue addressed in our order had been previously resolved as part of the November 19, 1990 CDA.

Claimant responds that the parties undertook negotiations concerning whether to include the aggravation issue within the terms of either the DCS or the CDA. Claimant states that SAIF was unwilling to include the aggravation issue within either agreement and, therefore, that the aggravation issue was "specifically and deliberately" excluded from the agreements. In addition, claimant contends that the aggravation issue was not raisable in WCB Case No. 90-04176 because that issue was already within the Board's jurisdiction here in WCB Case No. 89-03927. Further, claimant asserts that it would be unlawful for the November 1990 CDA to relieve SAIF of responsibility to pay temporary disability benefits for a period prior to the legal existence of CDAs.

CONCLUSIONS OF LAW AND OPINION

Medical Services

The Referee's January 5, 1990 order set aside SAIF's partial denial of claimant's cervical subluxation, ordered it accepted and remanded the claim for further processing. In our February 22, 1991 order, we concluded that, although not expressly dealt with by the Referee, the parties had litigated compensability of proposed back surgery directed to claimant's condition. On the merits, we concluded that the proposed surgery was compensable.

Following issuance of the Referee's order, on February 9, 1990, SAIF issued an express denial of authorization for the proposed surgery. That denial resulted in the parties' October 3, 1990 DCS. Pursuant to that agreement, claimant agreed to withdraw his hearing request challenging SAIF's denial, which was to remain in full force and effect.

In sum, prior to our February 22, 1991 order, SAIF had issued a denial of surgery for claimant's cervical condition. That denial was the subject of the February 1990 DCS. A Referee's order approving a DCS is a final "judgment."

See Proctor v. SAIF, 68 Or App 333 (1984). Accordingly, the surgery that we addressed in our order had already been finally settled by the parties' DCS. In accordance with the parties' agreement, SAIF's denial of surgery has become final and is not subject to further litigation. See Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560 (1989). We note that claimant offers no argument to the contrary on this issue. Therefore, we shall vacate that portion or our order that addressed compensability of claimant's proposed surgery.

Aggravation

While claimant does not offer argument in response to SAIF's position regarding the surgery issue, claimant does challenge SAIF's position regarding an alleged settlement of the aggravation issue. We conclude, however, that SAIF is correct, i.e., the parties' November 1990 CDA finally resolves the aggravation issue.

Claimant relies, in part, upon negotiations undertaken between the parties concerning whether to include the aggravation issue within the purview of their agreements. However, any such negotiations would be merged into the parties' written agreement. In this regard, the November 1990 CDA expressly provided that:

> "Pursuant to ORS 656.236, the parties have agreed to settle Claimant's claim for compensation and payments of any kind due or claimed for the past, the present, and the future, except compensable medical services, for the total sum of $15,000, to be paid in the manner provided herein. 'Compensation and payments of any kind due or claimed' includes temporary disability, permanent disability, vocational services, aggravation rights per ORS 656.373, and 'Own Motion' rights per ORS 656.278, but does not include compensable medical services.
>
> "Additionally, all pending requests for hearing, if any, shall be dismissed with prejudice, as to all issues raised or raisable at this time." (Emphasis supplied.)

Under the terms of the parties' CDA, claimant's claim for an aggravation, with resultant temporary disability benefits, is a "claim for compensation * * * due or claimed for the past * * *." Therefore, we agree with SAIF that the agreement, by its terms, extends to include claimant's aggravation claim in WCB Case No. 89-03927. It is clear from the language of the agreement that any and all claims resulting from claimant's compensable August 18, 1987 injury were encompassed within the agreement.

Despite the clear language of the CDA, claimant argues that the CDA could not validly encompass the aggravation issue because that issue is already within the Board's jurisdiction here in WCB Case No. 89-03927. In addition, claimant argues that it would be unlawful for the November 1990 CDA to resolve the aggravation issue because that issue involves a period of time prior to the Legislature's creation of CDAs pursuant to Oregon Laws 1990, Ch. 2, Section 9. Further, claimant argues that a denied aggravation claim is not properly subject to resolution by CDA.

As revised, ORS 656.236(1) permits parties, by agreement, to make "such disposition of any and all matters regarding a claim, except for medical services, as the parties consider reasonable." The first two limitations suggested

by claimant neither appear in the language of the statute nor may they be reasonably inferred from the statutory language. Moreover, all three of claimant's arguments amount to a collateral challenge to the November 1990 CDA. However, the CDA has been approved by the Board and that approval is final. See ORS 656.236(2). We conclude, therefore, that the aggravation issue has been resolved pursuant to the parties' November 19, 1990 CDA.

Accordingly, on reconsideration, we vacate those portions of our February 22, 1991 order that set aside SAIF's denial of surgery and aggravation and awarded claimant an assessed attorney fee of $2,200. SAIF's October 20, 1989 denial of an aggravation claim and medical/surgical treatment is reinstated. The remainder of our February 22, 1991 order is affirmed.

IT IS SO ORDERED.

July 29, 1991 Cite as 43 Van Natta 1659 (1991)

In the Matter of the Compensation of
PERRY D. McCOLLUM, Claimant
WCB Case No. 90-13402
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Westerband and Crider.

The self-insured employer requests review of that portion of Referee Gruber's order set aside its denial of claimant's aggravation claim. On review, the sole issue is aggravation. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee set aside the employer's denial, concluding that claimant had established a "worsening" of his accepted condition. We set aside the denial on procedural grounds.

An accepted claim which is properly classified as nondisabling at the outset may become disabling thereafter. If, within one year after the injury, a worker claims that a nondisabling injury has become disabling, the insurer or self-insured employer is obligated, under either former ORS 656.262(12) or newly adopted Oregon Laws 1990 (Special Session), chapter 2, section 48, to refer the claim immediately to the Director for consideration and issuance of a Determination Order.

In this case, the employer accepted claimant's claim as nondisabling on May 26, 1989. Within three months of the injury, claimant's attorney requested that the accepted nondisabling claim be reclassified as disabling. There is no evidence, however, that the employer ever submitted the claim to the Evaluation Section to determine whether reclassification was appropriate. Rather, it issued a denial of the condition it believed was responsible for claimant's request for reclassification, and later issued a denial of claimant's aggravation claim on the basis that there had been no "worsening" of the accepted condition. In doing so, the employer effectively sought to circumvent the statutory provisions that allow claimant to seek reclassification of his nondisabling injury as

disabling. That is impermissible. See Jay A. Hagan, 42 Van Natta 2489 (1990). Therefore, the denial must be set aside.

After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that $800 is a reasonable assessed fee for claimant's counsel's efforts on review concerning the denial issue. ORS 656.382(2). 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 presented, and the value of the interest involved.

ORDER

The Referee's order dated January 3, 1991 is affirmed. For services rendered on Board review, claimant's counsel is awarded an assessed fee of $800, to be paid by the self-insured employer.

In the Matter of the Compensation of
ROSSLYN McGAVOCK, Claimant
And, in the Matter of the Complying Status of
SUNNYSIDE CARE CENTER, Employer
WCB Case Nos. 90-13732 & 90-10775
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Kevin L. Mannix, Attorney
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Neidig and Westerband.

The Department of Insurance and Finance (DIF) requests and the noncomplying employer cross-requests review of that portion of Referee McCullough's order that awarded an attorney fee against the SAIF Corporation as processing agent for the employer. Initially, we review to determine whether we have jurisdiction. On review, the issues are jurisdiction and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the factual findings contained in the Referee's October 3, 1990 Order.

CONCLUSIONS OF LAW AND OPINION

The Hearings Division has jurisdiction over matters concerning a claim; that is, matters in which a workers' right to receive compensation, or the amount thereof, is directly at issue. ORS 656.283(1) and 656.704(3). The employer's consolidated request for hearing from SAIF's acceptance raised a matter concerning a claim. Because the Referee had jurisdiction over the consolidated requests for hearing, he also had jurisdiction over claimant's request for attorney fees. Because the attorney fee issue was raised before the Referee, it is now properly before the Board. See ORS 656.295(6). Accordingly, we proceed to the merits.

Claimant concedes that ORS 656.386(1) does not authorize an attorney fee because he did not request the hearing. Although ORS 656.054 provides for recovery of costs (including attorney fees) incurred by the Industrial Accident Fund, it does not provide for fee assessment. Because the Referee made no "finding" that claimant's compensation should not be disallowed or reduced,

ORS 656.382(2) does not authorize an attorney fee. See Liberty Northwest Ins. Corp. v. McKellips, 100 Or App 549 (1990). Inasmuch as there is no statutory authority for the Referee's attorney fee award, we reverse that portion of the Referee's order which awarded a fee.

ORDER

The Referee's order dated October 3, 1990, as reconsidered November 21, 1990, is reversed in part and affirmed in part. That portion of the order that awarded a $2,325 attorney fee is reversed. The remainder of the order is affirmed.

July 29, 1991 Cite as 43 Van Natta 1661 (1991)

In the Matter of the Compensation of
EDWARD K. McGUIRE, Claimant
WCB Case Nos. 87-12554, 87-07348, 87-10318, 87-07480 & 87-07481
ORDER ON REMAND
Richard A. Sly, Claimant Attorney
Norman B Cole (Saif), Defense Attorney
Acker, et al., Defense Attorneys
Roberts, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys
Lindsay, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Rose City Van & Storage v. McGuire, 107 Or App 404 (1991). The court has reversed our prior order, Edward K. McGuire, 42 Van Natta 511 (1990), in which we held Rose City responsible for claimant's neck, upper back and right shoulder condition because we found Rose City was the last "potentially causal employment" before the onset of claimant's disability. In reaching our decision, we had relied upon the medical opinions of Drs. Crumpacker and Walsh that claimant's underlying condition had worsened during late June and early July 1986. Notwithstanding this reliance, we found Rose City responsible because it was the last "potentially causal employment" (sometime between July 26 - August 8) prior to claimant's onset of disability on August 12, 1986.

Inasmuch as the July 26 - August 8 period was not within the discrete "late June to early July" period during which claimant's disability arose, the court held that we had erred in assigning responsibility to Rose City. Reasoning that responsibility for the claim is properly assigned to the last potentially causal employer within the "late June to early July 1986" period, the court has remanded for reconsideration to determine responsibility between Rose City and Lile International.

After conducting our reconsideration, we make the following findings concerning claimant's employment in late June and early July 1986. Claimant worked for Rose City on July 1, 1986. (Ex. 12A). As a grand total, between June 27 and July 11, 1986, claimant worked 25.75 hours for Rose City. (Ex. 12B).

Claimant worked on July 2, 10, 11, 12, 18 and 19, 1986 for Lile International. (Ex. 12A). He worked 13.75 hours on July 2, 6.75 hours on July 10, 17.5 hours on July 11, 9 hours on July 12, 8.5 hours on July 18, and 8 hours on July 19. (Ex. 15A).

In making these findings, we acknowledge a misstatement in our prior findings. Specifically, we previously found that claimant worked for Rose City on June 27, 1986 and July 11, 1986. Instead, as demonstrated by Rose City's

payroll records (Ex. 12A), claimant was paid for 25.75 hours of work performed between the two-week pay period beginning June 27, 1986 and ending July 11, 1986. Thus, claimant's work activities for Rose City on July 1, 1986 (Ex. 12) combined with additional hours performed between June 27 and July 11 to achieve a total of 25.75 hours during that period. However, since claimant worked for Lile International on July 2, 10, and 11, 1986 for hours approaching or exceeding an 8-hour day, it would be reasonable to conclude that his additional work hours for Rose City would not have occurred on those dates. (Particularly not on July 11, when claimant worked 17.5 hours for Lile International, and July 12, when he worked 9 hours for Lile).

Regardless of whether claimant worked for Rose City after July 1 during the June 27 - July 11 pay period, the record establishes that he did work for Lile International on July 2, 10, 11, 12, 18, and 19, 1986. We would not consider the latter two dates to be "early July." However, the remaining dates would satisfy such a description. Moreover, as days falling within the first two weeks of the month, July 10, 11, and 12 would in our opinion constitute the last possible dates which could still qualify as "early July."

Consequently, we find that the last potentially causal employer during the "late June to early July 1986" period was Lile International. Accordingly, responsibility for the claim rests with Lile International unless it can establish that claimant's work activities with a prior carrier were the sole cause of his disability or that it was impossible for claimant's activities while working for Lile International to have caused his disability. Bracke v. Baza'r, Inc., 293 Or 239, 248 (1982); FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified 73 Or App 223 (1985). Based on the opinions offered by treating neurologist Crumpacker and treating chiropractor Walsh, we are neither persuaded that claimant's work activity for a prior employer was the sole cause of his disability nor that it was impossible for claimant's work activity with Lile International to have caused his disability. Therefore, Lile International is responsible for the claim.

Accordingly, except as supplemented and modified herein, we adhere to and republish the findings, reasoning, and conclusions contained in our prior orders. The Referee's order dated March 29, 1988, as reconsidered April 18, 1988, is affirmed. Our prior award of a $600 insurer-paid attorney fee to be paid to claimant's counsel for services on Board review, shall be paid by Lile International's insurer, Liberty Northwest Insurance Corporation.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANIEL R. MULLER, Claimant
WCB Case No. 90-00445
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

The insurer requests review of that portion of Referee Livesley's order that assessed penalties and attorney fees for alleged unreasonable claims processing. On review, the issue is penalties and attorney fees. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's "Stipulation of the Parties" and "Findings of Fact", with the exception of the Referee's last sentence under the Findings section. We add the following supplementation.

Claimant filed a claim for an injury to his back on October 4, 1989. The employer had notice or knowledge of that claim by October 13, 1989.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the insurer did not accept or deny claimant's medical services claim within 60 days and no explanation had been provided for the delay. The Referee concluded that the insurer's inaction had the effect of delaying benefits which were compensable, and he assessed a penalty and related attorney fee. We disagree.

The insurer first argues that the parties stipulated to the amounts of the outstanding bills, but not as to when the insurer received the bills. The insurer also contends that, pending its acceptance of the claim, claimant's medical bills did not constitute "amounts then due." ORS 656.262(10). The court has held that, pending acceptance or denial of a claim, compensation payable to a claimant does not include medical benefits, and in such cases, a penalty may not be assessed under ORS 656.262(10). Eastmoreland Hospital v. Reeves, 94 Or App 698 (1989).

Finally, the insurer contends that, even if it is determined that a penalty and attorney fee is authorized for untimely payment of the medical bills, a penalty and attorney fee should not be based upon the outstanding physical therapy bills. The insurer argues that Dr. White did not comply with OAR 436-10-040(4)(a), which provides that physical therapy will not be reimbursed unless it is carried out under a written treatment plan prescribed prior to commencement of treatment. The rule further provides that the plan must include objectives, modalities, frequency of treatment and duration and must be completed and signed within one week of commencing treatment. See OAR 436-10-040(4)(a).

In the present case, the insurer argues that the objectives and modalities were not specified by Dr. White. The insurer asserts that it is not obligated to provide reimbursement for the therapy, therefore, the physical therapy bills do not constitute compensation "then due".

We agree with the insurer's argument that claimant has failed to show when the insurer received the medical bills in issue. Claimant contends that, in written closing arguments, the insurer conceded late payment of the medical services bills. However, the insurer argues that it was responding to claimant's description of the issue and it later stated that no penalty could be awarded "absent some proof of when those bills were received by the insurer." Under the circumstances, we do not find that the insurer conceded late payment of the medical bills.

Moreover, we are unable to find evidence in the record of when the insurer had knowledge of claimant's medical services claims. Although the Referee found that the insurer did not respond until eight months after notice of the claim, we conclude that the letter upon which he apparently relied (an enclosure submitted with the insurer's closing arguments which was dated May 15, 1990 and stated that billings for physical therapy had been received) contains no indication of when the medical services claims were received.

In addition, the record contains an April 11, 1990 letter from the insurer to Dr. White indicating that it had received claimant's physical therapy bills. However, there is no indication in the April 11 letter regarding the date of receipt. Moreover, the insurer's letter was dated only one month prior to the May 11 hearing. Although the insurer was required to furnish written notice of acceptance or denial of the claim within 60 days after it had notice or knowledge of the claim, claimant has failed to show that, prior to April 11, 1990, the insurer had received his medical bills. Accordingly, claimant has not proven that the insurer delayed compensation by failing to accept or deny the claim within 60 days of notice of the claim.

Because we have found that claimant has not proven that the insurer failed to accept or deny the claims within 60 days, we do not reach the issue of whether the bills constituted amounts "then due" pending the insurer's acceptance or denial of the claims. We also need not address the insurer's argument regarding Dr. White's compliance with the administrative rule providing for physical therapy treatment plans.

ORDER

The Referee's order dated July 2, 1990 is reversed in part and affirmed in part. That portion of the Referee's order that assessed a 25 percent penalty and related attorney fee of $1,450 is reversed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
EDWARD S. RIGGINS, Claimant
WCB Case No. 90-08090
ORDER ON REVIEW
Richard McGinty, Claimant Attorney
John Pitcher, Defense Attorney

Reviewed by Board Members Crider and Westerband.

The self-insured employer requests review of that portion of Referee Brown's order that set aside its March 14, 1990 and June 15, 1990 denials of chiropractic care in excess of two times per month. On review, the issue is medical services. We reverse.

FINDINGS OF FACT

We adopt sections (4) and (5) of the Referee's "FINDINGS," with the following supplementation.

Claimant sustained a compensable, nondisabling low back strain on November 27, 1989. He was initially treated by Dr. Peden, who prescribed physical therapy for five days, at the end of which claimant's symptoms resolved. (Exs. 4, 6, 8). Claimant lost no time from work.

Claimant changed his treating physician to Dr. Pomazal, chiropractor, on January 24, 1990. Claimant complained of low back, thoracic and shoulder pain. Pomazal proceeded to treat claimant daily except weekends through February 16, 1990, then three, two and four times over the next three weeks. (Ex. 35-1).

The employer denied treatment in excess of the guidelines on March 14, 1990.

Claimant discontinued chiropractic treatment from March 16 through April 15, 1990, when he returned to Dr. Pomazal, who proceeded to treat him more than two times per month. (Ex. 32-46).

The employer denied treatment in excess of the guidelines on June 15, 1990.

FINDINGS OF ULTIMATE FACT

Chiropractic treatments provided in excess of the guidelines were not reasonable and necessary.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside the March and June 1990 denials, based on his conclusions that claimant worsened in the absence of chiropractic treatment during the period leading up to the March denial and that his symptoms improved when treatment was resumed from April until the June 1990 denial. We disagree.

The hearing in this case convened after July 1, 1990. Therefore, the amendments to ORS 656.245 apply unless retroactive application of a law not yet in existence would produce an absurd or unjust result. Or Laws 1990, Special Session, Ch. 2, 10; see Ida M. Walker, 43 Van Natta 1402 (1991). In this case, the retroactive application of OAR 436-10-040, adopted by the Director as provided by ORS 183.335(5) and (6) to implement to amendment to ORS 656.245, would unreasonably require claimant's chiropractor to have adhered to treatment standards and practices not yet in effect. Accordingly, we apply former ORS 656.245 and former OAR 436-10-040.

A claimant was entitled to all reasonable and necessary curative or palliative medical care required for recovery from a compensable injury or for relief of pain. See former ORS 656.245(1); West v. SAIF, 74 Or App 317, 320 (1985); Wetzel v. Goodwin Bros., 50 Or App 101 (1981); McGarry v. SAIF, 24 Or App 883, 888 (1976). Claimant has the burden of proving that the treatment is reasonable and necessary. McGarry v. SAIF, supra.

In determining what was 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 identified two visits per month, after the initial 60 days, as the usual frequency of medical services. Former OAR 436-10-040(2)(a), (WCD Admin. Order 1-1990). However, a claimant was entitled to treatment in excess of the administrative guidelines if he or she proved that the treatment was 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).

Although the Board generally gives greater weight to the conclusions of a treating physician, it will not so defer when there are persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810, 814 (1983).

Claimant experienced a low back strain. Beginning on January 24, 1990 Dr. Pomazal treated claimant's low back, mid back, and upper back daily except weekends through February 16, 1990, then three, two and four times over the next three weeks.

The Western Medical Consultants examined claimant on February 20, 1990. They found no permanent impairment and opined that no further treatment was

necessary. Claimant was also evaluated by Dr. Hartmann, neurologist, in February 1990. He opined that claimant was not completely stationary, but would be soon. He stated that there was no need for further treatment, especially chiropractic treatment, and that claimant would probably improve further on his own if no treatment was given. Dr. Pomazal provided no explanation for the need for treatment, stating, "I am unable to estimate [claimant's] improvement to muscle injury . . . ." (Ex. 18).

After receiving the March 1990 denial, claimant discontinued chiropractic treatments until April 16, 1990, when he returned to Dr. Pomazal, who resumed treatments to the low, mid and upper back in excess of the guidelines. Pomazal referred claimant to Dr. Campagna, who reported two mild disc bulges and stated that only one chiropractic treatment per month was needed. (Ex. 24E). Dr. Hartmann agreed with Campagna's recommendation, stating that "this intensity of chiropractic treatment does not serve any useful purpose." (Ex. 24). Dr. Tilden, chiropractor, who performed an independent medical examination, stated that nothing in claimant's medical history suggested that claimant's chiropractic treatments after February 20, 1990 were reasonable and necessary. (Ex. 23).

Although Dr. Vranna, M.D., who saw claimant in May 1990 on referral from Dr. Pomazal, opined that claimant's chiropractic treatment to the present had been beneficial, Vranna also said that historically claimant experienced radicular symptoms. There was no evidence of radicular symptoms by history. Consequently, we are unpersuaded by Dr. Vranna's opinion, since it is based on an incorrect history.

Nor are we persuaded by the opinion or testimony of Dr. Pomazal. Dr. Pomazal had no treatment plan. (Tr. 70-74). Claimant's condition showed no subjective improvement after his third treatment in the last week of January, 1990. (Ex. 10). Therefore, we find Dr. Pomazal's opinion and testimony unpersuasive in light of the lack of improvement in claimant's condition. We are also unpersuaded that the course of claimant's condition was affected by treatment in excess of two times a month, despite his conviction that he hurt too much to work without treatment. (Tr. 13).

In conclusion, the weight of the medical evidence persuades us that chiropractic treatments in excess of two times per month are not reasonable and necessary medical services.

ORDER

The Referee's order dated October 19, 1990 is reversed in part and affirmed in part. That portion of the order that set aside the March 14, 1990 and June 15, 1990 denials is reversed. The self-insured employer's denials are reinstated and upheld. The Referee's attorney fee awards of $1,000 for the March 14, 1990 denial and $1,000 for the June 15, 1990 denial are reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
ROBERT G. SMITH, Claimant
WCB Case No. 90-12207
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Crider and Westerband.

Claimant requests review of those portions of Referee Black's order that: (1) increased claimant's unscheduled permanent disability award for a low back injury from 21 percent (67.2 degrees), as awarded by a Determination Order, to 24 percent (76.8 degrees); (2) affirmed a Determination Order which awarded 15 percent (20.25 degrees) scheduled permanent disability for loss of use or function of the right foot; (3) declined to order the SAIF Corporation to pay claimant's attorney 25 percent of the increased permanent disability granted by the modified May 1990 Determination Order after SAIF had dispersed the entire award to claimant; (4) declined to assess penalties and attorney fees for SAIF's failure to pay claimant's attorney 25 percent of the increased permanent disability granted by the modified May 1990 Determination Order; (5) declined to order SAIF to pay the entire 21 percent unscheduled permanent disability and 15 percent scheduled permanent disability awarded by the modified May 1990 Determination Order after SAIF had already paid claimant 20 percent unscheduled permanent disability and 15 percent scheduled permanent disability under the partially vacated December 1988 Determination Order; and (6) declined to assess penalties and attorney fees for SAIF's failure to pay claimant the permanent disability awarded under the modified May 1990 Determination Order. On review, the issues are extent of scheduled and unscheduled permanent disability, penalties, attorney fees, and enforcement. We affirm.

FINDINGS OF FACT

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

Claimant injured his back on January 4, 1988. SAIF accepted the claim as an aggravation of a December 1983 injury. After surgery in February 1988, and after his condition became medically stationary in November 1988, his claim was closed by Determination Order in December 1988 with an award of 20 percent unscheduled permanent partial disability and 15 percent scheduled permanent partial disability. Thereafter, in March 1989, claimant filed a request for hearing asserting that his January 1988 injury was not an aggravation of his 1983 injury, but rather a new injury. In May 1989, after the hearing convened but prior to the issuance of the Referee's order, SAIF accepted the January 1988 event as a new injury.

In his September 1989 order as reconsidered January 10, 1990, Referee Gruber found that the Evaluation Section did not have the February 1988 surgical report in its possession when it issued the December 1988 Determination Order. Therefore, he ordered that portion of the Determination Order awarding permanent disability set aside for redetermination in light of the surgical report. The order provided that, "claimant's attorney is allowed a fee of 25% of any increased compensation resulting from the redetermination of claimant's extent of disability, to be paid out of that increase." Thereafter, on May 14, 1990, a modified Determination Order issued, awarding claimant 21 percent unscheduled permanent partial disability and confirming the 15 percent scheduled permanent partial disability award. The May 1990 Determination Order specifically stated

that it became a part of and should be considered in conjunction with the December 1988 Determination Order which it modified.

After the modified May 1990 Determination Order issued, SAIF paid the entire increased permanent disability award directly to claimant. It did not pay 25 percent of the increased permanent disability award directly to claimant's attorney.

Except for one attorney fee issue not relevant to this proceeding, the Board affirmed Referee Gruber's September 1989 order, as reconsidered January 10, 1990, in Robert G. Smith, 43 Van Natta 104 (1991).

Claimant has no demonstrated loss of leg strength. He has numbness of the foot, not affecting the plantar surface.

FINDINGS OF ULTIMATE FACT

Claimant has sustained a 24 percent loss of earning capacity as a result of his January 1988 compensable low back injury.

Claimant has sustained a 15 percent loss of use or function of his right foot due to his compensable injury.

The January 1990 Order did not order SAIF to pay the out-of-compensation fee directly to claimant's attorney. Claimant's fee agreement with his counsel provided for payment by claimant to his attorney out of his compensation; claimant did not consent to direct payment by SAIF of out-of-compensation attorney fees.

SAIF offset the amount of permanent disability paid under the partially vacated December 1988 Determination Order against the unscheduled and scheduled permanent disability ordered paid under the modified May 1990 Determination Order. SAIF did not offset benefits paid on another claim against amounts due on this claim.

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Partial Disability

Because claimant's condition was last found medically stationary on November 8, 1988, and his claim was closed by Determination Order on May 14, 1990, the Referee applied the "standards" in effect at the time the Determination Order issued in rating claimant's permanent disability. Former OAR 436-35-001 et seq. (WCD Admin. Order 7-1988). These are the standards we apply as well. Specifically, former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent disability. Former OAR 436-35-010 through 436-35-260 apply to the rating of claimant's scheduled permanent disability.

Unscheduled Disability

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

The Referee increased claimant's unscheduled permanent partial disability award for his low back injury from 21 percent, as awarded by the modified Determination Order, to 24 percent. On review, claimant asserts that he is also entitled to a value of 4 percent for removal of a disc at the L4-5 level in 1972, as the L4-5 level was again injured in 1988. SAIF contends that claimant is not entitled to a second award for an injury for which he has been previously compensated. We affirm the Referee's award.

The parties do not dispute the following values assigned by the Referee: age (1), education (3), and adaptability (3). Therefore, we discuss only the issue of impairment.

Only loss of earning capacity "due to" the compensable injury is considered in determining the award of unscheduled permanent disability. Former ORS 656.214(5); see, e.g., Daniel G. Huff, 42 Van Natta 2805 (1990). Claimant has sustained multiple compensable injuries to the low back while employed by the insured. Prior to his 1988 L4-5 injury, claimant had undergone disc surgeries at L4-5 in both 1968 and 1972, for which he received permanent partial disability awards. As a result of another injury in 1988, claimant again underwent surgery at the L4-5. Claimant is entitled to receive an award for permanent partial disability for further low back residuals as a consequence of this injury.

Claimant's argument notwithstanding, we are unable to discern any basis for an award under former OAR 436-35-350(2) for the 1972 surgical procedure that was performed as a consequence of a separate compensable injury and for which claimant has already received an award of permanent disability. A prior award could, instead, bar an additional award for loss of earning capacity due to further injury to the back. However, the record establishes that claimant's recovery after his 1972 surgery was complete. He was able to return to and successfully perform his usual and customary job as a millwright without restrictions until the 1988 injury. Accordingly, we find that the prior award does not bar an award for residuals of the 1988 injury, including an award for further surgery, even though his previous award was in part for L4-5 disc removal. There is no basis to award claimant another value for the 1972 surgery just because the 1988 injury coincidentally occurred at the same site as the 1972 injury and surgery; the 1972 surgery is neither related to nor "due to" the compensable 1988 injury at issue.

Turning to the rating of claimant's compensable 1988 injury, we agree with Referee Black that claimant is entitled to values of 2 percent for loss of extension; 5 percent for laminotomy and 5 percent for a chronic condition limiting repetitive use of the back. These values are combined for a total impairment value of 11.6 percent. Former OAR 436-35-360(11).

Computation of Unscheduled Permanent Disability

When claimant's age value 1 is added to his education value 3, the sum is 4. When that value is multiplied by claimant's adaptability value 3, the product is 12. When that value is added to claimant's impairment value 11.6, the result is 23.6 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Id. Claimant's permanent unscheduled disability under the "standards" is, therefore, 24 percent.

Scheduled Disability

The Referee affirmed the Determination Order award of 15 percent scheduled permanent partial disability for claimant's right foot condition. On review,

claimant asserts that his award should be increased to reflect permanent loss of use or function of the entire leg, not just the foot. In addition, claimant asks the Board to clarify the basis for the scheduled permanent partial disability award. We agree that claimant is entitled to an award of 15 percent scheduled permanent partial disability for his right foot condition.

Scheduled disability means a permanent loss of use or function which results from injuries to those body parts enumerated in former ORS 656.214(2)(a) through (4). Former OAR 436-35-005(2). The leg and the foot are identified as separate body parts for which permanent disability can be awarded. Because claimant has occasional numbness of the right leg and increased leg and foot pain with activity, he alleges that his leg, rather than his foot, is impaired. Under the "standards," claimant is entitled to a value for leg impairment only if he establishes that he has loss of leg strength due to spinal nerve damage. Former OAR 436-35-230(8). Loss of sensation in the leg is not considered disabling and, hence, no separate impairment value is allowed. Former OAR 436-35-230(1).

The medical evidence does not support claimant's contention that he has any loss of right leg strength due to spinal nerve damage. In November 1988, Dr. Serbu, claimant's treating physician, noted right foot drop and motor weakness affecting the right foot. In February 1989, consulting neurosurgeon Dr. Gallo, recorded essentially the same findings--numbness of the dorsum of the right foot, inability to flex the toes and decreased motor strength of the right foot. She specifically noted the absence of other lower extremity motor deficits. Although she did speculate that claimant's impairment may be related to nerve root trauma, she was unable to attribute his foot weakness to nerve root damage with certainty. Under these circumstances, we attribute claimant's rateable impairment to his foot, not his leg.

Accordingly, we rate claimant's right low extremity impairment as it pertains to his right foot. Claimant has numbness of the dorsal surface of the foot. When numbness of the foot does not affect the plantar surface (sole of the foot), no impairment value can be awarded. Former OAR 436-35-200(1). For weakness of the right foot, specifically foot drop, we award claimant an impairment value of 10 percent. Former OAR 436-35-230(5)(a). Claimant is unable to flex his toes such that he cannot walk on uneven surfaces. Therefore, for a chronic condition limiting repetitive use of a scheduled body part, claimant is entitled to an impairment value of 5 percent. Former OAR 436-35-010(7).

These values are combined for a total impairment value of 14.5 percent. Former OAR 436-35-240(4). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-010(6). Claimant's permanent scheduled disability under the "standards" is, therefore, 15 percent.

Out-Of-Compensation Attorney Fee For Increased Permanent Disability Granted by the Modified May 1990 Determination Order

In his January 1990 order, Referee Gruber allowed claimant's attorney a 25 percent out-of-compensation fee for any increased permanent disability award that resulted from redetermination of that award. That redetermination resulted in an increase of 1 percent in claimant's unscheduled permanent partial disability award. SAIF paid the entire 1 percent increase to claimant, without paying 25 percent of that amount to claimant's attorney. Claimant urges the Board to enforce the prior referee's Order and order SAIF to pay the misdirected fee to claimant's attorney.

SAIF is not obligated to reimburse claimant's attorney for the attorney fee unless the prior referee ordered direct payment of the fee to the attorney

and claimant consented to such direct payment. Former OAR 438-15-085(1); Mohammad Zarifi, 42 Van Natta 670, 670 (1990). Here, Referee Gruber's order "allowed" a fee to claimant's attorney but did not order direct payment by SAIF to the attorney. Moreover, claimant's agreement with his attorney specifies that he will pay his attorney's fee out of his compensation; it does not consent to direct payment of attorney fees by SAIF. Under these circumstances, we find that SAIF is not obligated to reimburse claimant's attorney for his out-of-compensation fee. Zarifi, supra.

Furthermore, as SAIF has not refused to pay claimant's attorney 25 percent of the increased compensation due under a referee's order, there is no basis to award a penalty or attorney fee as it relates to this issue.

Portion of Permanent Disability Awarded Under the Modified May 1990 Determination Order Due Claimant

After the modified May 1990 Determination Order issued, SAIF paid claimant 1 percent unscheduled permanent partial disability--the difference between the 21 percent awarded under that Order and the 20 percent awarded under the partially vacated December 1988 Determination Order. SAIF paid no additional scheduled permanent partial disability. Reading the two Determination Orders together, and finding that the second Determination Order was an extension of and modification of the first, Referee Black agreed with SAIF's action to offset its prior payment against the total amount due. On review, claimant asserts that these two Determination Orders were for two separate injuries, one in 1983, and one in 1988. Therefore, claimant contends, under the rule in Steven M. Ginther, 42 Van Natta 526 (1990), SAIF could not offset the amount paid under one claim against the amount ordered paid under another separate claim. We find no support for claimant's argument that the two determination orders pertain to two separate claims.

Benefits already paid on one claim may not be offset against amounts due on another, separate claim. Ginther, supra. However, we do not find that SAIF's actions in this case equate with those prohibited by the rule in Ginther. Instead, we find the circumstances of this claim to be more analogous to the situation permitted by former ORS 656.268(10), whereby a Determination Order may include necessary adjustments in payments prematurely made, against permanent disability payments which are payable. Claimant was not issued, as he asserts, two separate Determination Orders for separate injuries in 1983 and 1988. Examining the language of both Referee Gruber's order as reconsidered January 1990, and the May 1990 Determination Order, the December 1988 and May 1990 Determination Orders compensate claimant for the same loss resulting from the same January 1988 event.

After the December 1988 Determination Order awarding him 20 percent unscheduled permanent partial disability and 15 percent scheduled permanent partial disability for a 1988 aggravation of his 1983 injury issued and was paid, claimant filed a request for hearing asserting that the January 1988 event constituted a new injury, rather than an aggravation. Therefore, by the time claimant requested a determination on his new injury claim, SAIF had already paid him for that same injury, albeit under a different label. SAIF accepted the January 1988 event as a new injury. Then, to avoid paying claimant doubly for the same accepted injury, when the second determination order issued, SAIF offset its payment under the modified May 1990 Determination Order against permanent disability payments prematurely paid under the partially vacated December 1988 Determination Order. Thus, SAIF offset benefits already paid on one claim against further amounts due on the same claim. Ginther, therefore, does not control. Rather SAIF's actions most closely paralleled the statutory provision allowing offset of benefits prematurely paid on a claim against the total

benefits ultimately due on the same claim. See analogously, former ORS 656.268(10).

Having determined that only one injury and one claim is involved, we proceed to construe the determination orders and determine what they awarded and what is due claimant. The dispute centers on, as Referee Black aptly labeled, "boilerplate language" in the May 1990 Determination Order awarding claimant not an increased award, but a duplicative award. We concur with Referee Black that the December 1988 and May 1990 Determination Orders complement each other and must be read together as one award compensating claimant for one disabling event. The December 1988 Determination Order was incomplete because the Evaluation Section did not have evidence of and could not consider the impact of claimant's February 1988 surgery on his award of unscheduled permanent partial disability. Once the underlying event was recharacterized as a new injury, Referee Gruber could have vacated the entire Determination Order, thereby creating a premature payment of the entire amount already paid by SAIF. Instead, he ordered only that portion of the Determination Order awarding unscheduled permanent partial disability be set aside for redetermination in light of the surgical report.

The May 1990 Determination Order clearly and on its face states that it becomes a part of and should be considered in conjunction with the December 1988 Determination Order which it modifies. After our review of the language of both documents, we find that the "boilerplate language" of the May 1990 Determination Order awarding claimant a duplicative award is inconsistent with the expressed intent of that Order. Therefore, we find that the May 1990 Determination Order revised claimant's unscheduled permanent partial disability award as a result of the January 1988 event upward to 21 percent; it did not award him 21 percent unscheduled permanent partial disability in addition to the 20 percent previously awarded. Similarly, we find that the May 1990 Determination Order affirmed claimant's 15 percent scheduled permanent partial disability award and did not award him an additional 15 percent scheduled permanent partial disability. Accordingly, we conclude that SAIF neither offset benefits paid on the 1983 claim against amounts due on the 1988 claim nor refused to pay compensation ordered by the May 1990 Determination Order.

As SAIF has paid claimant all amounts owing, there is no basis to assess a penalty or attorney fee for unreasonable refusal to pay benefits due. Moreover, even had we found claimant entitled to payment of an additional amount under the May 1990 Determination Order, we would still decline to assess penalties and attorney fees due to the inconsistent language of the second determination order. Under such confusing circumstances, we could not say that SAIF's actions were unreasonable.

ORDER

The Referee's order dated November 9, 1990 is affirmed.

In the Matter of the Compensation of
BRYAN L. DUNN, Claimant
WCB Case No. 90-09508
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Alice M. Bartelt, Defense Attorney

Reviewed by Board Members Westerband and Crider.

Claimant requests review of Referee Spangler's order that: (1) declined to award an insurer-paid attorney fee where the insurer rescinded its denial of claimant's injury claim prior to hearing; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable and untimely denial. On review, the issues are penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW

We adopt that portion of the Referee's order which found that the insurer's denial was not unreasonable. We also agree with the Referee's refusal to assess penalties and attorney fees for an allegedly untimely denial. However, in addition to the Referee's conclusion that there was no evidence of compensation "then due" or "resisted" for purposes of assessing penalties and attorney fees, our decision on this issue is based upon the following reasoning.

In deciding the penalty issue, the Referee applied the law as it was prior to Or Laws 1990 (Special Session), SB 1197. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in SB 1197, Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. SB 1197, Section 54(3). Moreover, the relevant 1990 amendments to ORS 656.262(6) merely extends by 30 days the time for acceptance or denial of a claim. Application of this change retroactively to this case will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Under the new law, the insurer had 90 days, rather than 60 days, from the date of the employer's notice or knowledge of claimant's injury claim within which to furnish claimant with written notice of its denial. ORS 656.262(6). Since the employer had notice of claimant's injury on January 22, 1990 and because the insurer issued its denial on April 18, 1990, the denial was timely.

We reverse that portion of the Referee's order that declined to award an insurer-paid attorney fee for claimant's counsel's efforts to bring about the rescission of the insurer's denial prior to the scheduled hearing. Relying upon Duane L. Jones, 42 Van Natta 875 (1990), the Referee held that claimant was not entitled to an attorney fee when the insurer's denial was rescinded prior to the hearing. The Jones decision has been affirmed by the Court of Appeals. Jones v. Oregon State Correctional Institution, 107 Or App 78 (1991).

However, on June 19, 1991, the Governor signed Senate Bill 540 A-Engrossed, which amends ORS 656.386(1) to provide that "[i]f an attorney is instrumental in obtaining compensation for a claimant and a hearing by the

referee is not held, a reasonable attorney fee shall be allowed." Section 1. Section 3 further states that the amendments "apply to all claims for which an order relating to the issue on which attorney fees are sought has not become final on or before the effective date of this 1991 Act, regardless of the date of injury." The Act took effect on its passage. Section 4.

Here, since this matter has not become final, the amendments to ORS 656.386(1) are applicable. Considering claimant's counsel's efforts in submitting hearing requests concerning the insurer's denial and its processing of the claim and in light of his counsel's efforts in eliciting a medical report from claimant's treating physician, we conclude that claimant's attorney was instrumental in obtaining compensation for claimant through the rescission of the insurer's denial prior to the scheduled hearing. Therefore, we hold that claimant is entitled to an insurer-paid attorney fee under revised ORS 656.386(1).

After considering the factors set forth in OAR 438-15-010(4), we conclude that a reasonable attorney fee concerning the rescission of the insurer's denial 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 the record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated October 30, 1990 is affirmed in part and reversed in part. As an attorney fee concerning the rescission of the insurer's denial prior to hearing, claimant's attorney is awarded $750, to be paid by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
LELA M. KENFIELD, Claimant
WCB Case No. 90-06475
ORDER ON REVIEW
Olson, Rowell & Walsh, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Crider and Neidig.

Claimant requests review of that portion of Referee Crumme's order that declined to assess penalties and attorney fees for an alleged "de facto" denial of medical services. The self-insured employer cross-requests review of those portions of the Referee's order that: (1) found that the doctrine of res judicata did not bar claimant from litigating the employer's denial of medical services provided since July 1, 1989 for claimant's low back, hip and left leg condition; and (2) set aside that denial. On review, the issues are res judicata, medical services, penalties and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following correction and supplementation. We replace the last sentence of finding number seven with the following. The employer did not pay the post-July 1, 1989 bills received from Dr. Scheer within 60 days of receipt. No denial of Dr. Scheer's post-July 1, 1989 treatments is in the record.

Finding number nine should read that the initial hearing was convened on June 25, 1990, not July 25, 1990.

The Disputed Claim Settlement (DCS) upheld the employer's denial dated January 26, 1989, which had denied claimant's aggravation claim because she had not established a worsening of her condition since the July 30, 1987 Determination Order. The DCS also established that certain medical services prior to July 1, 1989 were not compensable. The DCS did not address the issue of whether Dr. Scheer's treatments provided after July 1, 1989 were reasonable and necessary; nor did it address the causation of claimant's underlying condition.

CONCLUSIONS OF LAW AND OPINION

Res Judicata

The Referee found that there was no res judicata bar to the present litigation. We agree. Citing Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560 (1989), the employer argues that res judicata applies here because claimant failed to establish that her condition had changed so as to create a new set of operative facts.

A change in condition only needs to be proved when a claim for the same medical services is reasserted after having been denied. See Liberty Northwest Ins. Corp. v. Bird, supra. That is not the case here. The present claim is for different dates of treatment. Each separate doctor's bill submitted to an employer is a separate and distinct claim. Billie J. Eubanks, 35 Van Natta 131 (1983). The DCS resolved only the compensability of the pre-July 1989 medical services. Therefore, litigation of the present claim is not barred by the res judicata doctrine of "claim preclusion." See Travis W. Thorpe, 43 Van Natta 1462 (1991).

Nor is the present litigation barred under the res judicata doctrine of "issue preclusion." Although the DCS resolved the question of compensability of the earlier medical services, the compensability of claimant's condition was not resolved. Hence, the Referee correctly considered the compensability of the post-July 1, 1989 services on the merits. International Paper Co. v. Pearson, 106 Or App 121 (1991).

Accordingly, we affirm the Referee's ruling that the claim is not barred by the doctrine of res judicata.

Medical Services

We adopt the Referee's "Conclusions of Law" on the medical services issue.

Penalties & Attorney Fees

The Referee did not assess penalties and attorney fees because, although he found that the chiropractor bills incurred after July 1, 1989 were not paid within 60 days, he found that claimant had not proved that the employer had not issued a written denial within 60 days.

Claimant argues that a timely denial is an affirmative defense for the employer and the Referee erred in requiring claimant to prove the nonexistence of a timely denial. Claimant cites Lynn M. Elliott, 41 Van Natta 2063, 2066 (1989), which held that it is the insurer's burden, not claimant's, to prove an affirmative defense to an issue properly raised by claimant. In the alternative, claimant argues that, if it is her burden to prove the non-existence of a written denial, she met this burden by the employer's failure to provide it

under OAR 438-07-018(1) (insurer must provide all material documents 20 days before hearing). Claimant argues that failure of the employer to submit the denial creates a presumption that it does not exist.

The employer argues that a late denial is not necessarily unreasonable and that its denial was reasonable because there was legitimate doubt as to whether the DCS applied to the bills in question.

At least by closing argument the employer knew that claimant was requesting a penalty and attorney fee for failure to timely process Dr. Scheer's billings. Although the employer was in the best position to provide a copy of any denial it issued, it did not ask the Referee to leave the record open so that it could submit a denial. Under these circumstances, claimant has established a prima facie case that the claim was not timely processed. Thus, we find that claimant has established a "de facto" denial of the medical services.

Under former ORS 656.262(10), if the employer "unreasonably delays acceptance or denial of a claim . . . [it is] liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382." The employer has provided no explanation for its failure to process the claim. The employer's argument that its "denial" was not unreasonable does not relieve it from the responsibility of processing claims. The employer was required to either accept or deny the medical services claims within 60 days. See former ORS 656.262(6).

Here, the employer neither accepted nor denied the medical services claims received from Dr. Scheer after July 1, 1989. Accordingly, we find that the employer's failure to timely accept or deny the claim to be unreasonable and subject to penalty and attorney fee in accordance with former ORS 656.262(10) and ORS 656.382(1). Inasmuch as the claim in issue is for medical services on an accepted injury, as opposed to medical services from an initial claim, we find the medical services in question to be compensation then due. Hence, a penalty is appropriate. See ORS 656.005(8); 656.262(6); Kurt Kraal, 42 Van Natta 2634 (1990); Clinton F. Seals, 42 Van Natta 268 (1990). Moreover, there has been an unreasonable resistance to the payment of compensation. Former ORS 656.262(10); 656.382(1); Ellis v. McCall, 308 Or 74 (1989).

Accordingly, claimant is entitled to a reasonable attorney fee and a 25 percent penalty based on all compensation "then due" at the time of hearing. The compensation "then due" should be determined based on the unpaid billings from Dr. Scheer for medical services associated with claimant's compensable low back condition. See former ORS 656.262(10); Mollie E. Barrow, 43 Van Natta 617 (1991). After considering the factors set forth in OAR 438-15-010(4) we find $250 to be a reasonable penalty-related attorney fee.

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 medical services issue is $750, to be paid by the employer. 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 October 12, 1990 is affirmed in part and modified in part. For its unreasonable claims processing, the self-insured employer shall pay claimant a 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 from Dr. Scheer for medical services associated with claimant's compensable low back condition. The employer shall pay claimant's attorney an assessed fee of $250 for services related to the penalty issue. The remainder of the Referee's order is affirmed. For services on Board review concerning the medical services issue, claimant's attorney is awarded an assessed fee of $750 to be paid by the employer.

In the Matter of the Compensation of
ROBERT E. LEATHERMAN, Claimant
WCB Case No. 90-09814
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Crider and Westerband.

The insurer requests review of Referee McWilliams' order which set aside its denial of claimant's aggravation claim for his carpal tunnel syndrome. On review, the sole issue is aggravation.

We affirm and adopt the order of the Referee with the following supplementation.

On review, the insurer contends that the Referee incorrectly cited as objective findings establishing a worsening, loss of range of motion, loss of grip strength, and increased symptomatology. We agree with the Referee. Although it is unclear whether Dr. Evans himself noted the loss of range of motion in the wrists, he did note a loss of grip strength. (Ex. 12, 20-8-10.) Moreover, he diagnosed a worsening based on expert analysis of his examination findings and claimant's reported symptoms. (Ex. 12, 13, 20-16-17.) We have held that such evidence meets the definition of "objective findings." See Suzanne Robertson, 43 Van Natta 1505 (1991).

The insurer also contends that, to establish a compensable worsening under ORS 656.273, as amended in 1990, a worker must establish that the compensable injury is the major contributing cause of the worsened condition. We disagree. A compensable worsening is established by proof that the compensable injury is a material contributing cause of the worsened condition, provided that no off-the-job injury is the major contributing cause of the condition. ORS 656.273(1). The insurer does not contend, and there is no evidence, that any off-the-job injury is the major contributing cause of claimant's worsened condition. Hence, claimant has met his burden of proof.

Claimant's attorney is entitled to a reasonable assessed fee for his services on review relating to the aggravation issue. Former ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable fee for claimant's counsel's services on review is $1,000. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 31, 1990 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, payable by the insurer.

In the Matter of the Compensation of
RICARDO VASQUEZ, Claimant
WCB Case Nos. 90-09873 & 89-24251
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys
Kenneth Russell, Defense Attorney

Reviewed by Board Members Westerband and Crider.

The SAIF Corporation requests review of Referee McGeorge's order that: (1) set aside its denial of claimant's "new injury" claim for a low back injury; (2) upheld Intel Corporation's denial of claimant's aggravation claim for the same condition; and (3) assessed a penalty and related attorney fee for its allegedly unreasonable processing of claimant's claim. In its brief, SAIF also requests that this matter be remanded to the Referee for the taking of additional evidence and the submission of closing argument. On review, the issues are remand, responsibility, penalties and attorney fees. We deny the request for remand and affirm.

FINDINGS OF FACT

Claimant compensably injured his back in April 1986, while working for the Intel Corporation (Intel) as a systems packager. He initially sought treatment with Dr. Grassman, a chiropractor, who diagnosed acute cervico-thoracic and lumbar strain with attendant myofascitis and removed claimant from work. Claimant later sought treatment from Dr. Colletti, an orthopedic surgeon, and Dr. Espey, a chiropractor. His disabling injury claim was ultimately accepted by Intel and closed by a Determination Order on March 27, 1987, with no award of permanent disability.

In May 1988, claimant began doing landscape maintenance for his brother's company, Vasquez Landscaping. In December 1988, claimant experienced low back symptoms after using a backpack blower at work. In June 1989, he consulted Dr. Cox for increased complaints of low back pain and later filed a claim with Vasquez for "aggravation of previous low back injury." (Ex. 34). SAIF, insurer for Vasquez, denied the "new injury" claim in October 1989. In May 1990, Intel denied the aggravation claim, asserting that there had been no objective worsening of his condition.

ULTIMATE FINDINGS OF FACT

On January 20, 1987, claimant was fully recovered from the effects of the April 1986 injury. In June 1989, claimant suffered a new compensable injury while working for SAIF's insured.

CONCLUSIONS OF LAW AND OPINION

Remand

During the July 24, 1990 hearing, counsel for Intel objected to the admission of a report from Dr. Cox. The Referee admitted the report subject to Intel having the right to depose Dr. Cox and indicated that the record would be left open for two weeks. (Tr. 6). Later, at the conclusion of the hearing, the Referee asked the parties to submit written closing arguments to address whether the new law should apply and stated that the record would remain open until August 7, 1990. (Tr. 36).

Despite the assurance that the record would remain open for the receipt of additional evidence, the Referee issued her opinion and order on July 27, 1990, three days after the date of hearing. SAIF argues that the Referee's action was improper and that the matter should be remanded to the Hearings Division to rectify the error.

Whether or not the Referee should have left the record open, we conclude that remand is not warranted in this case for two reasons. First, given that SAIF was, in fact, the party that had initially submitted the report from Dr. Cox, we do not believe that it could have been prejudiced by Intel's inability to rebut that evidence. Intel has raised no objection to the Referee's actions. Second, as SAIF concedes in its appellant's brief (pg. 12), the record was sufficiently developed to allow the Board to decide this case on the merits. See ORS 656.295(5). Moreover, this matter is now before the Board and all parties have had an opportunity to submit written arguments for consideration. Consequently, we decline to grant SAIF's request that this case be remanded to the Referee and proceed with our review.

Responsibility

The question is which of two successive carriers is responsible for claimant's condition The parties do not dispute that, under prior law, responsibility would have been initially assigned to Intel, as the last carrier against whom claimant had an accepted claim for a low back injury. In order to shift responsibility to SAIF under the old rule, Intel would have been required to establish that claimant's subsequent employment independently contributed to a worsening of his low back condition. See Boise Cascade v. Starbuck, 296 Or 238 (1984); Stevens Equipment co. V. American Fabricators, 106 Or App 354 (1991).

Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in SB 1197, Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. SB 1197, Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Section 49 of Senate Bill 1197 provides, in part:

> "(1) When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability shall be processed as a new injury claim by the subsequent employer." Or Laws 1990 (Special Session), chapter 2.

It is unclear from its language what, if any, changes are created by Section 49(1) regarding the assignment of responsibility. Claimant argues that the provision merely codifies prior responsibility case law, which, in part, provided:

> "[I]f the second injury takes the form merely of a recurrence of the first, and if the second incident does not contribute even slightly to the causation of the disabling condition, the insurer on the risk at the time of the original injury remains liable for the second." Hensel Phelps Const. v. Mirich, 81 Or App 290 (1986).

SAIF, on the other hand, argues that responsibility now follows compensability under the new provision. It maintains that the subsequent employer is not responsible unless the subsequent incident is independently compensable.

When statutory language lends itself to more than one interpretation, we turn to its legislative history as an aid to resolving the ambiguity. Liberty Northwest Ins. Corp. v. Short, 102 Or App 495 (1990). The legislative history here clearly indicates that, in enacting section 49(1), the legislature intended to modify, rather than codify, the manner of assessing responsibility in workers' compensation cases.

As noted above, section 49(1), proposed in Senate Bill 1197, was added to Oregon's Workers' Compensation Act in 1990. During the first public hearing on the bill, authors of the proposed legislation agreed that, under section 49(1), the current judicial standards for responsibility would be eliminated and that a claimant would not sustain a new injury in terms of responsibility unless the new standards of compensability are met. See Minutes, Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 4, Side A at 184. Other legislative history was more direct. On May 4, 1990, Representative Mannix testified:

> "Let's state for the record that [section 49(1)] will do away with the current court interpretations of what is a new injury for responsibility purposes. Do you hear that judges on the Court of Appeals, members of the Board when you read the transcript of this hearing? * * * This says that there's going to have to be a new compensable injury, and this bill defines compensable injury. And so if there isn't a new compensable injury under the definition of the law, then responsibility remains with the first employer." Minutes, Interim Special Committee on Workers' Compensation, May 4, 1990, Tape 18, Side A at 320.

In light of the legislative intent apparent from the legislative history, and in the absence of any legislative history to the contrary, we conclude that, in cases in which an accepted injury is followed by an increase in disability during employment with a later carrier, responsibility rests with the original carrier unless the claimant sustains an actual, independent compensable injury during the subsequent work exposure. Thus, under the new analysis, Intel, as the last carrier against whom claimant had an accepted low back injury, remains presumptively responsible. In order to avoid responsibility, it now has the burden of establishing that claimant sustained a new compensable injury while working for SAIF's insured.

As amended by the 1990 Legislature, ORS 656.005(7)(a) defines a compensable injury as:

> "an accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death: an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings[.]" Oregon Laws 1990, ch. 2, section 3.

Under that amended statute, the traditional definition of a compensable injury, i.e., an accidental injury arising out of and in the course of employment, remains intact, but disability or the need for medical services must be established by medical evidence supported by objective findings. Accordingly, in order to establish a new compensable injury, Intel must establish, by medical evidence supported by objective findings, that claimant sustained a subsequent disability or need for medical services, the material contributing cause of which were his work activities with SAIF's insured. Mark N. Weidle, 43 Van Natta 855 (1991).

We first conclude that claimant's subsequent disability is established by medical evidence supported by objective findings. Amended ORS 656.005(19) defines "objective findings" to include "range of motion, atrophy, muscle strength, muscle spasm and diagnostic evidence substantiated by clinical findings." Or Laws 1990 (Special Session), ch. 2, section 3. In this case, Dr. Cox's initial clinical findings indicated that claimant had restrictions of lumbar motion on certain orthopedic maneuvers, i.e. flexion limited to 70 degrees, extension to 28 degrees, right and left material flexion to 30 degrees. (Ex. 37-1). Therefore, we proceed to the causation of claimant's current condition.

Considering claimant's prior injury to his back, we conclude that the cause of his condition is a complex medical question. Thus, while claimant's testimony is probative, the resolution of that question primarily turns on an analysis of medical evidence. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 259 (1985).

The parties introduced three expert opinions on medical causation. Dr. Cox, claimant's treating chiropractor, and the Western Medical Consultants believed that claimant's current condition is related to his earlier injury at Intel and is an aggravation of that injury. (Ex. 36, 39A). On the other hand, Dr. Simpson, a chiropractor who had performed an independent medical examination concerning both injuries, on May 29, 1986 and April 27, 1990 respectively, reported that there was no material causal relationship between claimant's current condition and his prior injury. He attributed claimant's disability to his work activities at SAIF's insured. (Ex. 41).

When there is a dispute between medical experts, we give greater weight to those opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). After our review of the record, we find only Dr. Simpson's opinion meets both criteria.

We give little weight to the opinion of Dr. Cox, because it is nothing more than a conclusory statement. His opinion, in its entirety, states:

> "The letter is to inform you that the treatment that [claimant] is currently receiving, [sic] is due to an aggravation of his previous injury, which occurred on April 24, 1986." (Ex. 36).

We also give little weight to the opinion of the Western Medical Consultants, who based their opinion on claimant's statements that he never recovered from his injury at Intel and that he continued to suffer from symptoms in his neck and back. The record reveals that, four months after the examination by the Western Medical Consultants, claimant did not relate symptoms continuing since the 1986 injury, but rather focused on a marked increase in symptoms occurring in February 1990. Moreover, Dr. Espey, claimant's initial treating chiropractor, reported in January 1987 that claimant was "fully recovered" and that claimant reported no neck or low back problems in November 1986. (Ex. 31).

Because a medical opinion is no better than the history on which it is based, Miller v. Granite Construction Co., 28 Or App 473 (1977), we do not find the consultant's opinion persuasive.

In contrast, Dr. Simpson's opinion was well-reasoned and based on a complete factual history. He believed that claimant became medically stationary with regard to the 1986 injury shortly after he first examined claimant in 1986, and agreed with Dr. Espey's report confirming that fact in January 1987. He expressed the opinion that the 1986 injury was "not a contributing factor at all to his current condition" and attributed claimant's back problems to his work activities with SAIF's insured. We find that opinion sufficiently persuasive to find that claimant's work at SAIF's insured was a material contributing cause of his condition. Therefore, because Intel has established, by medical evidence supported by objective findings, that claimant suffered a new compensable injury, SAIF is the responsible carrier and shall process claimant's claim as such. See Or Laws 1990 (Special Session), ch. 2, section 49.

In reaching this decision, we note that amended ORS 656.005(7)(a)(B) limits a carrier's liability for compensable injuries that combine with a preexisting disease or condition. The new statutory provision provides:

> "If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or the need for medical treatment, the resultant condition is compensable only to the extent that the compensable injury is and remains the major contributing cause of the disability or need for treatment." Or Laws 1990 (Special Session), chapter 2, section 3. (Emphasis supplied.)

Given our findings that claimant had fully recovered from the earlier 1986 injury, we need not determine if and how this provision affects questions of responsibility.

Penalty and Attorney Fees

We adopt the conclusions and reasoning regarding the penalty and attorney fee issue 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 $800 is a reasonable assessed fee for claimant's counsel's efforts concerning the issue of responsibility. See Dolly S. Mack, 43 Van Natta 389 (1991). 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 presented, 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 issues. Saxton v. SAIF, 80 Or App 63 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated July 27, 1990 is affirmed. For services on Board review, claimant's attorney is awarded a reasonable fee of $800, payable by the SAIF Corporation.

In the Matter of the Compensation of
KAREN A. VEGA, Claimant
WCB Case No. 90-05674
ORDER ON REVIEW
Ginsburg, et al., Claimant Attorneys
Susan Ebner (Saif), Defense Attorney

Reviewed by Board Members Westerband and Neidig.

The SAIF Corporation requests review of those portions of Referee Podnar's order that: (1) set aside its denial of claimant's medical services claim for a right shoulder, neck and upper back condition; (2) set aside a Determination Order as premature; (3) assessed a penalty for SAIF's allegedly unreasonable calculation of her temporary total disability benefits; and (4) assessed a penalty for SAIF's allegedly unreasonable resistance to the payment of compensation. On review, the issues are medical services, premature closure and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant is a 33 year old laundry worker. Her work involved ironing and repetitive lifting of five-gallon containers of cleaning solution. In April 1989, she began to have pain in her right forearm and sought treatment from Dr. Hinton, a naturopathic physician. He diagnosed thoracic outlet syndrome and provided conservative treatment.

On May 17, 1989, claimant filed a claim seeking compensation for "tendonitis." (Ex. 1B). She identified March 27, 1989 as the date of injury, but noted that the injury occurred over a period of time while performing work activities. On August 17, 1989, SAIF accepted the injury as an "overuse strain with right lateral humeral epicondylitis." (Ex. 1C).

On September 19, 1989, claimant was examined by Dr. Short, an orthopedist, and Dr. Rich, a neurologist, at the offices of the Orthopaedic Consultants. They concluded that claimant was not medically stationary and recommended that she treat with an orthopedic surgeon. (Ex. 3A).

On December 20, 1989, claimant was examined by Dr. Kiest, an orthopedist, and Dr. Marshall, a naturopathic physician, at the offices of the Medical Consultants Northwest. They diagnosed right extensor epicondylitis and noted right upper extremity pain related to the industrial injury. They concluded that claimant was medically stationary with no objective evidence of permanent impairment. (Ex. 4D).

On February 26, 1990, SAIF denied claimant's continued medical care, asserting that the treatments for her shoulder, neck and upper back condition were not related, reasonable or necessary for the accepted condition. (Ex. 10). On March 13, 1990, Dr. Hinton wrote SAIF, explaining that claimant sustained an over-use injury to her right shoulder girdle and arm as a direct result of her compensable injury and that claimant's physical therapy, orthosos, rest and manipulation represented appropriate treatment for the condition. He further noted that, while her elbow condition had resolved, claimant's right shoulder disability remained mildly impaired and was not yet medically stationary. (Ex. 11A).

A Determination Order issued April 2, 1990, awarding claimant temporary total disability from August 11, 1989, through December 20, 1989, the date she was declared medically stationary. (Ex. 12). Claimant requested a hearing.

On May 14, 1990, SAIF clarified its earlier partial denial of claimant's continued medical treatment. SAIF stated that it would continue to provide medical benefits related to claimant's accepted elbow condition, but reiterated that it did not believe that the treatments rendered for her shoulder, neck and upper back were beneficial for or related to that condition. (Ex. 13).

Claimant continued to treat with Dr. Hinton until July 1, 1990, when claimant sought alternative treatment from Dr. Karty, a chiropractor. Dr. Karty diagnosed a right shoulder sprain/strain due to trauma disorder and believed that the condition was industrially related. He concluded that claimant was not medically stationary and recommended an active physical therapy program. (Ex. 17).

At the time of injury, claimant earned $4.75 per hour and worked in excess of 40 hours per week. In the 18 weeks prior to the date of injury, claimant earned an average of $234.53 per week. Claimant's benefits for temporary total disability were calculated on a 40 hour work week at $4.25 per hour.

A hearing in this matter was convened on June 25, 1990.

CONCLUSIONS OF LAW AND OPINION

Medical Services

In determining the compensability of the disputed medical services, the Referee found that SAIF's acceptance of claimant's "overuse strain with right lateral humeral epicondylitis" was somewhat ambiguous. Because the contemporaneous medical evidence indicated that claimant had sought medical treatment for her shoulder girdle, neck and upper back strain, the Referee, in resolving the ambiguity in claimant's favor, concluded that SAIF had actually accepted the neck, upper back and shoulder condition as well as the attendant right upper extremity epicondylitis. Under that clarified acceptance, the Referee concluded that the disputed medical treatment was reasonable and necessary for claimant's condition and, therefore, was compensable.

On review, SAIF contends that its partial acceptance was not ambiguous and that the Referee erred in effectively rewriting the acceptance to include the right shoulder, neck and upper back condition. It argues that the only condition accepted in writing was claimant's right epicondylitis and, because that problem had resolved without impairment, any continued treatment was not related and, therefore, not compensable.

The compensability of medical services is not determined solely on the basis of whether the particular condition for which a claimant seeks treatment was accepted by the carrier. A claimant is entitled to medical services "for conditions resulting from the injury for such period as the nature of the injury or the process of recovery requires." ORS 656.245(1). (Emphasis supplied.) To establish the compensability of medical treatment for a condition, a claimant need only show that: (1) the compensable injury was a material contributing cause of that condition; and (2) that services rendered for that condition are reasonable and necessary. Jordan v. SAIF, 86 Or App 29 (1987); West v. SAIF, 74 Or App 317 (1985).

There is no dispute that claimant's upper back, neck and shoulder condition are industrially related. Dr. Hinton, the treating physician, reported that claimant sustained an over-use injury to her right shoulder girdle and arm as a direct result of her compensable injury. (Ex. 11A). Dr. Kiest and Dr. Marshall agreed, attributing the upper extremity pain related to holding her

right arm carefully and restricting motion. (Ex. 4D). There is no contrary medical evidence.

There is a dispute, however, whether the treatment provided by Dr. Hinton was reasonable and necessary. On September 19, 1989, Dr. Short and Dr. Rich reported that claimant had not improved with Dr. Hinton's treatments. (Ex. 3A-1). Dr. Short later wrote SAIF on October 17, 1989, reiterating that the treatment of claimant's condition was ineffective, although carried out twice a week since March 27, 1989. (Ex. 4A). Furthermore, Dr. Kiest and Dr. Marshall reported that there was no specific treatment by any medical discipline that was beneficial for claimant's condition and that her condition would recede with or without treatment. (Ex. 4D-5). Dr. Marshall also wrote individually to SAIF, questioning the continuation of any treatment past 12 months that offers little or no relief. In her May 25, 1990 letter, she characterized the particular treatments used by Dr. Hinton as "redundant" and "excessive." (Ex. 14).

In light of the substantial contrary evidence, we are not persuaded that the services rendered by Dr. Hinton were reasonable and necessary medical treatment for claimant's compensable injury. Accordingly, we conclude that claimant has failed to establish the compensability of the medical services and reinstate SAIF's denial.

Premature Closure

SAIF contends that the Referee erred in setting aside the April 2, 1990 Determination Order as premature, arguing that the medical evidence establishes that claimant was medically stationary on December 20, 1989. It relies on a December 20, 1989 report submitted by Dr. Kiest and Dr. Marshall, which provided:

> "[Claimant's] condition is medically stationary in that it has not responded to treatment over the past nine month period of time. * * * Time and restriction of the offending activity are usually all the treatment that is basically necessary." (Ex. 4D-5).

The doctors further noted:

> "We again reiterate that there is no future medical treatment that is medically necessary and none that is presumed to be beneficial from a curative standpoint. This condition will recede." (Id. at 6).

Whether claimant will benefit from future medical treatment is a factor in determining whether claimant is medically stationary; however, it is not a conclusive one. An injured worker is considered medically stationary when no further material improvement would reasonably be expected from medical treatment <u>or the passage of time</u>. ORS 656.005(17). (Emphasis supplied.) In this case, while Dr. Kiest and Dr. Marshall reported that no further material improvement was expected from medical treatment, they did believe that claimant's condition would improve over the passage of time. That conclusion is consistent with the medical record. Accordingly, we agree with the Referee's conclusion that claimant's condition was not medically stationary at the date of closure.

Penalty - Unreasonable Calculation of TTD Benefits

The Referee found that, while SAIF had based its calculations of claimant's temporary total disability benefits on a 40 hour work week at $4.25 per hour, claimant was actually earning $4.75 per hour at the time of injury and had worked an average of almost 50 hours per week. Accordingly, the Referee ordered

SAIF to recalculate claimant's temporary benefits based on a weekly wage of $234.53, and assessed a 25 percent penalty for SAIF's unreasonable calculation.

On review, SAIF contends that its erroneous miscalculation was not unreasonable, because claimant's temporary total disability rate was based on the figure of $4.25 per hour as provided on the 801 form. In addition, SAIF argues that it was not aware that claimant's actual wage at injury was $4.75 and that she had worked overtime until pay records were provided at hearing.

SAIF is correct that the employer reported claimant's wage as $4.25 per hour on the 801 form; however, the employer also noted that, while claimant worked eight hours per shift, the number of hours she worked varied with overtime. (Ex. 1B). Thus, even if SAIF reasonably relied on the hourly wage provided by the employer, we do not believe that its actions were reasonable in failing to further investigate claimant's earnings when notified of the fact that she worked overtime.

Penalty - Unreasonable Resistance to Compensation

It is undisputed that claimant was disabled and entitled to temporary total disability as of August 11, 1989. SAIF, however, began temporary total disability payments on August 15, 1989. SAIF provided no persuasive explanation for the delay. As a result, the Referee deemed SAIF's delay as an unreasonable resistance to the payment of compensation and awarded a penalty of 25 percent of the increase in temporary total disability benefits made payable by his order. On review, SAIF contends that the 25 percent penalty was excessive given the fact that the delay in payment of compensation amounted to only four days.

We need not address the amount of the penalty because we hold that, the Referee was unable to assess a penalty, in any amount, against additional temporary total disability made payable by his order. As discussed above, the Referee had already assessed a 25 percent penalty for SAIF's allegedly unreasonable calculation of claimant's temporary total disability benefits. That penalty was based "on the increased temporary total disability benefits made payable by virtue of the recalculated rate of temporary total disability and the previously unpaid days from August 11, 1989 through December 20, 1989[.] (O & O at 7). (Emphasis supplied.) Inasmuch as the Referee had previously assessed a full penalty against such benefits, he could not assess an additional amount based on the same compensation. See Kim L. Haragan, 42 Van Natta 311 (1990).

Attorney Fees on Review

Because SAIF requested review on the issue of premature closure and we are affirming that portion of the Referee's order, claimant's attorney normally would be entitled to a fee payable by SAIF under ORS 656.382(2). Claimant's attorney, however, filed no brief on Board review. Accordingly, no fee may be awarded. Randall P. Adams, 42 Van Natta 79 (1990).

ORDER

The Referee's order dated September 25, 1990, is affirmed in part and reversed in part. The SAIF's Corporation's May 14, 1990 denial of claimant's medical services claim is reinstated and upheld. The Referee's $1,512 assessed attorney fee award concerning the medical services denial is reversed. The Referee's assessed penalty for SAIF's four day delay in the payment of temporary total disability is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
DONALD A. WILLIAMS, Claimant
WCB Case No. 89-17142
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

The insurer requests that we reconsider and reverse our Order on Review dated May 31, 1991 that affirmed a Referee's order which set aside its denial of claimant's occupational disease claim for a left hip and low back condition. In the alternative, the insurer also requests that the case be remanded to the Referee to allow further proceedings in consideration of the proper legal standard. We abated our order on June 27, 1991 to allow further consideration in light of the court's recent decision in Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991). Having reviewed the compensability issue in view of the court's recent decision, we proceed with our reconsideration.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" including the first "Ultimate Finding of Fact" as supplemented.

Claimant's work activities were not the major contributing cause of his left hip and low back condition.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the claimant's symptomatic worsening of his left hip and low back condition was materially caused by his work activities. We affirmed the Referee's order based on our interpretation of former ORS 656.802, that only a material contribution to the worsening of the symptomology need be shown. However, the Court of Appeals recently held that to establish the compensability of an occupational disease under former ORS 656.802, claimant must prove that his work activities were the major contributing cause of his condition or of the worsening of his underlying condition. See Aetna Casualty Co. v. Aschbacher, supra.

The insurer has requested that we remand to the Referee for application of the correct burden of proof. We may remand for further evidence taking, correction or other necessary action if the Board determines that a case has been improperly, incompletely or otherwise insufficiently developed or heard by a Referee. Upon review of the record, we find that the compensability issue has been sufficiently developed to allow us to proceed with our review. Therefore, we decline to remand. See ORS 656.295(5).

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). At the time of hearing claimant was still employed as a mill operator. Therefore, the occupational disease law effective between January 1, 1988 and July 1, 1990 before its amendment is applicable. See Johnson, supra at 146-48.

Because claimant's left hip and low back condition involved repetitive movement and was gradual in onset, his claim is properly analyzed under former ORS 656.802(1)(c). To establish that his condition is compensable under subsection (1)(c), claimant must prove that his work exposure included a series of traumatic events which were the major cause of the onset or worsening of the

left hip and low back condition, requiring medical services or resulting in disability. See Aetna Casualty Co. v. Aschbacher, supra. Major cause means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening than all other activities or exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); Dethlefs v. Hyster Co., 295 Or 309-310 (1983).

We find that the causation issue is a complex medical question. Resolution of the issue requires expert medical evidence. See Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Claimant was initially treated by Dr. Gorman, a chiropractor, who opined that claimant's work activities which involved bending, twisting, lifting and pulling veneer for a number of years was a material contributing cause of claimant's condition. (See Ex. 13). When claimant's back became symptomatic in May 1989 he sought the advice of a surgeon, Dr. Smith. Dr. Smith, in turn, referred claimant to Dr. Collis, an orthopedic surgeon. Dr. Collis first saw claimant in July 1989, and found that claimant's "degenerative arthritis" was not job-related. (Ex. 9a). In subsequent correspondence with claimant's counsel, he opined that claimant's work for the employer over a 12 year period may have had "some contribution" to the development of his arthritis. (See Exs. 10, 10a). Again responding to claimant's counsel, Dr. Collis later stated that "this arthritic condition was probably aggravated by his work at the mill as a dryer grader and that his job hastened the need for his pending total hip replacement." (See Ex. 11). We find that Dr. Collis' reports establish only material contribution.

By the medical evidence, claimant has established that work-related activities did contribute materially to a worsening of claimant's preexisting condition. However, the evidence does not establish that claimant's work activities were the major contributing cause of the worsening. Consequently, we conclude that claimant has failed to carry his burden of proof. See Aetna Casualty Co. v. Aschbacher, supra.

ORDER

The Referee's order date July 3, 1990 is reversed. The insurer's August 28, 1989 denial is reinstated and upheld. The Referee's $3,000 assessed attorney fee award is also reversed.

July 31, 1991 Cite as 43 Van Natta 1688 (1991)

In the Matter of the Compensation of
PHYLLIS I. FULLER, Claimant
WCB Case No. C1-01492
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Kirkpatrick & Zeitz, Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Neidig and Westerband.

On July 19, 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.

In pertinent part, the agreement provides:

> "Claimant contends that she is permanently and totally disabled pursuant to ORS 656.206. The parties stipulate that the claimant's total disability came into existence as a result of injury and/or disease processes which became diagnosed and symptomatic after the date of injury. Furthermore, it is stipulated by all the parties that these conditions have no relationship to the injury, which gave rise to this claim." (p. 4, ll. 12-17).

The above language appears to dispose of claim(s) in which there is a bona fide dispute over the compensability of the claim(s). The parties apparently dispute whether claimant's total disability results from the compensable injury. The stipulations resolve the dispute against compensability. By so stipulating, the parties have essentially entered a disputed claim settlement. See OAR 438-09-001(2). Inasmuch as the disputed claim settlement is in the same document as a claim disposition agreement, it impermissibly exceeds the bounds of OAR 438-09-020(1)(b).

Furthermore, by stipulating that "injury and/or disease processes which became diagnosed and symptomatic after the date of injury" have no relationship to the compensable injury, the parties have effectively restricted, if not precluded, claimant's right to medical services for conditions which may relate to the compensable injury, but were not diagnosed or symptomatic until after the date of injury. Any such restriction on claimant's right to medical services exceeds the bounds of ORS 656.236(1) and the rules promulgated thereunder. See Jean E. Nealy, 42 Van Natta 2378 (1990); Kenneth D. McDonald, 42 Van Natta 2307 (1990). Because this agreement exceeds the bounds of existing statute and rules, we find the proposed disposition is unreasonable as a matter of law. See Louis R. Anaya, 42 Van Natta 1843, 1844 (1990). Accordingly, we decline to approve the agreement and return it to the parties. See ORS 656.236(1)(a).

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).

Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

July 31, 1991 Cite as 43 Van Natta 1689 (1991)

In the Matter of the Compensation of
MARILYN LONDON, Claimant
WCB Case No. C1-01266
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Ainsworth, Davis, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

On July 17, 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.

The agreement provides that the self-insured employer paid claimant all benefits due and payable up to the time that agreement was sent to her with the exception of outstanding medical bills for hospital and massage therapy services (p. 2, 11. 1-5). Those bills total $3,073.24. The agreement further provides that claimant shall pay the medical bills directly from the settlement proceeds of $9,000 (p. 3, 11. 8-12).

ORS 656.236(1) permits parties, by agreement, to dispose of any or all matters regarding a claim, except for medical services, subject to the terms and conditions prescribed by the Director of the Department of Insurance and Finance. The Director's rules define a "claim disposition agreement" as a written agreement which releases rights and obligations under ORS Chapter 656, except for medical services, in an accepted claim. OAR 436-60-005(9); see also OAR 438-09-001(1).

Claimant has the right to request a hearing on the employer's refusal to pay the outstanding medical bills. Inasmuch as that right arises from claimant's right to medical benefits for her compensable injury, it may not be released by claim disposition agreement. See id. By agreeing to pay those bills from settlement proceeds, claimant is effectively relinquishing that claim for medical benefits. That is an impermissible limitation on claimant's right to medical benefits for her compensable injury. See, e.g., Jean E. Nealy, 42 Van Natta 2378 (1990); Kenneth D. McDonald, 42 Van Natta 2307 (1990). Accordingly, we find the agreement is unreasonable as a matter of law. See Louis R. Anaya, 42 Van Natta 1843, 1844 (1990). We therefore decline to approve the agreement. See ORS 656.236(1)(a).

Inasmuch as the proposed disposition has been disapproved, the 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
BARBARA J. CLAXTON, Claimant
WCB Case No. 89-23495
ORDER ON RECONSIDERATION
Douglas L. Minson, Claimant Attorney
Schwabe, et al., Defense Attorneys

On July 12, 1991, we abated our June 12, 1991 Order on Review. We took that action in order to consider the insurer's motion for reconsideration. Having received claimant's response, we proceed with our reconsideration.

On reconsideration, the insurer first contends that our order on review, with regard to the compensability of claimant's TMJ condition, is ambiguous as to whether or not the insurer must accept claimant's TMJ condition or to process

the medical bills related to a temporary exacerbation of claimant's preexisting TMJ condition.

We note that the insurer denied claimant's TMJ condition. We concluded that the record indicates that claimant's compensable injury caused her TMJ condition to become symptomatically worse. Consequently, the insurer's denial is set aside only to the extent that it denies the worsened symptoms of claimant's preexisting TMJ condition. We do not prejudge at this time whether the exacerbation is temporary or permanent.

Next, the insurer requests that we reconsider that portion of our order finding the insurer's October 12, 1989 right knee condition denial was invalid and premature. We note that the exhibits to which the insurer directs our attention on reconsideration, refer to claimant's right "leg" and not a "right knee condition." Claimant's compensable injury consisted of her falling and landing on her lower spine. Prior to the insurer's October 12, 1989 "right knee condition" denial, the insurer had received barely legible chart notes from claimant's treating chiropractor indicating that claimant's right leg was "real sore." (Ex. 2-5). There is no "right knee condition" diagnosis prior to the insurer's October 1989 denial; the treating chiropractor makes no connection between a "real sore" right leg and a "right knee condition" so as to infer a claim for a "right knee condition" related to the compensable injury.

We conclude that there is no claim in the record for a "right knee condition." Further, the insurer's examining chiropractor, J.M. Burke, prior to the insurer's October 12, 1989 denial, wrote that claimant "denied any lower extremity symptoms but does note that she has had 'tendinitis' in her right knee." (Ex. 18-3). Burke went on to state that "[h]istory of right knee pain not related to the industrial injury in question." (Ex. 18-6). Burke's mention of claimant's right knee pain is not a claim for a "right knee condition." Accordingly, we adhere to our conclusion that the October 12, 1989 denial, insofar as it denies an alleged right knee condition, was an invalid, premature denial.

The insurer also requests that we reconsider the assessed attorney fees at hearing and on Board review. We conclude that these issues were adequately considered and addressed in our prior order.

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

IT IS SO ORDERED.

August 2, 1991 Cite as 43 Van Natta 1691 (1991)

In the Matter of the Compensation of
JAMES W. ROSE, Claimant
WCB Case Nos. 90-06389 & 90-21188
INTERIM ORDER
Coons, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys
Employers Defense Counsel, Defense Attorneys

The self-insured employer has requested Board review of Referee McWilliams' June 24, 1991 order. Noting that the Referee abated her order on July 9, 1991, the employer seeks guidance concerning who has jurisdiction over this matter. We conclude that jurisdiction rests with the Board.

FINDINGS OF FACT

The Referee's order issued June 24, 1991. On July 5, 1991, claimant filed a motion with the Referee, seeking reconsideration of the June 24, 1991. On July 8, 1991, the self-insured employer mailed, by certified mail, a request for Board review of the Referee's June 24, 1991 order. The next day, July 9, 1991, the Referee issued an order abating the June 24, 1991 order and granting the remaining parties 10 days to respond to claimant's motion. On July 22, 1991, the Board received claimant's request for Board review of the Referee's order.

CONCLUSIONS OF LAW

The employer's request for Board reivew of the Referee's order was filed on July 8, 1991, the date the request was mailed by certified mail. OAR 438-05-046(1)(b). Claimant sought reconsideration of the Referee's order prior to the filing of the employer's request for Board review. However, the Referee's abatement order did not issue until July 9, 1991, the date after the employer had mailed its request for Board review.

Upon mailing of the employer's request for review to the Board by means of certified mail, jurisdiction over this case vested with the Board. See ORS 656.295(2); OAR 438-05-046(1)(b); Ramey S. Johnson, 40 Van Natta 370 (1988).

Inasmuch as the request for review preceded the Referee's order of abatement, that order is a nullity. Consequently, the self-insured employer's request and claimant's cross-request for Board review will be processed accordingly. The transcript has been ordered. Upon its receipt, copies will be provided to the parties and the briefing schedule implemented.

IT IS SO ORDERED.

August 2, 1991 Cite as 43 Van Natta 1692 (1991)

In the Matter of the Compensation of
GERARDO VELASQUEZ, (Deceased), Claimant
WCB Case No. 87-08667
ORDER ON REVIEW
Ginsburg, et al., Claimant Attorneys
Snarskis, et al., Defense Attorneys

Reviewed by Board Members Westerband, Crider and Neidig.

Claimant's beneficiaries (his wife and children) request review of that portion of Referee Mills' order that approved the insurer's reduction under ORS 656.232(2) of claimant's temporary and permanent disability compensation on the basis of claimant's non-resident alien status. Claimant also seeks a penalty and related attorney fee for the insurer's failure to pay the full amount of compensation awarded by Determination Order. On review, the issues are the constitutionality of ORS 656.232(2) under the Oregon and United States Constitutions, the scope and proper application of ORS 656.232(2), and penalties and related attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant was a citizen of Mexico. On May 30, 1986, while working for Monrovia Nursery Company in Oregon, he compensably injured his back.

On April 16, 1987, a Determination Order issued awarding claimant temporary total disability for the period June 2, 1986 through February 22, 1987, and temporary partial disability for the period February 23, 1987 through April 2, 1987. The order reserved judgment on the extent of permanent disability, pending receipt of additional medical information on the question of extent that was not available at the time, principally because claimant was in Mexico receiving treatment for the compensable condition.

By letter dated September 21, 1987, the insurer's claims representative, advised the Workers Compensation Division's Compliance Department, that claimant was a Mexican citizen residing in Mexico. The letter "request[ed] authorization" to pay claimant time loss benefits, and further stated that "[w]hen and if authorization is made, please determine and advise of the amount of compensation per ORS 656.232(2);" and that "[w]ere Mr. Velasquez in the United States at this time, his TTD rate would be $152.82 per week." Compliance responded by letter dated November 20, 1987, as follows:

> "Effective January 1, 1988, the benefit entitlement level for Mexican aliens living outside the United States will remain at 50 percent of the Oregon benefit entitlement level.
>
> The claimant(s) should be notified that there is no change in the benefit level. A copy of the letter to the claimant should be provided to the Workers' Compensation Division."

On the basis of Compliance's letter, the insurer reduced by 50 percent the amount of time loss benefits awarded to claimant by the April 17, 1987 Determination Order from $152.82 per week to $76.41 per week.

On April 19, 1988, a Determination Order issued finding claimant medically stationary on March 3, 1988, awarding claimant temporary total disability from August 20, 1987 through March 29, 1988, and 40 percent unscheduled permanent partial disability (equal to 128 degrees). The order also stated:

> "THE INSURER IS NOW ORDERED TO PAY YOU $12,800.00. THIS IS THE VALUE BY THIS ORDER ONLY AND DOES NOT INCLUDE PAYMENTS PREVIOUSLY ORDERED. DEDUCTION OF OVERPAID TEMPORARY DISABILITY, IF ANY, FROM UNPAID PERMANENT DISABILTY IS APPROVED." (Emphasis in the Original).

The order did not mention that claimant was an alien or where he was residing; and, specifically, it did not authorize reduction of claimant's benefit entitlement because he was an alien residing outside the United States.

By letter dated May 4, 1988, the insurer notified claimant that it was reducing the amount of the permanent partial disability benefit awarded by 50 percent pursuant to the previously discussed letters from Compliance, leaving $6,300 owing to claimant after payment to claimant's attorney of $200 in attorney fees, pursuant to a November 30, 1987 Stipulation. The letter also stated that temporary disability had been paid through April 13, 1988 resulting in an overpayment of $165.55, which would further reduce the benefit amount from $6,300 to $6,134.45.

By letter dated June 2, 1988, Compliance notified the insurer that effective July 1, 1988, "the benefit entitlement level for Mexican aliens living outside the United states has increased to 55 percent of the Oregon benefit

entitlement level," and that claimant should be so notified. In subsequent correspondence, the insurer notified claimant of the benefit level increase to 55 percent, and that his monthly payments would be increased accordingly, effective July 1, 1988.

Claimant, while residing in Mexico, was killed in a noncompensable motor vehicle accident in late 1988, after issuance of the Referee's December 1, 1988 Opinion and Order. Claimant's beneficiaries (his wife and children) requested review.

CONCLUSIONS OF LAW AND OPINION

The beneficiaries contend that ORS 656.232(2) invidiously discriminates against claimant on the basis of his alienage, in violation of the Fourteenth Amendment - Equal Protection Clause of the Constitution of the United States. Alternatively, they contend that in treating him differently because of non-resident alien status, the statute violates Article 1, Section 20 of the Oregon Constitution. In the event those challenges fail, the beneficiaries also contend that the statute constitutes an unconstitutional delegation of legislative authority.

The Referee declined to reach these constitutional arguments on the ground that the Board is without authority to decide constitutional questions. In the past, we have held that the Board lacks authority to decide constitutional issues. See, Ray Lynn York, 35 Van Natta 558 (1983); Mellisa P. Johnson, 35 Van Natta 555(1983); Sidney A. Stone, 31 Van Natta 84 (1981), rev'd in part on other grounds, Stone v. SAIF, 457 Or App 808 (1982). However, since those decisions, the Oregon Supreme Court has held that an administrative agency "ordinarily can interpret a statute so as to exclude unconstitutional applications before it is forced to question the statute's validity." Cooper v. Eugene School District No. 4J, 301 Or 358, 365 (1986). Thus, if we are required in a case to reach a constitutional question concerning a statute's application, we have the authority to do so. Theron Stiehl, 41 Van Natta 116, 117 (1989); Jane Goodman, 38 Van Natta 1374 (1986).

Nevertheless, we, as the courts, reach constitutional issues only if a case may not be decided on a statutory ground. Planned Parenthood Assn Inc. v. DHR, 297 Or 562 (1984); State v. Lowry, 295 Or 337, 343 n. 4 (1983). Hence, we first address the beneficiaries' statutory contentions.

ORS 656.232 provides, in pertinent part:

> "(2) If a beneficiary is an alien residing outside of the United States or its dependencies, the director may, in lieu of awarding such beneficiary compensation in the amount provided by ORS 656.001 to 656.794, award such beneficiary such lesser sum by way of compensation which, according to the conditions and costs of living in the place of residence of such beneficiary will, in the opinion of the director, maintain the beneficiary in a like degree of comfort as a beneficiary of the same class residing in this state and receiving the full compensation authorized by ORS 656.001 to 656.794. The director shall determine the amount of compensation benefits upon the basis of the rate of exchange between the United States and any foreign country as determined by the Federal Reserve Bank as of January 1 and July 1 of the year when paid."

ORS 656.232(2) authorizes the Director to award to an alien residing outside the United States such lesser amounts which, "according to the conditions and costs of living in the place of residence of such beneficiary, will in the opinion of the director, maintain the beneficiary in a like degree of comfort as a beneficiary of the same class residing in this state and receiving the full compensation." Furthermore, the Director is required to determine that lesser amount based upon the rate of exchange between this and the foreign country involved. The statute requires that the adjustment be made directly by and under the Director's supervision and entitles the beneficiary, under ORS 656.283, to request a hearing from the Director's award.

We agree with the beneficiaries that the reduction of claimant's benefits was not carried out in the manner required by ORS 656.232(2). In this statutory scheme, "award," as used in ORS 656.232(2) is a term of art, which denotes an order issued by the Director awarding compensation to a claimant based on the claimant's individualized circumstances as determined by the Director. Thus, by the terms of ORS 656.232(2), the Director was required to issue an order awarding claimant whatever lesser amount that he determined was appropriate under the statutory criteria, assuming he decided upon examination of claimant's circumstances that any amount less than full compensation should be awarded. However, the Director's April 19, 1988 Determination Order awarded claimant full temporary total disability for a designated period (as had the prior Determination Order issued on April 16, 1987) and full permanent partial disability, and in accordance thereto, stated in relevant part that "THE INSURER IS NOW ORDERED TO PAY YOU $12,800.00." The order did not take into account claimant's alienage or his place of residence: it did not award claimant a lesser amount because of these factors. Instead, the reduction of claimant's compensation was made by the insurer after the Director issued his order, pursuant to letters between the insurer and the Compliance Unit. Thus, no appealable order issued by the Director awarding claimant any lesser amount.

The requirement of ORS 656.232(2) that the Director determine the lesser amount by order ensures that claimant will have the opportunity, before his compensation is reduced, to know what specific criteria the Director will use to determine the amount of the reduction, and to participate meaningfully in the process for determining that amount, even to the extent of arguing for no reduction or proposing some different percentage of reduction based on the statute's criteria. The informal process utilized in this case did not permit any meaningful participation by claimant although he was the individual most affected.

We believe the court's decision in Forney v. Western States Plywood, 66 Or App 155 (1983) is instructive. The Director had promulgated a rule which authorized insurers to recover unilaterally overpayments of benefits paid to a worker on an accepted claim. At some point after a referee's order set aside the employer's denial of the claimant's aggravation claim, the employer became aware that an overpayment had been made of 20 percent permanent partial disability. Pursuant to the Director's rule in question, the employer notified the claimant that it intended to deduct the overpayment at the rate of 25 percent of retroactive and ongoing temporary total disability as authorized by the rule. After the recoupment, the claimant requested a hearing. This Board affirmed the referee's holding that the employer had acted within its authority. On appeal, the Court of Appeals disagreed. The court declared the Director's rule invalid. The court held that the statutes involved required that prior to any offset by an insurer, the Director or this Board must authorize the offset. The court required the insurer to pay claimant the amount deducted by the employer under the Director's invalid rule.

Under ORS 656.232(2), the amount of any reduction of benefits due to a claimant's nonresident alien status, can only be determined by the Director

through an award of compensation that takes into account, along with the rate of exchange, "the conditions and costs of living in the place of residence of such beneficiary [which] will, in the opinion of the director, maintain the beneficiary in a like degree of comfort as a beneficiary of the same class residing in this state and receiving the full compensation authorized by ORS 656.001 to 656.794." The statute required the Director to designate the lesser amount by order subject to this Board's review. The Director's order in this case awarded claimant full benefits. The insurer unlawfully reduced the amount of compensation that the Director had awarded on the basis of letters of advice. Therefore, we must set aside that portion of the Referee's order which approved the reductions.

On review, beneficiaries contend for the first time, that penalties and related attorney fees should be assessed under ORS 656.262(10) on the grounds that the insurer's reduction of the benefits, was inconsistent with the Determination Order and constituted an unreasonable resistance to the payment of compensation. We reject this contention for two reasons. First, since this issue was not raised at hearing, it is not properly before us on Board review. Second, even if it were properly presented, it is clear that the insurer reduced claimant's compensation on the advice of the Workers' Compensation Division. Under the circumstances, its conduct was not unreasonable.

ORDER

The Referee's order dated December 1, 1988 is reversed in part and affirmed in part. That portion of the order which approved the reduction of claimant's temporary total and permanent partial disability benefits is reversed. The remainder of the Referee's order is affirmed. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

In the Matter of the Compensation of
KAREN S. PARAZOO, Claimant
WCB Case No. 89-19459
ORDER ON REVIEW
Aller & Morrison, Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The self-insured employer requests review of that portion of Referee Emerson's order that set aside its denial of claimant medical services claim for inpatient hospitalizations. Claimant cross-requests review of that portion of the order that upheld the employer's denial of her aggravation claim for a low back and hip injury. On review, the issues are medical services and aggravation. We affirm in part and modify in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Medical Services

The Referee concluded that claimant's hospitalizations, prescribed by Dr. Doupe, her treating physician, were reasonable and necessary treatment for her compensable condition. We modify.

Claimant is entitled to medical services for conditions resulting from her compensable injury "for such period as the nature of the injury or the process of recovery requires." ORS 656.245. Claimant carries the burden of proving by a preponderance of the evidence that the services are reasonable and necessary. West v. SAIF, 74 Or App 317 (1985).

After our de novo review of the record, we agree with the Referee that the initial hospitalizations were reasonable and necessary treatment for claimant's condition. Even Dr. Wolpert, the employer's principal medical expert, testified in his deposition that, given claimant's condition, he probably would have begun inpatient treatment as was prescribed by Dr. Doupe. (Ex 141-25).

We do not agree, however, that the continuation of such treatments after April 1, 1989, were reasonable and necessary when it became apparent that they were not achieving positive results.

We base this conclusion on the following reasoning. In March 1989, the Western Medical Consultants questioned the effectiveness of the inpatient treatments and believed that Dr. Doupe's efforts in trying to help claimant were inadvertently encouraging her to remain disabled. (Ex. 90). Dr. Wolpert reached a similar conclusion after diagnostic studies failed to find any objective basis for claimant's complaints. He reported that, because claimant's problems stem from a psychological problem, the hospitalizations were not reasonable for necessary treatment for claimant's condition. (Ex. 129.)

Even Dr. Doupe recognized that the hospitalizations had become counterproductive to claimant's recovery. In a letter dated April 8, 1989, Dr. Doupe reported:

> "All of [claimant's] hospital admissions have been reluctant ones when it seemed that there seemed to be no other recourse or way of helping [claimant] gain control of her pain and help improve her

coping behavior. I will be the first to admit that this approach has not been successful." (Emphasis supplied.) (Ex. 95).

Yet, after that report, Dr. Doupe admitted claimant to the hospital for "pain control" at least five additional times. (Exs. 114, 120, 127, 133, 134, 136).

Given Dr. Doupe's recognition that the hospitalizations were not achieving any positive results, and in light of medical evidence that such treatments were actually defeating the goal of returning claimant to an independent lifestyle, we conclude that after April 1, 1989, the continued hospitalizations to treat claimant were neither reasonable nor necessary. The Referee's order will be modified accordingly.

Aggravation

We adopt the conclusions and reasoning concerning the aggravation issue as set forth in the Referee's order.

Attorney Fees

The Referee awarded a $800 assessed attorney fee for claimant's counsel's efforts in overturning the medical services denial. Inasmuch as we have modified the Referee's ruling on the medical services issue, the attorney fee will be modified accordingly. After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that $500 adequately compensates claimant's counsel for partially prevailing on the medical services issue. 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 August 21, 1990 is affirmed in part and modified in part. That portion that ordered the employer to pay for all hospitalizations is modified. The employer's denial is upheld insofar as it denied payment of continued hospitalizations after April 1, 1989. The Referee's assessed attorney fee concerning the employer's denial is modified. In lieu of the assessed fee of $800, claimant is awarded a reasonable attorney fee of $500, payable by the employer. The remainder of the order is affirmed.

In the Matter of the Compensation of
MARTIN COELHO, Claimant
WCB Case No. C1-01388
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION
Gatti, et al., Claimant Attorneys
Gary Wallmark (Saif), Defense Attorney

On July 23, 1991, we disapproved the parties' claim disposition agreement in the above-captioned matter. We took this action in response to a July 16, 1991 letter from claimant, in which claimant had expressed dissatisfaction with the agreement and desired a settlement much larger than the settlement in the present proposed disposition. We interpreted claimant's letter as a request that the disposition be disapproved. Inasmuch as this disapproval request had been made within 30 days of the submission of the disposition to the Board, the request was granted. See OAR 438-09-025(2); ORS 656.236(1)(c).

Subsequently, claimant's counsel has timely requested reconsideration of our July 23, 1991 order. See OAR 438-09-035(1). Specifically, claimant's counsel represents that the July 16, 1991 letter submitted by claimant was not intended to be a request that the disposition be disapproved, but rather was an expression of dissatisfaction with the workers' compensation system. Moreover, on July 29, 1991, we received claimant's July 24, 1991 letter in which it is apparent that he desires approval of the agreement, and that further the terms of the agreement are acceptable. We are forwarding copies of claimant's July 24, 1991 letter to the attorneys of record.

Following our further review of this matter, and particularly in light of the aforementioned letters providing clarification of claimant's intentions in submitting his July 16, 1991 letter, we conclude that claimant did not intend his letter to be a request that we disapprove the disposition. Consequently, because the disposition is in accordance with the terms and conditions prescribed by the Director and we do not find any statutory basis for disapproving the agreement, the claim disposition is approved. See ORS 656.236(1).

Accordingly, our July 23, 1991 order is withdrawn, and replaced by the foregoing order.

IT IS SO ORDERED.

August 6, 1991 Cite as 43 Van Natta 1699 (1991)

In the Matter of the Compensation of
GEORGE J. FISHER, Claimant
WCB Case No. 90-18228
ORDER OF DISMISSAL
Westmoreland & Shebley, Claimant Attorneys
Carol Taaffe (Saif), Defense Attorney

Claimant requested review of Referee McGeorge's order concerning the rate per degree of claimant's scheduled permanent disability award. On July 30, 1991, we approved the parties' Claim Disposition Agreement (CDA), in which claimant agreed to fully release his rights to future workers' compensation benefits (including permanent disability), except medical services, for his compensable injury. WCB Case No. C1-01350.

Pursuant to the CDA, the parties agreed that all pending matters should be dismissed with prejudice. In light of our approval of the CDA, we dismiss the request for Board review with prejudice.

IT IS SO ORDERED.

August 6, 1991 Cite as 43 Van Natta 1699 (1991)

In the Matter of the Compensation of
ROGER H. HANSON, Claimant
WCB Case No. 90-13882
ORDER OF DISMISSAL
Welch, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

The insurer requested review of that portion of Referee Peterson's order that increased claimant's unscheduled permanent disability award for a low back injury from 31 percent (99.2 degrees) unscheduled permanent disability, as

awarded by a Determination Order, to 51 percent (163.2 degrees). On July 11, 1991, we approved the parties' Claim Disposition Agreement (CDA), in which claimant agreed to fully release his rights to future workers' compensation benefits (including permanent disability benefits), except medical services, for his compensable injury. WCB Case No. C1-01219. Inasmuch as permanent disability is the sole issue pending review, we dismiss the request for Board review.

IT IS SO ORDERED.

In the Matter of the Compensation of
RIGOBERTO M. MENDEZ, Claimant
WCB Case No. 90-12344
ORDER ON RECONSIDERATION
Ginsburg, et al., Claimant Attorneys
Dennis Martin (Saif), Defense Attorney

On June 26, 1991, we withdrew our June 18, 1991 Order on Review, which affirmed and adopted the Referee's order that declined to award claimant an attorney fee under ORS 656.386 for his counsel's services in obtaining the rescission of an aggravation denial prior to hearing. We took this action to reconsider our order in light of Senate Bill 540, which amended ORS 656.386 to allow a carrier-paid fee if an attorney is instrumental in obtaining compensation for a claimant prior to hearing. The SAIF Corporation was granted a ten day opportunity to respond to claimant's motion. Inasmuch as the time to respond has expired without a response from SAIF, we have proceeded with our reconsideration.

On June 19, 1991, the Governor signed Senate Bill 540 A-Engrossed, which amends ORS 656.386(1) to provide that "[i]f an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held, a reasonable attorney fee shall be allowed." Section 1. Section 3 further states that the amendments "apply to all claims for which an order relating to the issue on which attorney fees are sought has not become final on or before the effective date of this 1991 Act, regardless of the date of injury." The Act took effect on its passage. Section 4.

Here, since this matter has not become final, the amendments to ORS 656.386(1) are applicable. Therefore, considering claimant's counsel's efforts in submitting hearing requests concerning SAIF's aggravation denial and in light of SAIF's counsel's acknowledgment prior to the hearing that claimant's counsel had "provided significant legal services" for claimant, we conclude that claimant's attorney was instrumental in obtaining compensation for claimant through the rescission of SAIF's aggravation denial prior to the scheduled hearing. Consequently, we hold that claimant is entitled to an insurer-paid attorney fee under revised ORS 656.386(1).

After considering the factors set forth in OAR 438-15-010(4), we conclude that a reasonable attorney fee concerning the rescission of SAIF's denial is $700, 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 issue, and the value of the interest involved.

Accordingly, on reconsideration, we reverse the Referee's December 26, 1990 order. Claimant's attorney is awarded $700, to be paid by SAIF.

IT IS SO ORDERED

In the Matter of the Compensation of
DAISY J. GUYER, Claimant
WCB Case No. 89-20927
ORDER ON RECONSIDERATION
Emmons, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys
Vick & Gutzler, Attorneys

Claimant's former attorney has requested reconsideration of our June 24, 1991 Order on Review. On July 21, 1991, we abated our order to allow claimant, through his current attorney, as well as the self-insured employer, an opportunity to respond. That time having now expired and having received the employer's response, we proceed with our reconsideration.

Specifically, claimant's former attorney has requested reconsideration of those portions of our order involved with the assessment of attorney fees. The motion is directed not to the amount of the fees awarded, but to the identity of the attorney entitled to them. Noting that his firm rendered all services at hearing and filed claimant's respondent's brief on review, claimant's former attorney asks that the fees be awarded to his firm. We agree.

The record reveals that claimant was represented by the firm of claimant's former attorney from the filings of the hearing request until several months after the filing of claimant's brief as respondent on review and that the firm rendered all the services for which the assessed fees were awarded. The insurer does not dispute that fact. There is no evidence that claimant's current attorney rendered any services in this case, with the exception of the filing of an October 1990 Notice of Substitution of Counsel. Under the circumstances, we conclude that claimant's former attorney is entitled to fees awarded at hearing and on review for services rendered up to October 1990.

Accordingly, we modify our June 24, 1991 order as follows. The seventh, eight and ninth sentences in the "Order" section on Page 7 is amended to provide that: The Referee's assessed attorney fee for claimant's <u>former</u> attorney's efforts in overturning the insurer's denials is modified. In lieu of the combined assessed fee of $2,500, claimant's <u>former</u> attorney is awarded a reasonable attorney fee of $1,000, payable by the employer, for partially prevailing on review concerning the medical services issue. For services on review concerning the psychological services denial, claimant's <u>former</u> attorney is awarded $500, payable by the employer.

Our June 24, 1991 Order on Review is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our June 24, 1991 order. The parties' rights of appeal shall run from this date.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHARLES D. SPANO, Claimant
WCB Case Nos. 89-12192, 89-08254, 89-12190 & 89-12191
ORDER ON REVIEW
Gastineau & Smith, Claimant Attorneys
Cummins, et al., Defense Attorneys
David Schieber (Saif), Defense Attorney

Reviewed by Board Members Crider and Neidig.

The SAIF Corporation, on behalf of Northwest Mobile Home Service (Northwest), requests review of those portions of Referee Brown's order that: (1) set aside its denials of compensability and responsibility for claimant's back injury claim; (2) upheld its denial, on behalf of American Mobile Homes (American), of compensability and responsibility for the same claim; and (3) awarded a $4,000 assessed attorney fee. Claimant cross-requests review, contending that the Referee erred in upholding SAIF's denial on behalf of American. On review, the issues are evidence, compensability, responsibility, and attorney fees. We affirm in part, reverse in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's "FINDINGS," with the exception of sections (7) and (8) on pages 2 and 3.

FINDINGS OF ULTIMATE FACT

Claimant sustained an injury during the course and scope of his employment which required medical care and treatment.

American received timely notice of claimant's accident.

CONCLUSIONS OF LAW AND OPINION

Claimant's request for hearing was filed before May 1, 1990 and the hearing was convened before July 1, 1990. Accordingly, the law in effect before July 1, 1990 applies. Or Laws 1990 (Special Session), Ch. 2, 54(2).

Evidence

Northwest objects to the Referee's evidentiary ruling at hearing in which he declined to admit Exhibit 12 as either impeachment or substantive evidence under OEC 804(3)(f). Exhibit 12 is a signed statement dated January 8, 1988 by claimant's onetime girlfriend, witnessed by the noncomplying employer's representative and another employee, alleging that claimant faked his injury. The girlfriend, who was unavailable at hearing, had filed a criminal charge against claimant on December 31, 1987, after claimant had pawned the girlfriend's television set in order to buy another girl a Christmas present. (Ex. 14).

At hearing, American sought to impeach claimant with Exhibit 12, and, after the Referee refused to admit it for purposes of impeachment, offered it as substantive proof. The Referee declined to admit the statement as inherently untrustworthy. (Tr. 197-200). We affirm.

Referees are 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. Former ORS 656.283(7); Armstrong v. SAIF, 67 Or App 498 (1984). Nevertheless, referees have

discretion to exclude evidence which would be inadmissible under the rules of evidence when it is in the interest of substantial justice to do so. Former ORS 656.283(7). It is not error to exclude hearsay documents when the author is not available for cross-examination in the absence of strong indicia of reliability. Compare Lyle A. McManus, 43 Van Natta 863 (1991) with Herbert D. Rustrum, 37 Van Natta 1291 (1985). The girlfriend's statement at issue here carries no strong indicia of reliability. On the contrary, the record establishes that, at the time it was made, claimant and the girlfriend were not on good terms. Under these circumstances, we agree with the Referee's view that admission of her uncross-examined written statement would not serve the interests of substantial justice. Moreover, after reviewing the record, we find that the statement is cumulative impeachment evidence. Consequently, we are persuaded that the Referee did not abuse his discretion in declining to admit the statement.

Compensability

We affirm and adopt the Referee's opinion on this issue.

Responsibility

The Referee concluded that claimant's claim against American was barred by untimely notice under ORS 656.265(4)(c) because claimant did not provide notice to American within one year. Claimant contends that Northwest's knowledge of the claim should be imputed to American, the statutory employer under former ORS 656.029(1). We agree, and reverse the Referee on this issue.

A person who awards a contract involving the performance of labor that is a normal and customary part of the person's trade or business is responsible for providing workers' compensation insurance coverage for all nonexempt individuals who perform labor under the contract, unless the person to whom the contract is awarded provides such coverage before labor under the contract commences. Former ORS 656.029(1). In this case, American, who sold mobile homes, awarded a contract to Northwest to set up and install those mobile homes. Northwest hired claimant to perform this labor. Northwest did not provide workers' compensation coverage before commencement of labor began. (See Ex. 8). Consequently, American is the statutory employer under former ORS 656.029(1). See John C. Elmore, 42 Van Natta 2801 (1990); Barry Dunn, 42 Van Natta 1964 (1990).

Former ORS 656.265 requires the employee to report his accident to the employer. Providing notice of an injury to the employer who directs the worker and pays his wages satisfies the notice requirement. The worker need not report his accident to another employer who, by law, is his employer for workers' compensation purposes. See 3 Larson, Workmen's Compensation Law, 78.10 at 15-101 (esp. fn. 48); see also Kathleen Pearce, 42 Van Natta 1360 (1990) (knowledge by one of two joint employers is imputed to the other). We further note that, by analogy, payment by the actual employer waives the notice requirement for the statutory employer as well. See 3 Larson, 78.43(d) at 15-272.

Claimant's claim was timely reported to Northwest on December 18, 1987, the day of the injury. This oral report was followed by a timely written report from the doctor on December 30, 1987. We accordingly find that American received timely notice of claimant's claim and is therefore responsible for payment of workers' compensation benefits under former ORS 656.029(1).

Attorney Fees

The Referee awarded claimant's counsel an assessed attorney fee of $4,000 for his services at the hearings level, to be paid by Northwest.

Northwest contends that this award was excessive. American supports this contention in its brief on review.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we conclude that $4,000 adequately and reasonably compensates claimant's counsel for his services both at hearing and on Board review. In reaching this conclusion, we have particularly considered the time devoted to the case, as represented by the time spent in hearing, claimant's respondent's brief, the significant complexity of the issues, and the risk in this case that counsel's efforts may go uncompensated. Because compensability was raised by both Northwest and American at hearing and on review, and because responsibility lies ultimately with American, the assessed fee is to be paid by American.

ORDER

The Referee's order dated November 22, 1989 is affirmed in part, reversed in part and modified in part. The denials by the SAIF Corporation, on behalf of Northwest Mobile Home Service, are reinstated and upheld. The denial by SAIF Corporation, on behalf of American Mobile Homes, is set aside SAIF is directed to process the claim in accordance with law. The $4,000 assessed fee awarded by the Referee to be paid by SAIF Corporation on behalf of Northwest Mobile Home Service is modified. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $4,000, to be paid by the SAIF Corporation on behalf of American Mobile Homes. The remainder of the order is affirmed.

In the Matter of the Compensation of
JAIME BARACIO-ROMERO, Claimant
WCB Case No. 90-20174
ORDER DENYING MOTION TO DISMISS
Gatti, et al., Claimant Attorneys
Dennis Martin (Saif), Defense Attorney

Claimant has moved the Board for an order dismissing the SAIF Corporation's request for review and remanding this matter to the Referee for consideration of claimant's motion for reconsideration. The motion is denied.

FINDINGS OF FACT

On July 1, 1991, the Referee issued an Order on Reconsideration, adhering to his January 28, 1991 Opinion and Order and May 14, 1991 Order on Reconsideration. The SAIF Corporation requested Board review of the Referee's orders on July 17, 1991, when it mailed by certified mail its request for review to the Board. OAR 438-05-046(1)(b). Prior to the filing of SAIF's request, the Referee neither issued another reconsideration order nor an abatement order.

CONCLUSIONS OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). Upon the filing of a request for Board review of a Referee's order, jurisdiction over the case vests with the Board. Ramey S. Johnson, 40 Van Natta 370, 371 (1988).

Here, claimant asserts that he sought reconsideration of the Referee's July 1, 1991 Order on Reconsideration prior to SAIF's request for Board review. The record does not contain a copy of such a reconsideration motion. However, even if such a motion had been filed, the fact remains that the Referee neither reconsidered nor abated his July 1, 1991 order prior to the filing of SAIF's request for Board review.

Inasmuch as SAIF's request for review was mailed to the Board by means of certified mail, jurisdiction over this case vested with the Board on the date the request was mailed (July 17, 1991). See ORS 656.295; OAR 438-05-046(1)(b); Ramey S. Johnson, supra. Thus, because SAIF has requested Board review, the Referee lacks authority to further consider this matter.

Relying on James D. Whitney, 37 Van Natta 1463 (1985), claimant asks that SAIF's request be dismissed and this matter remanded to permit the Referee to respond to claimant's motion. We deny claimant's motion.

Whitney stands for the proposition that where simultaneous acts affect the vesting of jurisdiction in this forum, in the interest of administrative economy and substantial justice, we will give effect to the act that results in the resolution of the controversy at the lowest possible level. Here, the Referee took no action, simultaneous or otherwise, following his July 1, 1991 reconsideration order. Consequently, the Whitney policy has no application.

Alternatively, claimant has filed a cross-request for Board review of the Referee's July 1, 1991 order. By this order, we acknowledge that cross-request for review. The transcript has been ordered. Upon its receipt, copies will be provided to the parties' attorneys and a briefing schedule implemented.

August 8, 1991 Cite as 43 Van Natta 1705 (1991)

In the Matter of the Compensation of
RAYMOND E. CLONKEY, Claimant
WCB Case No. C1-01579
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Royce, Swanson & Thomas, Claimant Attorneys
Alan Ludwick (Saif), Defense Attorney

Reviewed by Board Members Neidig and Westerband.

On August 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 438-15-052 provides that, when a claim disposition agreement is approved, the Board may approve an attorney fee in an amount up to 25 percent of the first $12,500 of the agreement proceeds plus 10 percent of the remaining proceeds. Under extraordinary circumstances, an attorney fee exceeding those strictures may be approved. Id.

Here, the agreement provides for consideration of $8,000, out of which the SAIF Corporation shall recover an overpayment of $1,693.37. Thus, after SAIF recovers its overpayment, claimant shall actually receive agreement proceeds totalling $6,306.63. Out of that amount, claimant's attorney shall receive an attorney fee of $2,000. Based on our calculations, the proposed attorney fee exceeds the strictures of OAR 438-15-052 by $423.34. The agreement does not

indicate any extraordinary circumstances which would justify the excessive fee. Because the proposed disposition exceeds the bounds of our rules, we find it is unreasonable as a matter of law. See OAR 438-09-020(2); Dean P. Holdahl, 43 Van Natta 1316 (1991). 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
MICHAEL G. LAND, Claimant
WCB Case No. 90-06798
ORDER OF DISMISSAL
Welch, et al., Claimant Attorneys
David J. Lillig (Saif), Defense Attorney

Claimant has moved the Board for an order dismissing a request for review filed by MPI Entertainment, an alleged noncomplying employer, on the ground that the other parties did not timely receive notice of the request. The motion is granted.

FINDINGS OF FACT

The Referee's order issued March 6, 1991. On April 1, 1990, the Board received MPI's letter objecting to the Referee's March 6, 1991 order. The letter did not indicate that copies had been mailed to the other parties to the proceeding.

On April 9, 1991, the Board mailed a computer-generated letter acknowledging the request for review. Copies of the acknowledgment were mailed to claimant, MPI Entertainment, SAIF and SAIF's legal counsel. Receipt of this acknowledgment represents the remaining parties' first notice of MPI's request for Board review.

CONCLUSION OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

Here, the 30th day after the Referee's March 6, 1991 order was April 5, 1991. Since MPI's request was received by the Board on April 1, 1991, it is timely.

However, the record fails to establish that all parties to the proceeding before the Referee were either provided with a copy, or received actual

knowledge, of MPI's request for review within the statutory 30-day period. Instead, based on claimant's counsel's unrebutted statement and the record as a whole, claimant's first notice of MPI's request occurred upon receipt of the Board's April 9, 1991 acknowledgment letter. Under such circumstances, we conclude that notice of MPI's request was not received by a party to this proceeding within 30 days of the Referee's March 6, 1991 order.

Since claimant did not receive notice of MPI's request for Board review within 30 days of the Referee's March 6, 1991 order, we lack jurisdiction to review the Referee's order. See ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, supra.

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

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
GLEN A. MARSHALL, Claimant
Own Motion No. 91-0372M
OWN MOTION ORDER
Bettis & Ricker, Claimant Attorneys
SAIF Legal Department, Defense Attorney

The SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his December 4, 1984, industrial injury. Claimant's aggravation rights have expired. Claimant seeks the payment of temporary disability benefits. SAIF accepts responsibility for claimant's right knee condition, but opposes the payment of temporary disability benefits, contending that claimant is not in the work force.

We may, on our own motion, authorize the payment of temporary disability benefits when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). However, in order to qualify for the payment of temporary disability benefits, claimant must be in the work force. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Cutright v. Weyerhaeuser Company, 229 Or 290 (1985); Fred Lotfi, 43 Van Natta 430 (1991).

Claimant has been incarcerated in a correctional institution and has not been working. He advises that he returned to work at the institution's vocational rehabilitation center following previous surgery on the right knee, but that he had to discontinue working due to his worsening condition. He contends that he was willing to work but the compensable injury made it impossible for him to obtain and perform work for which he is qualified.

Claimant relies on Dr. Weeks's April 5, 1991, letter. Weeks opines that, on the basis of an operative report dated June 2, 1989, claimant has various

physical restrictions on his ability to perform heavy work. However, there is no evidence that claimant has not been able to obtain or perform work within those limitations or that such modified work is not available at the institution. Absent such evidence, we do not find that the compensable injury made it impossible for claimant to obtain or perform any work for which he is qualified. There is also no evidence that claimant has been making reasonable efforts to find work. Accordingly, we conclude that claimant does not qualify for the payment of temporary disability benefits.

Entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

August 8, 1991 Cite as 43 Van Natta 1708 (1991)

In the Matter of the Compensation of
GREGORY C. PAPASADERO, Claimant
WCB Case No. 90-09318
ORDER DENYING RECONSIDERATION
Welch, et al., Claimant Attorneys
Tim Egerton (Saif), Defense Attorney

On May 21, 1991, we issued our Order on Review affirming and adopting a Referee's order that declined to award an attorney fee for claimant's counsel's services in obtaining rescission of an injury claim denial prior to hearing. Claimant has petitioned the Court of Appeals for review of our order. Relying on the recent legislative amendment to ORS 656.386(1) (Senate Bill 540) and Jones v. Oregon State Correctional Institution, 107 Or App 78 (1991), rev'd on recon 108 Or App 230 (1991), claimant seeks withdrawal of our order for reconsideration.

An appealed order may be withdrawn for purposes of reconsideration. ORS 183.482(6); ORAP 4.35; Glen D. Roles, 43 Van Natta 278 (1991). However, this authority is rarely exercised. Ronald D. Chaffee, 39 Van Natta 1135 (1987).

We decline to exercise the aforementioned authority to reconsider our appealed order. In reaching this conclusion, we are particularly mindful that, in light of the recent statutory revision, there is apparently no legal impediment to the resolution of the dispute short of further litigation.

Accordingly, the motion for reconsideration is denied. The issuance of this order neither "stays" our prior order nor extends the time for seeking review. International Paper Company v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656 (1985).

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT BROWN, Claimant
WCB Case Nos. 90-12237 & 90-07211
ORDER ON REVIEW
Charles Robinowitz, Claimant Attorney
Roderick D. Peters (Saif), Defense Attorney

Reviewed by Board Members Neidig and Crider.

Claimant requests review of those portions of Referee Tenenbaum's order which: (1) declined to award temporary disability compensation between April and November 1988; (2) declined to increase the rate of permanent total disability compensation beyond the $1,455.42 per month paid by the SAIF Corporation; and (3) declined to award temporary disability compensation for the period March 8, 1989 to February 7, 1990. On review, the issues are entitlement to temporary disability compensation and rate of temporary disability.

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

Whereas, after April 1, 1974, cost of living adjustments for temporary total disability benefits are made pursuant to ORS 656.210(1), cost of living adjustments for earlier injuries and for permanent total disability benefits are made through the Retroactive Reserve. See former ORS 656.506(3); OAR 436-75-030, 050.

ORDER

The Referee's order dated December 10, 1990 is affirmed.

In the Matter of the Compensation of
BRENDA M. HINKLE, Claimant
WCB Case No. 89-14395
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Carol Taaffe (Saif), Defense Attorney

Reviewed by Board Members Crider and Neidig.

Claimant requests review of Referee Mills' order that upheld the SAIF Corporation's denials of her aggravation and medical services claims for a current low back condition. On review, the issues are res judicata, aggravation and medical services, if the claims are not barred. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," but not his "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

Res Judicata

The Referee found claimant's current claims to be barred, by operation of res judicata, specifically claim preclusion. In so doing, the Referee relied on Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560 (1989), stating that claimant's current aggravation and medical services claims are barred because she has not proven that her condition changed since it was finally determined to be unrelated to her 1985 compensable injury. We do not agree.

The doctrine of res judicata precludes relitigation of claims and issues previously litigated. North Clackamas School District v. White, 305 Or 48, 50, modified 305 Or 468 (1988). "Claim preclusion" is the name for the preclusive effect of prior litigation on a claim and "issue preclusion" describes the preclusive effect of a prior adjudication on an issue. Id.; Restatement (Second) of Judgments, Introduction at 1-5 (1982).

The rule of claim preclusion is that if a claim is litigated to final judgment, the judgment precludes a subsequent action between the same parties on the same claim or any part thereof. Id. at 17-19, 24; see also Carr v. Allied Plating Co., 81 Or App 306, 309 (1986); Million v. SAIF, 45 Or App 1097, 1102, rev den 289 Or 337 (1980). A claim or cause of action is an aggregate of operative facts which compose a single occasion for judicial relief. Restatement (Second) of Judgments 24(2) (1982); see also Dean v. Exotic Veneers, Inc., 271 Or 188, 192-3 (1975); Carr v. Allied Plating Co., supra at 310.

The rule of issue preclusion is that if an issue is actually litigated and determined by a valid and final judgment and the determination is essential to the judgment, the determination is conclusive in a subsequent action between the parties, whether on the same or a different claim. North Clackamas School District v. White, supra, 305 Or at 53; Restatement (Second) of Judgments 27 (1982).

In Liberty Northwest Ins. Corp. v. Bird, supra, the court held that, to avoid application of res judicata to a claim for medical services, the claimant must prove that his condition changed since an earlier denial of the same medical services became final. On remand, the Board found that claimant's condition had not changed. Consequently, the later medical services claim was barred. Raymond R. Bird, 42 Van Natta 1292 (1990), aff'd mem Bird v. Liberty Northwest Ins. Corp, 106 Or App 364 (1991).

The principles articulated in Bird do not justify a similar result in this case. In Bird, the second claim was for the same medical services as the first. Hence, it was the "same claim," for res judicata purposes, unless the claimant's condition has changed. Here, in contrast, the second claim is for different medical services than the first, including a myelogram, which neither was nor could have been previously claimed. It is not the "same claim." Therefore, the medical services claim is not barred by claim preclusion. See Drews v. EBI Companies, 310 Or 134, 140 (1990).

Inasmuch as claimant's current aggravation claim arises from operative facts which include her asserted need for new medical services, it is not the same aggravation claim which was previously finally determined. Consequently, the aggravation claim also is not barred by claim preclusion.

Moreover, the causation issue was not necessary to the prior adjudication. In this regard, we note that, although the Board's 1990 Order on Review finally decided that claimant's then current condition was not related to her 1985 injury, that finding was merely an alternative basis for upholding the denial of claimant's then current claims. See Brenda M. Hinkle, 42 Van Natta 993, 995 (1990). As such, the Board's finding was not necessary to its conclusion. Therefore, the pivotal issue in both present claims -- whether claimant's current condition is compensably related to her accepted 1985 injury -- was not necessarily decided by the prior proceedings. Therefore, the issue before us is not precluded by issue preclusion. See Drews, supra at 139. See also Restatement of the Law of Judgments 2d 27i (1982).

Inasmuch as claimant's current claims are not barred by operation of res judicata, we proceed to the merits.

Medical services

Claimant is entitled to medical services for conditions resulting from her compensable injury. ORS 656.245(1). Claimant bears the burden of proving the necessary causal relationship between her current problems and her compensable injury. See Harris v. Albertson's Inc., 65 Or App 254, 256-57 (1983).

In view of the passage of time since the 1985 injury and the consequent number of potential causes for claimant's current problems, we find that causation is a complex medical question in this case. The answer to the causation question depends largely on expert medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Claimant relies on the opinions of Dr. Mulnick, treating chiropractor, and Dr. Brett, neurologist. Although Mulnick and Brett stated that claimant's current complaints are related to her compensable injury of 1985, neither conclusion is supported by persuasive reasoning. Mulnick apparently reasoned that, because claimant's complaints have continued since her injury, and he is aware of no other potential causes, her current condition and need for treatment is causally related to the 1985 injury. (See Exs. 36-3, 42). Brett's opinion is conclusory, except that he agreed with Mulnick's "findings and recommendations." (Ex. 39). We find the conclusory opinions of Drs. Mulnick and Brett lacking in persuasive force.

Western Medical Consultants examined claimant and reviewed her history on September 22, 1989. They noted a continued absence of objective findings indicating low back impairment, as well as refusals and inconsistencies during their examination. (Ex. 38).

Based on our de novo review of the record, particularly the aforementioned medical reports, we conclude that claimant has not carried her burden of establishing that her current condition, for which she claims medical services, is causally related to her compensable injury of 1985.

Aggravation

ORS 656.273 provides, in relevant part: "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury." In a claim for a worsened condition, as in a claim for medical services, claimant must establish that the condition for which she seeks compensation is causally related to her compensable condition. Perry v. SAIF, 307 Or 654 (1989).

In this case, we have concluded that claimant failed to establish that her current condition is related to her 1985 injury. Therefore, she has not carried her burden regarding the aggravation claim.

ORDER

The Referee's order dated October 29, 1990 is affirmed.

In the Matter of the Compensation of
DONNA M. MUNOZ, Claimant
WCB Case No. 88-03474
ORDER OF DISMISSAL
Quintin B. Estell, Claimant Attorney
Acker, et al., Defense Attorneys

Claimant has requested review of Referee Baker's dismissal order dated May 21, 1991. The insurer has moved for dismissal of the request, contending that claimant did not timely request review of the Referee's order. The motion is granted.

FINDINGS OF FACT

The Referee's dismissal order issued May 21, 1991. On June 3, 1991, claimant requested a hearing, contesting a "May 21, 1991 denial." That request was acknowledged and given a new WCB case number.

On July 10, 1991, the Board received a July 9, 1991 letter from claimant's counsel. Stating that the June 3, 1991 request for hearing was in error and was intended to be a request for Board review of the Referee's May 21, 1991 Order of Dismissal, counsel asked that the recent hearing request be processed as a request for review.

On July 16, 1991, the Board mailed a computer-generated letter to the parties acknowledging a 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 656.298(3). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

The request for review by the Board of a Referee's order need only state that the party requests a review of the order. ORS 656.295(1). While no "magic words" are required for compliance, the statute contemplates a modicum of information sufficient to properly identify a document as a party's request for Board review of a Referee's order. Gerardo V. Soto, Jr., 35 Van Natta 1801, 1803 (1983). Where a party has not expressly requested Board review, but their intention to do so is both clear and unmistakable, we have concluded that we have jurisdiction pursuant to ORS 656.295. See Rochelle M. Gordon, 40 Van Natta 1808 (1988).

Here, claimant concedes that, through error, her counsel submitted a hearing request concerning a May 21, 1991 denial rather than a request for review of the Referee's May 21, 1991 order. However, contending that her hearing request was intended as a request for review from the Referee's denial of her right to a hearing, claimant asserts that the June 3, 1991 hearing request actually constitutes a request for Board review of the Referee's order.

We disagree with claimant's interpretation of the June 3, 1991 submission. The submission, which was presented on a Board "Request for Hearing" form, was expressly entitled a request for hearing and was specifically directed to the Hearings Division.

Under such circumstances, we conclude that the intention expressed in claimant's June 3, 1991 request is both clear and unmistakable, i.e., she was

requesting a hearing before the Hearings Division. Consequently, we hold that claimant's June 3, 1991 request does not constitute a request for Board review.

Claimant's July 9, 1991 letter, which accompanied a copy of the June 3, 1991 request, does express an intention to request review of the Referee's May 21, 1991 order. Thus, that letter, which was received by the Board July 10, 1991, does constitute a request for Board review. However, July 10, 1991 is more than 30 days after the Referee's May 21, 1991 order. Consequently, the request for review is untimely. ORS 656.289(3); 656.295(2).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

August 9, 1991 Cite as 43 Van Natta 1713 (1991)

In the Matter of the Compensation of
CIRIACO SOSA, Claimant
WCB Case No. 89-18144
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Westerband and Neidig.

Claimant requests review of Referee Daron's order that upheld the SAIF Corporation's denial of his occupational disease claim for a keratoma condition. In its brief, SAIF contends that the Referee erred by not dismissing claimant's request for hearing and by admitting claimant's out-of-court statements into the record. On review, the issues are dismissal, evidence and compensability. We affirm.

FINDINGS OF FACT

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

Neither claimant nor his attorney appeared at the December 11, 1989 hearing. The Referee found that claimant had abandoned his request for hearing and he entered an order of dismissal. On January 5, 1990, claimant requested reconsideration of the Referee's order of dismissal. The Referee abated his order and rescheduled a hearing on the issue of whether claimant had shown "good cause" sufficient to grant a postponement.

A second hearing was convened May 30, 1990. Claimant did not appear but his counsel was present. Claimant's counsel explained that both he and his client were not present at the first hearing because they had mistakenly assumed that the hearing was scheduled for later in December. At the hearing, the Referee and both parties agreed that claimant was entitled to a hearing on the compensability of his keratoma condition. The hearing was postponed until an undetermined date.

A third hearing was convened September 25, 1990. Claimant did not appear at the hearing. Claimant's counsel was present at the hearing and, in opening remarks, he moved for a postponement. Claimant's counsel stated that claimant had left the country and his wife was unable to contact him. The Referee denied claimant's motion for postponement.

At hearing, claimant's attorney offered and SAIF objected to the admission of exhibits 1, 3, 4, and 5, and alleged that the documents were based upon claimant's history. The Referee overruled SAIF's objection and admitted the documents into evidence.

CONCLUSIONS OF LAW AND OPINION

Dismissal

SAIF argues that, following claimant's failure to appear at the first hearing, the Referee properly dismissed the request for hearing on the grounds of abandonment. SAIF disagrees with the Referee's reconsideration and abatement which allowed a second hearing for "good cause" arguments.

SAIF contends that, by not attending the hearing, claimant caused an unjustified delay of more than 60 days and the Referee should have dismissed the case as abandoned. Former OAR 438-06-071(1). SAIF also contends that claimant's unjustified failure to attend constituted a waiver of appearance and the Referee was required to dismiss the request for hearing unless extraordinary circumstances existed. Former OAR 438-06-071(2). SAIF argues that no extraordinary circumstances have been shown in this case.

We agree with SAIF's argument that dismissal of claimant's request for hearing was proper following the first hearing, as neither claimant nor his attorney were present at hearing. See former OAR 438-06-071; Vincent G. Jacoban, 42 Van Natta 2866 (1990). However, at the second hearing, which was held to determine whether extraordinary circumstances prevented claimant's appearance at the first hearing, counsel for SAIF agreed that, "under the case law, this is the proper way to proceed and the claimant is entitled to some type of a hearing." (Tr. 5) Subsequently, the Referee and both parties agreed that claimant was entitled to a hearing on the merits of his case. We conclude that, under the circumstances, SAIF waived its right to move for dismissal of claimant's request for hearing. The Referee acted within his discretion when he set aside his dismissal order and postponed the second hearing.

Finally, we agree that the Referee appropriately declined to dismiss claimant's request for hearing at the third hearing. In Williams v. SAIF, 99 Or App 367 (1989), reversed and remanded 310 Or 320 (1990), the Court of Appeals, in dicta, stated that former OAR 438-06-071 did not require the claimant to personally attend the hearing. The court reasoned that, when claimant's attorney did attend the hearing and was prepared to proceed without the benefit of claimant's testimony, it would be error to dismiss the request for hearing on the ground that claimant did not personally attend the hearing. Williams v. SAIF, supra. We have specifically adopted the Court of Appeals' interpretation of the rule. Jose Arisqueta-Martinez, 42 Van Natta 2072 (1990).

Here, because claimant's attorney appeared at the third hearing and was prepared to proceed, the Referee acted appropriately by not dismissing the request for hearing and proceeding to the merits. See Audrey Rudd, 42 Van Natta 2322 (1990).

Evidence

SAIF contends that the Referee should not have allowed Exhibits 1, 3, 4 and 5 into the record, as the documents contained claimant's statements and he was not present at hearing to be cross-examined.

We review the Referee's evidentiary rulings for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991). Under the circumstances, we conclude that the Referee did not abuse his discretion by admitting the exhibits into evidence. See Froylan L. Zurita, 43 Van Natta 1382 (1991) (To the extent that such statements are reasonably pertinent to diagnosis or treatment, statements made by claimant to his physician for purposes of medical diagnosis or treatment are admissible even though they are hearsay and claimant is not available at hearing for cross examination.)

Compensability

The Referee concluded that claimant failed to establish the relationship between his work activities and his keratoma condition. We agree.

We have concluded that the Referee did not abuse his discretion by admitting Exhibits 1, 3, 4 and 5 into evidence. We now turn to the question of whether the statements within the exhibits are reasonably pertinent to diagnosis or treatment. In Zurita, supra, we held that, while there may be a strong indicia of accuracy in hearsay reports of how injuries occurred, there is no such indicia of accuracy in hearsay reports of where injuries occurred. Additionally, we concluded that statements that an injury happened at work are not reasonably pertinent to the doctor's diagnosis and treatment and are not prima facie evidence of the fact asserted. Zurita, supra; ORS 656.310(2).

Here, on July 20, 1989, claimant filed a Form 801, alleging that he had a gradual onset of pain in his feet, caused by wet and cold conditions outdoors. In August 1989, Dr. Mesdag, D.P.M., reported that claimant was first seen at his office in May of 1989. Dr. Mesdag stated that, at that time, claimant had a complaint of a painful corn between the fourth and fifth toes of his left foot. Claimant reported that the problem had existed for many months and he had received no prior treatment.

Dr. Mesdag noted that physical examination revealed a "deeply seeded keratoma." He suspected that the keratoma resulted from rubbing of the two opposing joints of the toes and he felt that claimant's wearing slip-on shoes without socks was a material contributing factor to his condition. He concluded that "work at the farm wearing rubber boots may have been a contributing factor only in the fact that the boots were basically of rubber and non-supporting allowing constant moisture build-up inside."

In December 1989, in response to a letter from claimant's counsel, Dr. Mesdag agreed that, in terms of reasonable medical probability, claimant's corn was a condition which preexisted his employment, however, his work exposure to wet conditions, wearing rubber boots and having to stand for long periods throughout the work shift had combined to result in a worsening of his condition.

We conclude that claimant's statement that he had a gradual onset of pain in his feet, caused by wet and cold conditions, is a statement reasonably pertinent to diagnosis and treatment. Claimant's statements regarding the fact that he wore shoes without socks and rubber boots for long periods of time are also reasonably pertinent to diagnosis and constitute prima facie evidence. However, any statements made by claimant that his condition was caused by wearing boots at work or standing for long periods of time during his work shift, are statements not reasonably pertinent to diagnosis and treatment. We conclude that such statements are not prima facie evidence of the fact asserted and we accord them little weight.

Under the circumstances, we conclude that claimant has failed to establish by a preponderance of the evidence that his condition arose in the course and scope of his employment. Therefore, we affirm the Referee's order.

ORDER

The Referee's order dated October 23, 1990 is affirmed.

In the Matter of the Compensation of
FARRELL C. FINLEY, Claimant
WCB Case No. C1-01598
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Emmons, Kropp, et al., Claimant Attorneys
Nelson, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

On August 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.

OAR 438-15-052 provides that, when a claim disposition agreement is approved, we may approve an attorney fee in an amount up to 25 percent of the first $12,500 of the agreement proceeds plus 10 percent of the remaining proceeds. Under extraordinary circumstances, we may approve an attorney fee exceeding those strictures.

Based on our calculations, the proposed attorney fee of $5,000 exceeds the strictures of OAR 438-15-052 by $1,125. The agreement does not indicate any extraordinary circumstances which would justify the excessive fee. Because the proposed disposition exceeds the bounds of our rules, we find it is unreasonable as a matter of law. See OAR 438-09-020(2); Dean P. Holdahl, 43 Van Natta 1316 (1991).

Furthermore, the agreement indicates that the claim number for the September 19, 1988, injury is 604-204066; however, files of the Department of Insurance and Finance show the correct claim number is 604-024066. Additionally, although the agreement refers to claim number C604-261892, it does not show that the industrial injury giving rise to that claim occurred on January 2, 1990.

Finally, because the agreement involves more than one claim, the agreement must contain all of the information prescribed in OAR 436-60-145(3) and (4) for each claim. See OAR 436-60-145(1). Therefore, the agreement should provide a separate summary sheet for each claim, along with separate amounts of consideration and attorney fees. Because we find the agreement is unreasonable as a matter of law, we decline to approve the agreement and return it to the parties. ORS 656.236(1)(a).

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
WALTER JONES, Claimant
Own Motion No. 66-0010M
OWN MOTION ORDER
SAIF Legal Department, Defense Attorney

The SAIF Corporation has submitted to the Board claimant's claim for temporary disability and medical benefits relating to his October 6, 1962, industrial injury. SAIF recommends reopening of claimant's claim to provide medical benefits, but opposes the payment of temporary disability benefits on the ground that claimant's condition does not require surgery or hospitalization.

By order dated August 9, 1990, we postponed action on the own motion request pending the outcome of litigation regarding claimant's entitlement to permanent total disability benefits (WCB Case No. 90-07999). In WCB Case No. 90-07999, by Order on Review dated May 8, 1991, the Board affirmed a Referee's order which affirmed a Determination Order that terminated claimant permanent total disability benefits. Claimant has requested judicial review of that order. Nevertheless, the Board concludes that it would be in the best interest of the parties to proceed with our own motion review.

We may authorize, on our own motion, the payment of temporary disability benefits when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). Here, claimant does not require surgery or hospitalization. Therefore, temporary disability benefits will not be authorized. See id.

On the other hand, 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). SAIF recommends payment of various medical expenses, including the expenses of independent medical examinations (IME) by Orthopaedic Consultants on November 9, 1989, and Dr. Holland in May, 1990, as well as the attendant travel expenses. The record does not indicate the purposes of those IMEs. However, inasmuch as the IMEs were conducted before a July 24, 1990, hearing regarding claimant's entitlement to permanent total disability (PTD) benefits, we find that the expenses may have been incurred as a cost of litigating the PTD issue, not for the treatment of the compensable injury. Consequently, we decline to authorize payment for the following expenses: (1) the IME by Orthopaedic Consultants on November 9, 1989; (2) the worker's travel expenses to Orthopaedic Consultants; and (3) the IME by Dr. Holland and attendant expenses.

We find that the remaining medical services are reasonable and necessary for the compensable injury and required to maintain claimant's medically stationary status. Accordingly, claimant's claim is reopened to provide medical services and supplies in an amount not to exceed $4,289.35. See OAR 438-12-037(1)(c). 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.

Finally, should our May 8, 1991, Order on Review in WCB Case No. 90-07999 be reversed on judicial review, claimant would be entitled to medical benefits in accordance with ORS 656.245. See OAR 438-12-037(2). In that event, we shall withdraw this own motion order insofar as it addresses claimant's request for medical benefits, and SAIF shall be obligated to reimburse the Reopened Claims Reserve for any medical benefits awarded under this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
BARRIE W. MUNGER, Applicant
WCB Case No. CV-91007
CRIME VICTIM ORDER
Thomas E. Ewing, Assistant Attorney General

Reviewed by Board Members Neidig and Westerband.

Barrie W. Munger (hereafter referred to as "applicant"), has requested Board review of the Department of Justice's February 20, 1991 Order on Reconsideration. By its order, the Department denied applicant's claim for compensation as a victim of a crime under ORS 147.005 to 147.375. The Department based its denial on insufficient evidence to establish that applicant's injuries were the result of a compensable crime as required by ORS 147.015(1).

Following our receipt of the request for Board review, applicant was advised that he was entitled to present his case to a hearing officer. To exercise his right to a hearing, applicant was instructed to notify the Board within 15 days from the date the Department mailed him a copy of its record. The Department mailed a copy of its record to applicant on April 30, 1991. Applicant has requested that this case be considered based on the record and his written argument. See OAR 438-82-030(2).

We have conducted our review in accordance with applicant's wishes. The standard for our review under the Act is de novo, based on the entire record. ORS 147.155(5); Jill M. Gabriel, 35 Van Natta 1224, 1226 (1983). Based on our de novo review of the record, we make the following findings and conclusions.

FINDINGS OF FACT

On May 21, 1990, the Department received applicant's May 14, 1990 claim for compensation as a victim of a crime. According to the application, the crime occurred on February 12, 1990, when applicant was assaulted while walking along a street. Applicant was initially hospitalized for three days. He primarily sustained injuries to his right eye: a "ruptured globe with uveal prolapse;" and "superficial eyelid lacerations." Dr. Cherne, applicant's ophthalmic surgeon, opined that the injury was apparently due to a "sharp object though a rupture-like extension off the laceration was also present." Several surgeries have been required to repair the damage.

In response to applicant's claim for benefits, the Department conducted an investigation. Police reports of the incident were requested.

On June 4, 1990, the Department received the police reports. Officer Burks, an investigating officer, stated that applicant was "very intoxicated and was unable to explain how he got injured." Burks interviewed Mr. Machen, an individual who resided near where applicant had been found. Machen reported that applicant had been walking around trying to find someone who would let him out of the cold and snow. When Machen later left his residence, he found applicant laying on the ground and bleeding from the face. Machen did not see anyone around applicant. Thereafter, Machen returned to his residence to call for assistance.

Officer Burks also contacted Mr. Martin, another individual who resided in the area. Martin had allowed applicant to enter Martin's residence to get warm. At that time, applicant was not injured. Applicant left after approximately 10 minutes. Several minutes later, Martin saw applicant laying on the ground with no one around him.

When Officer Burks investigated the scene, he located applicant's eye glasses on the sidewalk. Burks also observed blood and marks in the snow where

applicant had been laying. No footprints or signs of a struggle were located. Following his investigation, Burks concluded that "[i]t was possible [applicant] fell down outside the residences, causing his injuries."

Officer Flora accompanied applicant to the hospital. Flora reported that applicant was conscious, but initially incoherent. Flora also detected an odor of alcoholic beverage on applicant, who eventually stated that a "white male" had struck him with a "left fist." Applicant was unable to further describe the alleged assailant. Furthermore, he was unsure where he was at the time of the incident or his reason for being there. Flora concluded that "[n]othing was discovered in our investigation to substantiate an assault had occurred."

In describing applicant's condition when he arrived at the hospital, Dr. Morgan, emergency room physician, noted the "heavy odor of alcohol on [applicant's] breath and his speech is somewhat slurred." Stating that applicant was initially "somewhat confused," Morgan also reported that applicant provided no information concerning the "altercation" that had resulted in his injury. Applicant's blood alcohol was measured at .30. In addition to examining applicant's right eye and eyelid injuries, Morgan repaired a small laceration of applicant's right upper lip, as well as a laceration in the posterior parietal scalp which appeared to be due to a contusion.

Ms. Nelson, a representative of the Lane County District Attorney's Crime Victim Assistance Program, responded to the Department's request for information. Nelson reported that no suspect had been identified.

On January 16, 1991, the Department issued its Findings of Fact, Conclusions and Order. Relying upon the police reports, the Department found that neither the witnesses nor the area where applicant had been found supported applicant's claim that he had been struck by a white male. Concluding that there was insufficient evidence to establish that applicant had been injured as a result of a compensable crime under ORS 147.005(4), the Department denied his application for benefits pursuant to ORS 147.015(1).

On February 13, 1991, the Department received applicant's request for reconsideration of its denial. Contending that he had struck from behind and had not reported to any police officer that he had been assaulted by a white male, applicant argued that the police report was erroneous. On that basis, as well as in light of the extensive medical bills and lost earnings resulting from the assault, applicant sought reconsideration of the prior order and acceptance of his claim.

Following further consideration, on February 20, 1991, the Department found no basis for altering its prior order. Consequently, the Department adhered to its January 16, 1991 decision. Thereafter, applicant requested Board review.

CONCLUSIONS OF LAW AND OPINION

An applicant is entitled to an award under the Act if, among other requirements, he is a victim of a compensable crime that resulted in a compensable loss of more than $100. ORS 147.015(1). "Compensable crime" means an intentional, knowing or reckless act that results in serious bodily injury or death of another person and which, if committed by a person of full legal capacity, would be punishable as a crime in this state. ORS 147.005(4).

Applicant disagrees with the Department's findings, which are based on the police reports. Specifically, he contends that he was struck from behind on the back of the head. Furthermore, because he was rendered unconscious, he denies that he told any police officer that he was assaulted by a white male.

Considering the numerous reports documenting the heavy odor of alcohol on applicant's breath and in light of the highly elevated level of his blood alcohol content at the emergency room shortly after the incident, we are not inclined to rely upon applicant's recollections of the events surrounding his injury. In any event, even if the references in the police reports concerning applicant's initial statements are totally disregarded, we remain unpersuaded that applicant was the victim of an intentional, knowing or reckless act. Consequently, applicant is not entitled to benefits under the Act. ORS 147.005(4); 147.015(1).

Our conclusion is based on the following reasoning. Notwithstanding applicant's reported statements that he did not know what happened or that he was struck by the left fist of a white male, neither the witnesses who saw applicant shortly before and after his injury nor the area surrounding where he was found on the snow supported applicant's claim that he was assaulted by another individual. Not only is there no indication that the witnesses either heard or saw anyone in the vicinity, but the area where applicant was found neither contained marks nor footprints suggesting that an assault had occurred. Notwithstanding applicant's account that he was struck from behind and the fact that he suffered a laceration to the back of his head, the witnesses' and investigating officers' observations do not lead us to a conclusion that applicant's injuries were caused by an intentional, knowing or reckless act. Since such a finding is statutorily required to entitle applicant to an award of compensation, we conclude that the claim for benefits must be denied.

In conclusion, we recognize the physical, emotional, and financial trauma that this incident has caused applicant. Yet, to recover benefits as a victim of a crime under the Act, the Legislature has mandated that several specific prerequisites must be satisfied. One of those requirements is that applicant must establish that he is the victim of an intentional, knowing, or reckless act. For the reasons detailed above, the record does not support such a conclusion. Inasmuch as applicant's claim does not satisfy all of the statutory requirements for receiving benefits under the Act, his claim for benefits must be denied.

ORDER

The January 16, 1991 Findings of Fact, Conclusions and Order of the Department of Justice, as reconsidered February 20, 1991, is affirmed.

In the Matter of the Compensation of
RONALD E. OCHSNER, Claimant
Own Motion No. 88-0224M
OWN MOTION ORDER REFERRING FOR FACTFINDING HEARING
Merrill Schneider, Claimant Attorney
Schwabe, et al., Defense Attorneys

By Own Motion Order dated July 1, 1988, we reopened claimant's claim for the payment of temporary disability benefits. The claim remains in open status. The self-insured employer requests that we suspend claimant's entitlement to those benefits and refer for an evidentiary hearing the issue of whether claimant is entitled to further temporary disability benefits.

For all claims which were in open status on December 31, 1990, temporary total disability benefits must be paid until termination of such benefits is authorized by ORS 656.268. See OAR 438-12-018, 438-12-035(2). ORS 656.268(3) provides for termination of temporary total disability benefits when one of the

following events first occurs: (1) the worker returns to regular or modified employment; (2) the attending physician gives the worker a written release to return to regular work; or (3) the attending physician gives the worker a written release to return to modified work, such work is offered in writing to the worker and the worker fails to begin the work. Following the termination of temporary total disability benefits, claimant is still entitled to the payment of temporary partial disability benefits insofar as he remains temporarily and partially disabled. See OAR 438-12-035(3).

The employer alleges that claimant has been working for his wife's business since June, 1989, and earning sufficient wages to relieve the employer of its obligation to pay temporary disability benefits. However, there is no persuasive evidence in the record to support those allegations. Absent such evidence, we decline to authorize the suspension of temporary disability benefits.

On the other hand, this is an appropriate matter for referral to the Hearings Division for an evidentiary hearing. Accordingly, we refer this matter for an evidentiary hearing. The Referee shall take evidence and make findings of fact regarding whether claimant has returned to work and, if so, what wages he has earned during his employment. The Referee shall then make a recommendation regarding whether claimant is entitled to the further payment of temporary disability benefits and, if so, to what extent those benefits should be paid. The Referee shall forward the recommendation to us. Thereafter, we shall issue an order in this own motion matter.

IT IS SO ORDERED.

August 14, 1991 Cite as 43 Van Natta 1721 (1991)

In the Matter of the Compensation of
LINDA J. HUGHES SMITH, Claimant
WCB Case Nos. 89-26261 & 88-11457
ORDER ON RECONSIDERATION
Olson, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Claimant requests reconsideration of our June 28, 1991 order that reversed a Referee's order which increased claimant's unscheduled permanent disability award for a low back injury from 23 percent (73.6 degrees), as awarded by a Determination Order, to 60 percent (192 degrees). On July 24, 1991, we abated our order to allow adequate time to consider the motion and to grant the SAIF Corporation an opportunity to respond. Having received SAIF's response, we now proceed with our reconsideration.

Claimant contends that the appropriate legal standard was incompletely stated in our order and thus, the Board misapplied the law to the facts of this case. Specifically, claimant argues that the Order on Review fails to follow Clemons v. Roseburg Lumber Co., 34 Or App 135 (1978), which states that determining the reasonableness of refusal to submit to treatment must take into account the worker's perspective. Id. at 139. (Emphasis added). The court in Clemons further stated that "there may be a significant difference between the detached analysis of an experienced surgeon and the appraisal of a worker who must actually undergo the treatment with its attendant risks." Id. at 139-40. In Clemons, the treatment that the claimant refused was major surgery; a right transaxillary rib resection.

In our prior order, relying on Nelson v. EBI Companies, 296 Or 246 (1984) (citing Clemons v. Roseburg Lumber Co., supra), we concluded that claimant did not make reasonable attempts to mitigate her damages by submitting to proffered medical and vocational services offered by SAIF. (See e.g. Exs. 33-5, 34, 41,

42, 45, 53-1, 69). Claimant now argues that she did not unreasonably fail to accept the services because her treating physician, Dr. May, did not refer her to those services. However, it is apparent from the record that Dr. May did not refer claimant because she was not motivated to participate nor to improve her condition.

As early as July 1986, claimant's initial treating physician recommended that claimant attend a pain center. (Ex. 12). She was evaluated at Northwest Pain Center that same month. Initially, she was encouraged by the possibility of improvement by attending the pain center, but then broke down and cried and said that she just wants to be "basically left alone." The evaluators were concerned by the substantial amount of pain medication claimant was taking, while at the same time saying she did not need to participate in a pain treatment program. (Ex. 13-2). The psychological evaluation at the Pain Center revealed that claimant had reduced incentive for reduction in pain behavior due to secondary gains in the areas of relief from work pressures, relief from household duties and financial compensation. (Ex. 14-6).

In February 1988, claimant was evaluated at Salem Hospital Industrial Medicine Program. Dr. Chester, M.D., noted that claimant was angry and frustrated and did not want to become involved with the work hardening process, because she sees it as a "ploy of the insurance company and of no value to her". (Ex. 33-5). The psychological screening at Salem Hospital revealed that claimant had many underlying psychological problems, and claimant reported to Dr. Pitchford, Ph.D., that she did not want to learn any strategies that might make it easier for claimant to tolerate pain. (Ex. 34-3).

In August 1988, SAIF offered to provide psychological or psychiatric treatment for claimant if Dr. May felt that it would make her employable again. (Ex. 41). Dr. May indicated that he spoke with claimant about the offer and that she was agreeable to enter into psychological consultation. (Ex. 42). Claimant confirmed that she did discuss this option with Dr. May. (Tr. 44). On November 17, 1988, Dr. May indicated that claimant would not be referred for such counseling unless she explicitly requests it herself. (Ex. 45).

In December 1988, claimant was evaluated at Oregon Pain Center. Dr. Kuller, M.D., felt that pain center treatment could afford her an opportunity of getting to a much more functional and productive level. During a psychological evaluation at the Pain Center, it was noted that claimant was initially adamant that she would not enter pain center treatment. By the end of the evaluation she had reversed her attitude, admitting that she needed help and asking that someone speak to her doctor and husband, who she claimed were resistive to this type of treatment. (Ex. 48-5).

During an office visit with claimant on January 9, 1989, Dr. May noted that he had received the Oregon Pain Center report and stated that claimant is "currently deciding whether she wants to embark upon treatment" at the Center. (Ex. 65-2). On January 20, 1989, Dr. May advised that he had decided not to refer claimant to a pain clinic. (Ex. 51A). He later noted that "[i]t has never been a question as to whether she could be able to participate in a pain center. Rather, it has been a question that she has chosen not to participate in a pain center, and I have taken the position that it would be inappropriate for me to refer her to a pain center and pressure her to attend a pain center when her motivation for such a referral is poor." (Ex. 71).

Dr. Holmes noted that the Oregon Pain Center had often treated patients who are quite discouraged, skeptical, hostile and demoralized, such as claimant. However, he noted that those patients generally attend the Center under firm recommendation from their physicians. (Ex. 53-3). It is clear that Dr. May

acceded to claimant's wishes that she not attend the program and declined to encourage her to attend Oregon Pain Center. (Ex. 54).

We agree with claimant's argument that, pursuant to Clemons, reasonableness of refusal of treatment must take into account claimant's perspective. Relevant factors listed in Clemons, supra at 139, which should be considered when assessing reasonableness from claimant's perspective, include the worker's present physical and psychological condition, the degree of pain accompanying and following treatment, the risks posed by the treatment and the likelihood that it would significantly reduce the worker's disability. In Clemons those factors were applied in light of a recommended major surgery which was relatively painful, required general anesthesia (with its accompanying risks), and the success of which was questionable. Id. at 140. Here, the pain and risks of the recommended treatment are greatly reduced from those in Clemons. In addition, the likelihood of significant reduction in claimant's disability is good but for claimant's lack of motivation.

It is apparent, from the abovementioned evidence in this record, that claimant is not motivated to improve her situation. We agree that it is unlikely that a person in claimant's situation from a non-compensable injury would not avail herself of treatment programs such as those offered to claimant to improve her tolerance to pain, improve her physical capacities and improve her vocational options.

Moreover, we adhere to our prior conclusions that claimant has not made reasonable attempts to mitigate her damages and that any unscheduled permanent disability which she suffers in excess of that determined by the "standards" should not be compensated. See Nelson and Clemons, supra.

Accordingly, our June 28, 1991 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our June 28, 1991 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

August 14, 1991 Cite as 43 Van Natta 1723 (1991)

In the Matter of the Compensation of
WONDER WINDOM-HALL, Claimant
WCB Case No. 90-06799
ORDER ON REVIEW (REMANDING)
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

Claimant, pro se, requests review of Referee Daron's order that dismissed her request for hearing for failure to appear. On review, the issue is whether the Referee should have dismissed the request for hearing. We remand.

FINDINGS OF FACT

On March 28, 1990, through counsel, claimant requested a hearing raising compensability and medical services as issues. The matter was initially set for hearing on August 27, 1990. That hearing date was subsequently advanced to June 25, 1990 by Notice of Accelerated Hearing. On that date, claimant appeared through her counsel. The hearing was convened and continued to a later date. The Board subsequently issued a Notice of Hearing which scheduled the continued hearing for August 27, 1990.

By letter dated July 3, 1990, claimant's then-counsel notified the Board that claimant had decided to employ substitute counsel. The hearing set to reconvene on August 27, 1990 was subsequently postponed.

Claimant filed a new Request for Hearing, through substitute counsel, on November 30, 1990. By Notice dated December 7, 1990, the hearing was set for February 8, 1991.

On December 21, 1990, claimant's substitute counsel notified the Board that claimant no longer wished to have him represent her in the matter. Claimant confirmed with the Board by letter dated December 24, 1991 that she had dismissed her substitute counsel. Claimant requested a postponement of the February 8, 1991 hearing in order "to prepare and review this case with new counsel." The employer objected to the postponement request.

By letter dated January 3, 1991, Assistant Presiding Referee Lipton acknowledged claimant's postponement request. As there remained one month before claimant's scheduled hearing date, Referee Lipton suggested that claimant attempt to retain new counsel. In the event claimant's new counsel required additional preparation time, claimant was advised that a postponement would be considered.

Pursuant to military orders dated February 7, 1991, the day before the scheduled hearing, claimant's husband was notified that, as a result of Operation Desert Storm, he was being called to involuntary active military duty as of February 8. Pursuant to the same orders, Dr. Edward Conrad, Jr., was also called to active duty as of the same date. Dr. Conrad had previously reviewed claimant's medical records. Dr. Conrad authored a report on February 6, 1991 discussing the possible causal relationship between claimant's work and her medical condition. By cover letter dated February 8, 1991, Dr. Conrad forwarded this report to Referee Lipton. The report was received by the Hearings Division on February 21, 1991.

A hearing was convened in this matter on February 8, 1991. Claimant neither appeared personally nor through counsel. The employer's counsel moved that claimant's hearing request be dismissed for failure to appear. Referee Daron orally granted the motion. By order dated February 13, 1991, Referee Daron dismissed claimant's request for hearing.

By letter dated February 12, 1991, claimant requested that the "February 8, 1991" dismissal order be "overruled." The letter recited that, prior to dismissal, Referee Lipton had been informed of "[claimant's] physical condition and the status of [claimant's husband's] military activation." The letter was treated as a request for reconsideration. By reconsideration order dated March 14, 1991, Referee Daron denied claimant's request, reasoning that claimant had failed to establish "good cause" for her failure to appear. Claimant filed a request for Board review on April 1, 1991.

CONCLUSIONS OF LAW AND OPINION

The Referee dismissed claimant's hearing request pursuant to OAR 438-06-071. That rule provides:

> "(1) A request for hearing may be dismissed if a referee finds that the party that requested the hearing has abandoned the request for hearing or has engaged in conduct that has resulted in an unjustified delay in the hearing of more than 60 days.

> "(2) Unjustified failure of a party or the party's representative to attend a scheduled hearing is a waiver of appearance. If the party that waives appearance is the party that requested the hearing, the referee shall dismiss the request for hearing as having been abandoned unless extraordinary circumstances justify postponement or continuance of the hearing."

OAR 438-06-081 provides, in turn, that hearings shall not be postponed except "upon a finding of extraordinary circumstances beyond the control of the party ... requesting the postponement."

Both prior to hearing and in her request for review, claimant argues that she was sick and could not appear at the hearing. However, the materials from Dr. Conrad, upon which claimant relies in support of this assertion, do not establish that claimant was unable to attend the hearing due to illness. To the extent those materials address claimant's physical condition, they discuss only the causal relationship between claimant's condition and her work; they do not address whether claimant was physically capable of attending the hearing. Moreover, although claimant states in her appellant's brief that she was not medically stationary, that she was on medication, and that she had physical restrictions, these assertions fall short of establishing inability to attend her hearing due to her condition. Therefore, we agree with the Referee that claimant failed to establish her own inability to attend the hearing as a basis for granting a postponement.

Claimant also argues that a postponement should have been granted to her because her husband and Dr. Conrad were unavailable to attend the February 8, 1991 hearing because they were both ordered to report for active military duty on that day. Claimant's brief indicates that she intended that her husband and Dr. Conrad make "a personal appearance on [her] behalf to state and verify [her] medical condition at the scheduled hearing of 8 February 1991." Claimant submits a copy of her husband's and Dr. Conrad's military orders in support of this contention.

OAR 438-06-081 provides several examples which do <u>not</u> qualify as "extraordinary circumstances beyond the control of the party ... requesting the postponement." In particular, subsection (2) states that "[u]availability of a party, <u>witness</u> or representative due to nonemergency medical or dental appointment, occupational, personal or professional business or appointments" does not justify postponement. We conclude the fact that claimant's husband and Dr. Conrad were called to active duty is not subject to this provision. We note that the military orders directing claimant's husband and Dr. Conrad to report for active duty are dated just one day prior to the scheduled hearing. In addition, we do not equate being called to involuntary active military duty during wartime with "occupational, personal or professional business or appointments" as expressed in OAR 438-06-081(2). Instead, we conclude that the unique circumstances here amount to extraordinary circumstances beyond claimant's control.

The insurer argues that no evidence has been presented that either claimant's husband or Dr. Conrad is a "necessary party" to this case. We do not agree that the issue should be framed in terms of whether either claimant's husband or Dr. Conrad is a "necessary party." Instead, we conclude that the issue is whether claimant's husband or Dr. Conrad can provide probative evidence to the trier of fact for purposes of resolving this matter. The record is not fully developed on this issue. Recognizing that claimant has appeared

pro se in this matter, we conclude that substantial justice would best be served by permitting the parties to address that issue. ORS 656.283(7).

We note that the record does not establish that claimant timely provided the insurer with notice of an intent to call Dr. Conrad as a witness at her hearing. See OAR 438-07-016. However, failure to disclose under the rule does not preclude such testimony. Instead, the rule allows for the testimony of undisclosed experts at the Referee's discretion.

Accordingly, we vacate the Referee's order and remand the case to the Presiding Referee with instructions to assign a referee to determine whether either claimant's husband or Dr. Conrad can provide probative testimony on the underlying compensability issue thereby justifying postponement and, if so, whether Dr. Conrad should be allowed to testify under OAR 438-07-016. The proceeding to make such a determination shall be held in any manner that achieves substantial justice. If the assigned Referee determines that dismissal was justified, then a final appealable dismissal order shall be issued. If the assigned referee finds that claimant's hearing request should not have been dismissed, then the referee shall proceed to a hearing on the merits of claimant's hearing request. Following the hearing on the merits, the referee shall issue a final, appealable order incorporating the ruling as to dismissal.

ORDER

The Referee's order dated February 13, 1991, as reconsidered March 14, 1991, is vacated and the case is remanded to the Presiding Referee to reassign the case for further proceedings consistent with this order.

August 15, 1991 Cite as 43 Van Natta 1726 (1991)

In the Matter of the Compensation of
VERNE E. DAVIS, Claimant
WCB Case No. TP-91012
THIRD PARTY PARTIAL DISTRIBUTION ORDER
Olson, et al., Claimant Attorneys
Darryl Nelson, Defense Attorney

Liberty Northwest Insurance Corporation, as a paying agency, has petitioned the Board to resolve a conflict concerning a "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Noting that claimant's permanent disability resulting from his aggravation claim has not been finally determined, Liberty Northwest asks that claimant's attorney be directed to retain the remaining balance of settlement proceeds in trust pending that final determination. We grant Liberty Northwest's request.

FINDINGS OF FACT

In March 1988, while performing his employment duties as a log truck driver, claimant was involved in a motor vehicle accident when the truck he was operating was struck by another log truck which had skidded out of control on an icy road. Claimant filed a claim for a left shoulder bruise or strain.

Claimant's injury claim was accepted as nondisabling. In August 1988, the claim was closed by Determination Order. Claimant was considered to be medically stationary on June 3, 1988. No compensation for temporary or permanent disability was granted.

Claimant engaged legal counsel to pursue a third party cause of action for negligence against the driver of the other logging truck involved in the March 1988 accident. Sometime in 1989, a complaint for negligence was filed.

In January 1990, claimant's compensable condition worsened. Liberty Northwest accepted claimant's aggravation claim and began providing temporary disability benefits.

In February 1991, claimant's third party complaint proceeded to trial. On February 11, 1991, claimant was awarded $120,773 in damages by a circuit court judge. On February 27, 1991, with Liberty Northwest's approval, claimant and the third party agreed to settle claimant's cause of action for $120,000.

The third party settlement agreement provided that the proceeds would be distributed in the following manner. Claimant received $26,838.44, his attorney received $40,257.67 for attorney fees and $1,617.42 for reimbursed litigation expenses, and Liberty Northwest received $33,988.19 for its "current lien." The parties further stated that the balance of the settlement proceeds would be held by claimant's counsel in trust "pending either further stipulation of the parties or Order of the Workers' Compensation Board or Court." Agreeing that the distribution of the remaining settlement proceeds would be governed by ORS 656.593, the parties stipulated that Liberty Northwest would "forthwith" petition the Board for any sums to which it sought entitlement under the statute. Finally, claimant reserved the right to respond to Liberty Northwest's petition.

On April 25, 1991, Liberty Northwest petitioned the Board for resolution of a conflict concerning the distribution of the remaining proceeds from the third party settlement. Noting that claimant's aggravation claim remained in open status, Liberty Northwest requested that the Board direct claimant's counsel to hold the remaining balance of settlement proceeds in trust until such time as a final determination regarding the extent of claimant's permanent disability could be achieved. Liberty Northwest has not asserted a lien for future medical expenditures. The remaining balance present in claimant's counsel's trust account totals $18,298.28.

On June 12, 1991, a Determination Order issued, closing claimant's aggravation claim. Claimant was awarded temporary disability from January 2, 1990 through May 23, 1991, as well as 43 percent unscheduled permanent disability. Pursuant to the Determination Order, either party has 180 days from the date of the order to request reconsideration or a hearing.

CONCLUSIONS OF LAW

If the worker or beneficiaries settle 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). Finding no persuasive reason to depart from our general approach of distributing third party settlement proceeds in accordance with ORS 656.593(1), we proceed with our analysis.

Pursuant to ORS 656.593(1)(a), cost and attorney fees incurred shall be initially disbursed. Then, the worker shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b).

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. See ORS 656.593(1)(c). Such other costs include assessments for reserves in the Insurance and Finance Fund, but do not include any compensation which may become payable under ORS 656.273 or 656.278. Following the aforementioned distribution of a third party recovery, any remaining balance shall be paid to the worker. ORS 656.593(1)(d).

Here, claimant contends that Liberty Northwest has wrongfully claimed and recovered reimbursement from the third party settlement for compensation payable under ORS 656.273. We disagree.

To begin, we are not inclined to revise the parties' written agreement at this late date. In reaching this conclusion, we draw upon the court's reasoning in the Williams decision. In Williams, the claimant, during negotiations of a third party settlement, requested a statement of the paying agency's lien. The agency provided a statement that did not include its anticipated future claim costs. Relying upon the statement, claimant settled the third party action. Thereafter, the paying agency asserted its lien, which included an additional amount for anticipated future claim costs. The court held that the paying agency's "just and proper" share of the third party settlement would be limited to the amount of the originally asserted lien. In doing so, the court reasoned that:

> "[W]hen either a worker or an agency, in the course of negotiating a third-party settlement, makes a representation to the other which could affect the other's position on the amount of the settlement, the other is entitled to rely on that representation." Id. at p. 620. (Emphasis supplied).

Here, the third party settlement agreement demonstrates that Liberty Northwest's approval was provided in conjunction with claimant's agreement to honor its $33,988.19 lien. Inasmuch as claimant made a representation that he would satisfy Liberty Northwest's lien from the $120,000 settlement and since Liberty Northwest expressly relied upon that representation in approving the settlement, we hold that the parties should abide by their mutually agreed "just and proper" distribution. Therefore, we decline to grant claimant's request to effectively revise the parties' previously agreed upon "just and proper" distribution of settlement proceeds.

The aforementioned analysis is likewise applicable to Liberty Northwest's right to petition the Board for recovery of any additional sums to which it asserted entitlement. Since Liberty Northwest's approval was expressly conditioned upon the opportunity to seek a further share of the remaining balance of settlement proceeds, such an agreement shall be honored.

In reaching this conclusion, we acknowledge claimant's assertion that Liberty Northwest has not complied with the settlement agreement in that it did not "forthwith" file its petition with the Board. We do not consider such an argument persuasive, particularly when: (1) the February 27, 1991 agreement did not attempt to expressly quantify the time within which the petition should be filed; (2) the petition was filed less than 60 days after the agreement; and (3) the claim remained in open status and Liberty Northwest was continuing to provide compensation when the petition was filed (thereby making an accurate determination of its lien difficult if not impossible).

We also disagree with claimant's contention that Liberty Northwest is prohibited from recovering reimbursement for compensation that has actually been

provided as a result of the reopening of his claim pursuant to ORS 656.273. ORS 656.593(1)(c) states that a paying agency is entitled to recover reimbursement for its actual claim costs. Specifically, the statute provides for such reimbursement to the extent that the paying agency is compensated for its expenditures for compensation, first aid, or other medical, surgical or hospital service.

"Compensation" includes all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to ORS Chapter 656. ORS 656.005(8). Inasmuch as benefits paid as a result of the reopening of claimant's claim satisfy the definition of "compensation," we conclude that Liberty Northwest is entitled to recover such benefits from the third party settlement.

This conclusion is further reinforced by the following observation. The provision in ORS 656.593(1)(c), which prohibits the recovery of compensation "which may become payable under ORS 656.273 or 656.278," is expressly in reference to the term "other costs" as used in the immediately preceding sentence in the same subsection. That sentence provides that, in addition to actual claim costs, a paying agency may recover "the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim." (Emphasis supplied). When read in tandem, these statutory provisions establish that a paying agency is prohibited from recovering the present value of expenditures attributable to future reopenings of the claim.

Thus, in the event that a third party recovery is achieved while a claim has been reopened, a paying agency is entitled to recover reimbursement for its claim costs attributable to compensation paid as a result of that reopening. However, a paying agency is foreclosed from claiming as part of its lien the present value of its reasonably to be expected future expenditures for compensation and other costs resulting from subsequent reopenings of the claim pursuant to ORS 656.273 and 656.278.

We apply the aforementioned reasoning to the present dispute. Since the third party settlement was achieved while the claim was in open status, we conclude that Liberty Northwest is entitled to recover from the $18,298.28 remaining balance of settlement proceeds its previously unreimbursed claim costs resulting from the reopening of the claim.

Inasmuch as the June 12, 1991 Determination Order closing the aggravation claim has not become final by operation of law, we further hold that it would be premature to reach a final determination regarding these previously unreimbursed claim costs. Claimant has asserted his intention to decline temporary or permanent disability compensation resulting from the closure of his aggravation claim. In addition, he has expressly forsaken further vocational assistance efforts. Yet, notwithstanding such contentions, claimant has been awarded temporary and permanent disability benefits as a result of the Determination Order. Thus, barring a settlement or other disposition of these benefits, Liberty Northwest is statutorily obligated to provide this compensation.

Consequently, we deem it appropriate to defer a ruling concerning the remaining amount of Liberty Northwest's unreimbursed lien. See Ray Littlefield, 41 Van Natta 1781, 2102 (1989); John C. Adams, 40 Van Natta 1794 (1988); John T. Elicker, 40 Van Natta 68 (1988). Since Liberty Northwest has waived its right to seek a lien for future medical expenditures, we note that should neither party timely contest the Determination Order a determination of the actual claim costs which have been previously unreimbursed will be readily achievable. Under such circumstances, we are hopeful that the parties will be able to resolve this matter without further assistance from this forum.

Accordingly, the remaining balance of proceeds from the third party settlement shall be held in trust by claimant's counsel pending a final determination concerning the extent of claimant's disability arising from the recent closure of his aggravation claim. Once the aforementioned determination has become final by operation of law, claimant's counsel shall distribute to Liberty Northwest from the remaining balance of proceeds the amount that satisfies Liberty Northwest's previously unreimbursed lien for its claim costs resulting from the reopening of the claim for aggravation. If Liberty Northwest's lien exceeds the remaining balance of proceeds, the entire balance shall be forwarded to Liberty Northwest. Any proceeds remaining after distribution to Liberty Northwest shall be forwarded to claimant. In the event that the parties are unable to resolve any dispute regarding the final distribution of settlement proceeds, they may seek further Board assistance.

IT IS SO ORDERED.

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

I concur in that portion of the order that holds that Liberty Northwest is entitled to payment of its lien for actual compensation paid in the claim, including payments made pursuant to the reopening of the claim under ORS 656.273. I dissent, however, from that portion of the order which requires claimant's attorney to hold in trust the remaining balance of the settlement proceeds for distribution to Liberty Northwest of future temporary and permanent disability compensation payable pursuant to the January 1990 reopening of the claim.

Liberty Northwest is entitled, under its agreement with claimant and under ORS 656.593(1)(c), to that portion of the recovery which remains after claimant and claimant's attorney take their statutory shares to the extent of "its expenditures for compensation, first aid or other medical, surgical or hospital service...." Contrary to claimant's contention, there is nothing which limits an insurer's lien for actual expenditures to compensation payable prior to reopening of the claim under ORS 656.273. Hence, I agree with that portion of the order which holds that Liberty Northwest was entitled to reimbursement for its actual expenses including temporary disability compensation paid since the reopening of the claim in January 1990.

On the other hand, the statute does not entitle an insurer to a lien for all reasonably expected future expenditures in the claim. The statute entitles the insurer to

> "the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794. Such other costs include assessments for reserves in the Insurance and Finance Fund, but do not include any compensation which may become payable under ORS 656.273 or 656.278."

This statutory rule regarding the extent of the lien for future costs does not permit the insurer to recover the cost of disability compensation which will become payable pursuant to an aggravation or own motion claim after the recovery.

The majority's reading of the statute's injunction against recovery of the present value of future costs incurred under ORS 656.273 and ORS 656.278 to apply to costs incurred only on future reopenings is without basis. It not only deprives claimants of a portion of their recoveries to which they are legally entitled; it also unnecessarily delays complete distribution of the proceeds of third party actions.

It is the Board's practice, when the workers' compensation claim has never been closed, to require that monies be held in trust for the insurer pending determination of permanent disability upon first closure of a claim. This is an appropriate expedient to avoid the necessity of estimating the amount of permanent disability compensation which a claimant will receive and for which an insurer is entitled to be reimbursed. There is no justification for the majority's extension of this practice to circumstances in which the claim has already once been closed, for the insurer will not be entitled to reimbursement for any future costs incurred due to the reopening of the claim.

I am aware that this Board took a similar approach in Ray Littlefield, 41 Van Natta 1781 (1989). The issue was not clearly framed by the parties in that case. To the extent our ruling in that case is contrary to the rationale articulated herein, I would disavow it.

August 15, 1991 Cite as 43 Van Natta 1731 (1991)

In the Matter of the Compensation of
MARIA J. OREJAL, Claimant
WCB Case No. C1-01627
ORDER DISAPPROVING CLAIMS DISPOSITION AGREEMENT
Michael B. Dye, Claimant Attorney
Nelson, et al., Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

On August 6, 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 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 it exceeds the bounds of existing statutes or rules. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990).

Here, the proposed agreement purports to release claimant's further rights to workers' compensation benefits, except for medical services, payable under her workers' compensation claim. However, on page 4 of the agreement, it provides that in exchange for a portion of the stated sum, "any possible, future claim for home care services or modification of claimant's motor vehicle or dwelling will not, therefore, be compensable in connection with this claim." This language directly limits claimant's right to medical services. See ORS 656.245(1)(c); Stoddard v. Credit-Thrift Corp., 103 Or App 283 (1990). Any such limitation on claimant's right to medical services exceeds the bounds of ORS 656.236(1) and the rules promulgated thereunder. See Kenneth D. McDonald, 42 Van Natta 2307 (1990); Sharon Watkins-Aubert, 42 Van Natta 2093 (1990). Because this agreement exceeds the bounds of the existing statute and rules, we find the proposed disposition unreasonable as a matter of law. Louis R. Anaya, supra. Accordingly, we decline to approve the agreement and return it to the parties. ORS 656.236(1)(a).

We also note that although claimant and her counsel actually signed the agreement, the insurer's representative's signature appears to be photocopied.

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).

Following our standard acknowledgment procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

August 16, 1991 Cite as 43 Van Natta 1732 (1991)

In the Matter of the Compensation of
HAROLD T. BIRD, (Deceased), Claimant
WCB Case Nos. 88-10784, 89-07112, 89-07113, 89-07114 & 89-12866
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
E. Jay Perry, Defense Attorney
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Neidig and Crider.

Liberty Northwest Insurance Corporation requests review of Referee Seymour's order that: (1) set aside its denial of a claim for death benefits filed by the deceased claimant's surviving spouse; and (2) upheld the SAIF Corporation's denial of the same claim. In its brief, Liberty contends that the Referee erred by admitting a report from an out-of-state consultant into evidence. On review, the issues are evidence, compensability and responsibility. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's "Findings and Opinion," with the exception of the last three paragraphs in that section.

CONCLUSIONS OF LAW AND OPINION

Evidence

At hearing, Claimant offered a report authored by Dr. Monroe, who apparently holds a PhD in environmental toxicology. The report offered an opinion about the cause of claimant's condition. Dr. Monroe was not present to testify. He resides in the state of Washington. The insurers objected to admission of the report under ORS 656.310(2) because Dr. Monroe neither treated nor examined claimant.

The Referee denied the motion, concluding that, because Dr. Monroe was a toxicologist and not a medical doctor, his report was admissible. On review, the insurers renew their objection to the Referee's admission of the report. Claimant contends that the report is admissible under ORS 656.283(7).

ORS 656.310(2) reads, in pertinent part, as follows:

> "The contents of medical, surgical and hospital reports presented by claimants for compensation shall constitute prima facie evidence as to the matter contained therein; so, also, shall such reports presented by the insurer or self-insured employer, provided that the doctor rendering medical and surgical reports consents to submit to cross-examination. This subsection shall also apply to medical or surgical reports from any treating or examining doctor who is not a resident of Oregon, provided that the claimant, self-insured employer or the insurer shall have a reasonable time, but no less than 30 days after receipt of notice that

> the report will be offered in evidence at a hearing, to cross-examine such doctor by deposition or by written interrogatories to be settled by the referee."

ORS 656.310(2) creates an exception to the hearsay rule and provides that specified reports are admissible without testimony from the physician. However, the exception provided by ORS 656.310(2) applies only to reports by treating or examining physicians who reside outside the state of Oregon. Downey v. Halvorsen-Mason, 20 Or App 593 (1975). We conclude that Dr. Monroe's reports are medical reports as they offer an opinion as to the cause of claimant's myeloma condition. Because Dr. Monroe did not treat or examine claimant, his reports are not admissible under ORS 656.310(2).

Claimant argues that, even if the reports are not admissible under ORS 656.310(2), they should be admissible under ORS 656.283(7), which provides that, except as otherwise provided, the referee is not bound by common law or statutory rules and may conduct a hearing in any manner that will achieve substantial justice. We disagree.

ORS 656.283(7) provides that substantial justice is the sole guide to deciding evidentiary disputes "except as otherwise provided in this section and rules of procedure established by the board...." Under the circumstances, we conclude that, because the legislature has specifically addressed the issue of admissibility of medical reports, ORS 656.283(7) should not be read to authorize admission of documents that are neither admissible under ORS 656.310(2) nor under the Oregon Evidence Code. Accordingly, we conclude that the reports of Dr. Monroe are not admissible under ORS 656.283(7), and we do not consider them in our review of claimant's case.

Compensability/Masking theory

The Referee found that, because claimant's work-related accident masked his multiple myeloma, the myeloma condition was not promptly diagnosed. The Referee, therefore, concluded that claimant's claim was compensable. Liberty argues that the Referee erred by finding the claim compensable on a "masking" theory. We agree.

A disease that would otherwise not be compensable becomes compensable if an on-the-job injury produces symptoms which "mask" manifestations of the earlier condition to the worker's detriment. See Waibel v. State Compensation Department, 3 Or App 38 (1970). In Waibel, the claimant's accident and immediate symptoms misled the worker and doctors into believing that the symptoms were produced by trauma. Consequently, treatment for an underlying Hodgkins disease was delayed and total disability was not forestalled. Waibel, supra. Liberty argues that claimant's case does not fit within the test of Waibel, as the physicians were not misled by the trauma into mistakenly attributing symptoms of the underlying disease to the trauma.

In the present case, three physicians examined claimant in 1988 before his myeloma condition was diagnosed on April 8, 1988. The physicians' work-ups were systematic and efficient. There is no evidence that they were side-tracked in the diagnostic task by a history or effects of any traumatic injury.

On January 23, 1988, claimant was examined by his treating doctor, Dr. Moshofsky, who recorded claimant's complaints of hip pain which had bothered him for about three months. Dr. Moshofsky did not report a lifting incident and noted "no history of injury."

Dr. Kitchel examined claimant on March 10, 1988. Claimant reported that he had suffered back pain for two months. Although claimant could not relate the back pain to one specific event, he believed that it came on as a result of overuse at work. Dr. Kitchel suspected that claimant's back pain was primarily mechanical, but due to claimant's failure to respond to medication and his slowly intensifying pain, he suggested that claimant obtain a bone scan.

On March 25, 1988, claimant treated with Dr. Matteri. He reported that his pain began in his right hip and came at the end of a lot of lifting and bending. Claimant stated that he "got along quite nicely until he was helping somebody move a heavy piece of metal and the other end was dropped." Claimant reported that the incident jarred his back and from then on he began having back and right thigh pain. Despite claimant's report of an incident at work, Dr. Matteri diagnosed back and thigh pain of "undetermined etiology."

We agree with Liberty's contention that the physicians in this case were not misled by the trauma into mistakenly attributing symptoms of the underlying disease to the trauma. Although claimant may have related his back problems to his work activities, the doctors did not. Additionally, the one doctor to whom claimant reported a lifting incident at work, Dr. Matteri, diagnosed back and thigh pain of unknown etiology. Under the circumstances, we conclude that claimant's physicians were not misled by a trauma and did not attribute the symptoms of his myeloma condition to a work-related trauma. We, therefore, conclude that claimant's myeloma condition is not compensable under a "masking" theory.

Compensability/Occupational Disease

The Referee did not reach the issue of whether claimant had proven a compensable occupational disease. Because we have not found claimant's myeloma condition compensable under a "masking" theory, we proceed to address the issue of compensability on an occupational disease basis. Both parties agree that claimant must prove that his exposure to chemicals at work was the major contributing cause of his myeloma condition. Former ORS 656.802; Dethlefs v. Hyster Co., 295 Or 298 (1983).

Four experts have provided opinions on the issue of causation of claimant's condition. However, as a result of our conclusion that the report of Dr. Monroe should be excluded, we do not consider his report on review.

Dr. Morton, M.D., Phd, specializes in environmental medicine at Oregon Health Sciences University. He stated that he believed there was "reasonable medical probability (at least 51%) that (claimant's) occupational chlorophenol exposure made a significant contribution to his myeloma risk and at least caused it to occur earlier than it otherwise would have."

Dr. Morich, M.D., an oncologist and claimant's treating doctor, stated that, "One cannot extrapolate from an increased incidence of soft tissue sarcomas or lymphomas that the incidence of multiple myeloma should be equally increased. The cause of these diseases is multifactorial and the role of one particular agent in causing this disease cannot clearly be identified or quantified."

Dr. Wagner, M.D. and professor of clinical toxicology at Oregon Health Sciences University, stated that, "if pentacholorophenol were a demonstrated and proven human carcinogen, then I would agree with Dr. Morton that the probable cause, i.e., 51% or better, would be that the pentachlorophenol exposure either caused his cancer or played a role in its development. Since pentachlorophenol is not a proven carcinogen in humans by established criteria, this statement

cannot be made. In my judgment, the most probable cause of Mr. Bird's cancer simply cannot be established."

The insurers argue that Dr. Morich should be deferred to in this case because he is the treating physician. We disagree. We conclude that, because the case is a complex medical matter requiring expert analysis rather than external observation, there is no reason to defer to the treating physician. In addition, Dr. Morich first saw claimant when he was admitted to the hospital on April 8, 1989, at which time he obtained a history from claimant's wife. Consequently, we conclude that there is no reason to defer to the opinion of Dr. Morich on the basis of long term treatment or observation of claimant.

Finally, we conclude that the remaining expert opinions directly contradict each other. Both Dr. Morton and Dr. Wagner are well-qualifed and their opinions are reasoned and complete. However, each expert has provided different interpretations of the same studies and test results and we find neither opinion to be more persuasive than the other.

Under the circumstances, we find that claimant has not proven his claim by a preponderance of the evidence. We conclude that the medical evidence is insufficient because it does not show with reasonable certainty that there was a causal connection between claimant's exposure to chemicals at work and his multiple myeloma condition. See Gormley v. SAIF, 52 Or App 1055 (1981). Accordingly, we reverse the Referee on the issue of compensability.

Responsibility

Because we have concluded that claimant did not establish compensability of his myeloma condition, we do not reach the issue of responsibility.

ORDER

The Referee's order dated August 13, 1990 is reversed. Liberty Northwest Insurance Corporation's denial is reinstated and upheld. The Referee's attorney fee award of $15,000 is also reversed.

August 16, 1991 Cite as 43 Van Natta 1735 (1991)

In the Matter of the Compensation of
LARETA C. CREASEY, Claimant
WCB Case No. 90-08415
ORDER ON REVIEW
Nichols & Bogardus, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Westerband and Crider.

The insurer requests review of that portion of Referee Podnar's order that set aside its denial of claimant's current back condition. On review, the issues are compensability and aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's "FINDINGS" from paragraph one through three and paragraphs five and six on page 2, with the following supplementation.

The insurer had notice that claimant's injury became disabling on December 13, 1989.

The insurer's November 30, 1988 acceptance of the 1988 industrial injury claim did not include claimant's underlying degenerative disc disease, which is a separate condition from the acute strain listed on the 801 Form claimant submitted for that injury.

The denial addresses future compensation in the accepted claim.

FINDINGS OF ULTIMATE FACT

Claimant's compensable injury combined with her preexisting degenerative disease and was the major contributing cause of her disability and need for surgery. Claimant's claim that her nondisabling injury became disabling was made more than one year but within five years after the date of injury. Her worsened condition was established by medical evidence supported by objective findings. Due to the worsened condition, claimant's ability to work was diminished. Claimant had received no prior award of permanent disability compensation.

CONCLUSIONS OF LAW AND OPINION

The Referee found claimant's claim compensable. We affirm, with the following comment.

In deciding this matter, the Referee applied the law as amended by Or Laws 1990 (Special Session), Ch 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

The Referee decided this case under two alternate theories. In the first, he hypothesized that claimant's underlying degenerative joint disease was accepted as part of the original injury and that the denial should have been set aside under Georgia Pacific v. Piwowar, 305 Or 494 (1988). He then applied ORS 656.262(6) and concluded that the insurer failed to establish by clear and convincing evidence that claimant's industrial injury should not remain in accepted status. Alternatively, the Referee concluded that if the denial was a partial denial, claimant proved that the industrial injury was the major contributing cause of the worsening of her underlying disease and need for treatment. Under either theory, the Referee found the claim compensable. We affirm the Referee's conclusion and write to clarify the proper analysis in this case.

Propriety of Denial

A partial denial is permissible where the denied condition was not previously accepted and the condition is separate from the accepted injury. Johnson v. Spectra Physics, 303 Or 49 (1987); Melvin G. Monday, 42 Van Natta 2411 (1990). In the case at bar, the insurer accepted an acute low back strain. (Ex. 1). Contemporary medical evidence supports that characterization of claimant's condition. (Exs. 1A, 2, 3, 4, 5, 7). When claimant's condition became disabling, it was identified as a preexisting degenerative arthritic condition upon which the industrial injury was superimposed. (Exs. 8, 9, 10, 14, 19). Although the insurer's denial was inartfully worded, the insurer only denied claimant's preexisting degenerative arthritic condition. (Ex. 20). Accordingly, we find that the denial is a valid partial denial. Johnson v. Spectra Physics, supra; Melvin G. Monday,

supra. Nevertheless, although an insurer may, as here, deny a separate condition, or a current need for medical services, it may not deny future compensation in an accepted claim. See Johnson v. Spectra Physics, supra; Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989); Green Thumb, Inc. v. Basl, 106 Or App 98 (1991); Melvin G. Monday, supra. Because the insurer's inartfully worded denial purports to deny future compensation for the accepted claim, we set aside the sentence in the denial that states: "No further treatment and/or disability will be covered under this claim."

Compensability

We affirm the Referee on this issue and supplement as follows.

It is claimant's burden to prove by a preponderance of the evidence that her accepted 1988 low back injury which combined with her preexisting degenerative joint disease is and remains the major contributing cause of her disability and need for treatment. ORS 656.005(7)(a)(B).

We give greater weight to the conclusions of a treating physician unless there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986). We do not find the Western Medical Consultants' conclusory opinion that claimant's surgery is due to the preexisting degenerative joint disease persuasive, as their opinion does not address the effect that the injury may have had on claimant's condition. Furthermore, because Dr. Bomengen's "check the box" responses to the parties' queries are contradictory, we decline to rely on them. (See exs. 23 and 24).

We are instead persuaded by the opinion of Dr. Wenner, claimant's treating neurosurgeon. Dr. Wenner offered the following response to the insurer's request for concurrence with the statements in their letter, which Wenner did not sign: "[Claimant] did not complain until her 1988 injury, and her progressive symptoms began at that time." He goes on to say that the "main reason" for claimant's back pain is the injury, although the injury in and of itself was not the sole reason for her current disability and need for surgery. (Ex. 26). As a matter of law, the injury need not be the "sole reason" for the current condition to satisfy the requirement of major contribution. We thus conclude that the "main", or major reason is the injury. For further amplification of this view, we rely on Wenner's earlier, more detailed opinion (ex. 20D-1), in which he says, "The degree of [claimant's] stenosis is rather unusual in my experience, in a woman of her relatively young age, suggesting that there was some inciting incident or even multiple incidents, which led to the accelerated degenerative changes and subsequent stenosis;" and "She certainly has been having ongoing degenerative arthritis of her spine for some time. This condition has undoubtedly been exacerbated by her work as a nurse's aide, and could certainly have been worsened by a major incident such as [the 1988 injury]." We are accordingly persuaded that claimant's injury and work as a nurse's aide is and remains the major cause of claimant's disability and need for surgery.

Aggravation

Claimant's accepted injury occurred on November 6, 1988. Claimant's claim that her nondisabling injury became disabling was made more than one year after the date of injury. Accordingly, the current claim is a claim for aggravation under ORS 656.273. Or Laws 1990 [Special Session], Ch. 2, 48(2).

Claimant is entitled to additional compensation for a worsened condition resulting from the original injury. ORS 656.273(1). To establish a compensable worsening of her unscheduled condition, claimant must show that increased

symptoms or a worsened underlying condition resulted in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds, Lucas v. Clark, 106 Or App 687 (1991). Further, the medical worsening must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

At the time of injury, Dr. Bomengen, claimant's treating physician, found tenderness at L4, with muscular tightness and spasms and reported tingling down claimant's left leg. (Ex. 4). At the time claimant's claim became disabling, Dr. Wenner, claimant's treating neurosurgeon, reported numbness, tingling and pain in the back and right leg, and found stenosis and degenerative *** desiccation of the discs at L2-3, L3-4 and L4-5, a disc bulge at L2-3, and radicular pain into the right leg. He requested surgical decompression at these levels. (Exs. 15, 16 and 17). Claimant has thus shown a worsening of her condition by medical evidence supported by objective findings. See Suzanne Robertson, 43 Van Natta 1505 (1991).

Moreover, claimant missed no time from work until November 16, 1989. At that time, she began missing work. Her functional capacity was limited. Her physician advised her to avoid lifting and indicated that she would have difficulty with working as a nurse's assistant. Thus, she suffered diminished earning capacity. Because she did not receive a prior award, she need not establish that the worsening was in excess of the disability for which she was previously compensated. See ORS 656.273(8); Louis A. Duchene, 41 Van Natta 2399 (1989). Consequently, we conclude that claimant's disabling condition is a compensable aggravation of her industrial injury.

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 and aggravation issues 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 issues, and the value of the interest involved.

ORDER

The Referee's order dated November 6, 1990 is affirmed. For services on Board review, claimant's attorney is awarded $750, to be paid by the insurer.

In the Matter of the Compensation of
GORDON C. GREEN, Claimant
WCB Case No. 86-09604
ORDER ON REMAND
Pozzi, et al., Claimant Attorneys
Randolph Harris (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Green v. Pelton Concrete, 106 Or App 421 (1991). The court has reversed our order, Gordon C. Green, 42 Van Natta 234 (1990), which reversed a Referee's order that granted claimant permanent total disability. Concluding that neither our order nor the Referee's order determined whether the claim had been prematurely closed, the court has remanded for reconsideration of that issue. We proceed with our review.

FINDINGS OF FACT

The Board adopts the "Findings of Fact" in our Order on Review, with the following supplementation.

In January 1986, Dr. Manley reported that claimant would not be medically stationary before he reached the age of 65, the stated age that claimant intended to retire. Manley provided no medical explanation for this opinion. In response to an inquiry concerning possible future vocational rehabilitation opportunities, Manley opined that claimant might be able to do sedentary work.

Dr. Struckman performed an independent medical examination in April 1986. Struckman was unaware of any further treatment that would benefit claimant because his condition continued to worsen. Struckman felt that the claim could be closed, but that claimant would need periodic medical care as well as future knee surgery.

In response to Dr. Struckman's examination, Dr. Manley wrote that apparently Dr. Struckman felt claimant was medically stationary. Dr. Manley noted that claimant was concerned that he was becoming worse.

After Dr. Struckman's examination, SAIF requested claim closure. A Determination Order issued June 19, 1986.

At the time of closure, it could reasonably be anticipated that claimant's condition would worsen over time, eventually requiring surgery. However, at the time, neither treatment nor the passage of time would be expected to improve claimant's status.

Claimant was medically stationary at the time the claim was closed.

CONCLUSIONS OF LAW AND OPINION

The Referee granted permanent total disability, and erroneously concluded that there was no need to address the premature closure issue raised by claimant. On review, we reversed the award of permanent total disability and rated claimant's permanent partial disability, but we did not consider the premature closure issue. The court found substantial evidence to support our conclusion that claimant was not entitled to permanent total disability, but remanded, reasoning that whether claimant's claim was prematurely closed is a question that must be decided before any award of benefits could be made.

To establish that the Determination Order prematurely closed his claim, it is claimant's burden to show he was not medically stationary as of the date the Determination Order issued. Scheuning v. J.R. Simplot & Co., 84 Or App 622, rev den 303 Or 590 (1987); Aldrich v. SAIF, 71 Or App 168 (1984); Berliner v. Weyerhaeuser Corp., 54 Or App 624, 628 (1981); 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). The term "medically stationary" does not mean that there is no longer a need for continuing medical care. Maarefi v. SAIF, 69 Or App 527, 531 (1984). 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. Schuening, supra.

Here, Dr. Manley, claimant's treating physician, on January 2, 1986, stated that he did not think claimant would "become medically stationary to the point where he could reasonably return to any type of work before he reached age 65" in December 1986, the date claimant intended to retire. The doctor thought

it was unreasonable to attempt to help claimant get back to work at age 64 when claimant intended to retire in less than a year. (Ex 5b). At that time, Dr. Manley did not indicate whether claimant would reasonably improve with further medical treatment or the passage of time.

Dr. Struckman examined claimant in an independent medical examination in April 1986. (Ex. 6). Struckman said that, while claimant may not be yet medically stationary by definition, he doubted that claimant wuld ever get to the point where his knee pain ceased getting worse. He also stated that he did not know of any further conservative treatment which would be of any benefit to claimant. (Ex. 6-2).

Thereafter, the insurer requested claim closure by the Evaluation Section. A Determination Order issued June 19, 1986.

In July 1986, Dr. Manley stated that claimant was totally disabled from his occupation in carpentry. He did, however, think that claimant could work at a sedentary job. At that time, Dr. Manley noted that claimant's medically stationary date was at issue. He stated that his understanding of medically stationary was that one had basically plateaued and was not necessarily getting medically better or worse. He did not specifically state whether he thought claimant was medically stationary (by his definition) at that time, although he continued to state that claimant was totally disabled because of his age and intent to soon retire. (Ex. 10a). By a chart note dated July 1, 1986, Dr. Manley noted that Dr. Struckman apparently felt that claimant was medically stationary, but claimant related to Manley that he was becoming worse. (Ex. 10).

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, notwithstanding the references to a deteriorating condition, 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. See Julio G. Mejia, 43 Van Natta 467 (1991).

Dr. Manley noted continuing pain and the need for future surgery, as did Dr. Struckman. However, no additional medical treatment was being proposed in 1986 that would improve claimant's condition. Moreover, there is no evidence in the record that, as of the date of the Determination Order, claimant would be expected to improve with the passage of time. To the contrary, the medical evidence suggested further deterioration and the eventual need for a total knee arthroplasty. Accordingly, claimant has failed to establish that, as of the date of the Determination Order, he was not medically stationary as defined by statute. Thus, his claim was not prematurely closed.

On reconsideration, as supplemented herein, we adhere to and republish our January 31, 1990 Order on Review.

IT IS SO ORDERED.

In the Matter of the Compensation of
CONCETTA M. CROWDER, Claimant
WCB Case Nos. 90-14058 & 90-14059
ORDER ON REVIEW (REMANDING)
Black, et al., Claimant Attorneys
C. Douglas Oliver (Saif), Defense Attorney
Daryll E. Klein, Defense Attorney

Reviewed by Board Members Westerband and Crider.

The SAIF Corporation requests review of those portions of Arbitrator Brown's order which: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) upheld Scott Wetzel Services' denial of claimant's "new injury" claim for the same condition. On review, the issue is responsibility. We remand.

We review the Arbitrator's order solely on questions of law. ORS 656.307(2). Where an arbitrators' order is not consistent with applicable law, we remand for the proper application of law. See Yolanda Carrasco, 42 Van Natta 2289 (1990).

The Arbitrator stated that in order for SAIF to shift responsibility, SAIF had to affirmatively prove that claimant's later employment with Scott Wetzel's insured had independently contributed to a pathological worsening of her underlying low back condition, citing Spurlock v. International Paper Co., 89 Or App 461 (1988); Crowe v. Jeld-Wen, 77 Or App 81 (1985) and Fred Meyer v. Benjamin Franklin Savings and Loan, 73 Or App 795 (1985). He concluded that SAIF failed to carry its burden of proof.

Thus, we find that the standard of proof applied by the Arbitrator was the "last injurious exposure rule." This standard of proof, when applied to successive injuries cases, places responsibility on the last employment which independently contributed to the worker's disability. We note, however, that at the time of hearing, the law regarding responsibility had changed. Here, claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, regardless of ORS 656.202, the 1990 amendments to ORS Chapter 656 apply retroactively to claimant's claim. See Or Laws, Special Session, Ch 2 54; Ida M. Walker, 43 Van Natta 1402 (1991).

The current version of Chapter 656 states that when a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer. Or Laws, Special Session, Ch. 2 49. There is no explicit reliance on the last injurious exposure rule in order to determine responsibility.

Thus, we conclude that SAIF was required to prove that claimant sustained a new compensable injury while employed for Scott Wetzel's insured in order to shift responsibility. Although we note that the Arbitrator did find that there was no "new incident" at Scott Wetzel's insured, that does not answer the question of whether or not there was a "new compensable injury" under Section 49.

Inasmuch as the Arbitrator applied the standard of proof in effect prior to the 1990 amendments to Chapter 656, as opposed to the current version, we find the Arbitrator failed to apply the applicable law. Because we review only questions of law, we must remand for additional findings, and a determination of

which carrier is responsible when the correct rule of law is applied. See ORS 656.307(2); ORS 656.295(5); Thomas N. Thorn, 42 Van Natta 2325 (1990); Inez Horsey, 42 Van Natta 331 (1990).

ORDER

The Arbitrator's order dated November 5, 1990, as amended November 6, 1990 is vacated. This matter is remanded to Arbitrator Brown for a determination of the responsible carrier. Arbitrator Brown may make that determination with or without further proceedings in any manner to achieve substantial justice.

In the Matter of the Compensation of
ROXIE A. LINGLE, Claimant
WCB Case No. 90-19192
ORDER ON REVIEW
David Gernant, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Westerband and Crider.

The self-insured employer requests review of Referee Seifert's order that set aside its denial of claimant's right knee injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant, a 32 year old certified nursing assistant, was employed at an adult care center. On August 14, 1990, she reported to work as usual at 6:30 AM, and began to help an instructor set up a training class for nursing assistants. Later that morning, while walking down the hallway with the instructor, her right knee buckled without warning. She did not fall to the floor, but caught herself by leaning on a railing.

Claimant had not experienced previous incidents of giveway nor had she suffered prior knee injury. She reported the incident to the charge nurse and finished her shift despite pain. Claimant returned to work the next day, still having a fair amount of right knee pain that caused her to limp. She worked till noon the following day, then left due to pain. She stayed home the next three days, resting the knee and applying ice.

Claimant returned to work on August 20, 1990, but was sent home by her supervisor who told her to see a doctor. Later that day, claimant saw Dr. Isaacson, an orthopedic surgeon, who initially diagnosed an internal derangement of the right knee and believed that claimant had a meniscal tear. (Ex. 4). Dr. Isaacson ordered an arthrogram which she interpreted as normal except for a small effusion. (Ex. 4-2).

Claimant continued to have knee pain and, on September 14, 1990, was examined by Dr. McNeill, an orthopedic surgeon. He also suggested the possibility of an internal derangement of the knee and recommended an arthroscopy to determine whether claimant had interarticular pathology. (Ex. 7).

Dr. Isaacson performed an arthroscopy on October 9, 1990, and found softening of the patellar cartilage and some softening and fissuring of the lateral tibial plateau. (Ex. 9). She later ordered a bone scan, which showed increased uptake in all phases consistent with a reflex sympathetic dystrophy. She

believed claimant could return to sedentary work and, in early December 1990, started claimant on a course of physical therapy. (Ex. 10-2).

On December 11, 1990, claimant was examined by Dr. Geist, an orthopedic surgeon, and Dr. Brown, a neurologist, at the offices of the Orthopaedic Consultants. They diagnosed a right knee strain and reflex sympathetic dystrophy and believed that claimant was not medically stationary. They found nothing that indicated thather knee problem was due to a preexisting condition not connected to her employment, but were unable to explain exactly what happened to claimant's knee on the date of injury. (Ex. 13-6).

CONCLUSIONS OF LAW AND OPINION

The Referee determined that claimant's knee injury was compensable. He analyzed the question in terms of whether claimant has sufficiently established a relationship between her injury and employment to justify a holding that it arose out of her employment. Relying on Hubble v. SAIF, 56 Or App 154 (1982), the Referee concluded that claimant had and set aside the employer's denial. We disagree.

The facts surrounding the claimant's injury in Hubble v. SAIF, supra, are markedly similar to the facts before us. There, the claimant suffered a knee injury as he walked down a straight corridor. The injury occurred when, as he stepped forward with his left foot to take his next step, his left knee buckled. As in this case, the claimant had never injured his knee prior to that day and did not slip, twist, change direction or alter his stride prior to the incident.

In that case, however, the medical evidence established that the claimant's walking on the job had caused a tear in his left medial meniscus, which, in turn, had caused his knee to buckle. That fact, coupled with the fact that walking was a part of the claimant's job, led the court to find a sufficient work relationship between the injury and employment to justify recovery.

In this case, unlike Hubble v. SAIF, supra, there is no medical evidence that claimant's knee buckled as a result of a risk of her employment. Dr. Geist and Dr. Brown speculated that the injury was work-related due to the lack of prior knee problems, suspecting that claimant may have had some element of twisting of the knee on the date of injury that claimant did not recall. They admitted, however, that they were unable to determine exactly what occurred to cause the buckling. Dr. Isaacson, claimant's treating physician, also was unable to establish a causal link between the injury and a risk of claimant's employment.

After our review of the record, we conclude that the evidence establishes no more than that it was equally possible that the cause of claimant's buckling knee was a preexisting problem, that is, idiopathic, as that it was connected to claimant's employment. That is not enough to satisfy claimant's burden of proof. See Mackay v. SAIF, 66 Or App 415 (1984).

Claimant contends that this case should be analyzed under the standard approved in Phil A. Livesly v. Russ, 296 Or 25 (1983). Under that standard, a truly unexplained fall that occurs on the employer's premises while the worker is performing required duties is compensable if the worker can eliminate all idiopathic causes. That analysis, however, is applicable only when a worker falls for unknown reasons and an injury results from the fall. Folkenberg v. SAIF, 69 Or App 159 (1984). Here, had claimant fallen, the cause of the fall would have been known: her knee buckled. Accordingly, this is not a true unexplained fall case. See McAdams v. SAIF, 66 Or App 415 (1984).

ORDER

The Referee's order dated February 4, 1991 is reversed. The self-insured employer's denial is reinstated and upheld. The Referee's assessed attorney fee of $1,500 is reversed.

August 20, 1991 Cite as 43 Van Natta 1744 (1991)

In the Matter of the Compensation of
STEVEN D. PEFFER, Claimant
WCB C1-01676
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Goldberg & Mechanic, Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Neidig and Westerband.

On August 13, 1991, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of a stated sum, claimant releases certain rights to future workers' compensation benefits except medical services, for the compensable injury. The proposed agreement purports to justify attorney fees which exceed the strictures of OAR 438-15-052 with an explanation of extraordinary circumstances surrounding the claim. We set aside the proposed disposition.

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 proceeds in excess of $12,500. See OAR 438-15-052. Under extraordinary circumstances, a fee may be approved in excess of the strictures of OAR 438-15-052. Rollie Clark, 43 Van Natta 194 (1991).

Here, the attorney fee exceeds the amount allowed under OAR 438-15-052. Specifically, the agreement provides that the insurer will pay claimant a total of $20,000 with $5,000 of that amount as an attorney fee pursuant to the attached affidavit of claimant's counsel. The attached affidavit indicates that the attorney fee is justified due to the extraordinary amount of time expended preparing for hearing on the insurer's denial of "all current need for psychological treatment and chemical dependency and abuse treatment as not compensably related to the accepted claim."

The extraordinary circumstances raised by the parties to justify a larger attorney fee are not directly related to the obtaining or formulation of the proposed claim disposition agreement. The circumstances cited as extraordinary are either for legal services in connection with further medical benefits, which are not subject to this agreement, or for legal services in connection with benefits that are being released by this agreement. Consequently, the Board finds that extraordinary circumstances do not exist to justify a fee greater than provided under normal circumstances. See David D. Buchanan, 43 Van Natta 1187, 1188 (1991). The agreement is, therefore, unreasonable as a matter of law and is set aside. See ORS 656.236(2); Louis R. Anaya, 42 Van Natta 1843, 1844 (1990).

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(40(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
LORI A. SOSA, Claimant
WCB Case No. 89-11536
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Westerband and Crider.

The insurer requests review of those portions of Referee Mills' order that: (1) set aside its denial of claimant's claim for a bilateral vestibular condition; (2) set aside its "de facto" denial of claimant's temporomandibular joint (TMJ) dysfunction condition; (3) assessed a penalty-related attorney fee for its untimely claims processing; and (4) assessed a penalty-related attorney fee for its alleged failure to provide timely discovery. On review, the issues are compensability and penalty-related attorney fees.

We affirm and adopt the order of the Referee as supplemented.

Compensability of TMJ

The medical record indicates that claimant's condition has not been definitively diagnosed by either her treating physician or by the independent medical examiner. The lack of a definitive diagnosis does not per se defeat the claim. See Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988). It is not a necessary predicate to compensability that the medical experts know the exact mechanism of the disease. Robinson v. SAIF, 78 Or App 581 (1986). However, the causation issue, as opposed to the question of diagnosis, must be resolved. Stewart E. Myers, 41 Van Natta 1985 (1989). This issue is of sufficient medical complexity as to require expert medical opinion. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

With respect to the causation issue, we adopt the reasoning of the Referee. Accordingly, we conclude that there is persuasive medical evidence that the compensable November 1987 injury was a material contributing cause of claimant's condition, tentatively diagnosed as TMJ.

Penalty-related attorney fee for unreasonable claims processing

We find that Liberty was put on notice of the "TMJ" claim upon receipt of Dr. Black's June 15, 1988 letter. As such, we conclude that the letter constituted a claim which triggered Liberty's duty to accept or deny with 60 days. At the time of hearing, Liberty had neither accepted nor denied the claim. The Referee found there were no "amounts then due" to base a penalty on. Nonetheless, an attorney fee may be awarded, pursuant to ORS 656.382(1), for unreasonable resistance to compensation. See Lloyd L. Cripe, 41 Van Natta 1774 (1989).

As discussed above, we have found this claim to be compensable. We further find that Liberty's failure to respond to claimant's claim was unreasonable and that it had the effect of delaying compensable benefits, such as the diagnostic MRI requested by Dr. Summers. As such, claimant is entitled to a penalty-related attorney fee. See Jack O. Pichette, 41 Van Natta 2136 (1989).

Penalty-related attorney fee for untimely discovery

OAR 438-07-015(5) requires the full and complete disclosure of all facts and opinions pertaining to the claim being litigated. Failure to comply with this rule "shall, if found unreasonable, be considered delay or refusal under ORS 656.262(10)." See OAR 438-07-015(5). Former ORS 656.262(10) provides for the payment of attorney fees in accordance with ORS 656.382.

Liberty had 15 days from the day of mailing of the request for hearing filed by claimant to provide discovery. The pleadings indicate that the request was mailed on June 16, 1989. However, Liberty did not provide two of the documents until August 2, 1989. In the case of Dr. Summer's report, claimant did not receive the document until November 22, 1989. Thus, the Referee found, and we concur, that Liberty failed to provide discovery timely, and that further this failure was unreasonable.

In addition, we also find that Liberty's inaction delayed putting claimant on notice that further diagnostic medical services were being sought by Dr. Summer, and thus, potentially delayed resolution of this claim. Inasmuch as we have found that the claim is compensable, we conclude there has been an unreasonable resistance to the payment of compensation. As such, we conclude that claimant is entitled to a penalty-related attorney fee.

Claimant has prevailed in a rejected case. Therefore, she is entitled to an assessed fee under ORS 656.386(1). After considering claimant's statement of services, as well as 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 on the compensability issues is $700, 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 March 19, 1990 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $700, to be paid by Liberty Northwest.

August 20, 1991 Cite as 43 Van Natta 1746 (1991)

In the Matter of the Compensation of
ROBERT G. VANDOLAH, Claimant
And, In the Matter of the Complying Status of
FRED G. OVCHINNIKOFF, dba Fairgrounds-Mobile
And, In the Matter of the Assessment of a Civil Penalty
FRED G. OVCHINNIKOFF, dba Fairgrounds-Mobile
WCB Case Nos. 89-13886, 89-24774, 89-16814 & 89-16815
ORDER ON REVIEW
Max Rae, Claimant Attorney
Robert J. Thorbeck, Attorney
Roberts, et al., Defense Attorneys
Lester Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Westerband and Crider.

The noncomplying employer requests review of those portions of Referee Myzak's order which: (1) dismissed his request for hearing concerning his noncomplying status on the basis that it was untimely; and (2) dismissed his request for hearing concerning the assessment of civil penalties on the basis that

it was untimely. Claimant cross-requests review of that portion of the Referee's order which declined to assess a penalty or related attorney fee for an allegedly unreasonable denial issued by the SAIF Corporation on behalf of the noncomplying employer. On review, the issues are jurisdiction and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

The Department investigator did not interview Mr. Kirkpatrick prior to the issuance of SAIF's July 19, 1989 denial. At the time of SAIF's denial, the only medical evidence in its possession concerning the June 1989 incident was an 827 form from Dr. McFie. The 827 form from Dr. McFie stated that claimant's need for treatment stemmed from "Overexertion on job 6-6-89 aggravation pre-existing injuries of 8/88 which occurred during a fall." (Ex. 28).

CONCLUSIONS OF LAW AND OPINION

Timeliness

We adopt the conclusions and reasoning concerning the timeliness of the noncomplying employer's request for hearing as set forth in the Referee's order.

Penalties and Attorney Fees

The Referee found that SAIF's denial of July 19, 1989 was reasonable and declined to assess a penalty or related attorney fee. We disagree.

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). If a carrier, after reviewing the evidence, had a legitimate doubt as to its liability, its conduct is not unreasonable. Price v. SAIF, 73 Or App 123, 126 (1985); Norgard v. Rawlinsons, 30 Or App 999, 1003 (1977). The reasonableness of a carrier's action must be gauged on the basis of the information available to it at the time of its action. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988).

The Referee found SAIF's denial reasonable based on statements made by Mr. Kirkpatrick and claimant's history of prior back problems. However, Mr. Kirkpatrick's statement was taken in August 1989, approximately two weeks after SAIF issued its denial. Therefore, Mr. Kirkpatrick's statement was not available at the time SAIF issued its denial. Moreover, although claimant did have a history of prior back problems, the only medical evidence concerning the June 6, 1989 incident came from Dr. McFie who indicated that the incident was related to claimant's low back condition and need for medical treatment.

Under these circumstances, we conclude that at the time of the June 6, 1989 denial, SAIF did not have a legitimate doubt as to the compensability of claimant's claim. Accordingly, we find SAIF's denial unreasonable and assess 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 concerning the unreasonable denial is $500, to be paid by the SAIF Corporation. 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.

Attorney Fees/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 timeliness of the request for hearing regarding non-compliance issue is $500, to be paid by SAIF on behalf of the noncomplying employer. 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 issues, and the value of the interest involved.

ORDER

The Referee's order dated June 29, 1990 is reversed in part and affirmed in part. That portion which declined to assess a penalty and attorney fee for SAIF's unreasonable denial is reversed. Claimant is awarded a penalty equal to 25 percent of all compensation owing at the time of hearing, payable by the SAIF Corporation. Claimant's counsel is awarded an assessed attorney fee of $500 for services regarding the unreasonable denial issue, payable by the SAIF Corporation. The remainder of the order is affirmed. For services on review concerning the timeliness issue, claimant's counsel is awarded an assessed attorney fee of $500, payable by the SAIF Corporation on behalf of the noncomplying employer.

In the Matter of the Compensation of
PETE ALANIS, Claimant
WCB Case No. 90-10819
ORDER ON REVIEW
Carney, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Crider and Westerband.

Claimant requests review of that portion of Referee Neal's order which declined to award an assessed attorney fee for services concerning the insurer's rescission prior to hearing of its denial of claimant's left inguinal strain condition. On review, the issue is entitlement to attorney fees and amount of attorney fees. We reverse.

FINDINGS OF FACT

We adopt the "FINDINGS OF FACT" numbered 1) through 4) as set forth in the Referee's order.

FINDINGS OF ULTIMATE FACT

We adopt the "FINDINGS OF FACT" numbered 5) as set forth in the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Attorney Fees/Rescinded Denial

The Referee, relying on Duane L. Jones, 42 Van Natta 875 (1990), concluded that no attorney fee was available if a compensability denial is rescinded prior to hearing. However, since the Referee's order, the legislature has effectively overruled Jones by amending ORS 656.386(1) to allow an attorney fee if an attorney is instrumental in obtaining compensation, even though a

hearing is not held. See ORS 656.386(1) (amended June 19, 1991, Senate Bill 540-A Engrossed). The amendments apply to all claims for which an order relating to the issue on which attorney fees are sought has not become final on or before the effective date of this 1991 Act, regardless of the date of injury. See Section 3, Senate Bill 540. The Act took effect on its passage. Section 4, Senate Bill 540.

Here, since this matter has not become final, the amendments to ORS 656.386 apply. Therefore, since the parties stipulated that the efforts of claimant's attorney were instrumental in the insurer's decision to rescind the denial and accept claimant's claim, we conclude that claimant is entitled to an insurer-paid attorney fee under revised ORS 656.386(1).

After considering the factors set forth in OAR 438-15-010(4) and in view of the parties' stipulations as documented by the Referee's order, we conclude that a reasonable attorney fee concerning the rescission of the insurer's denial is $1,000, 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), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 13, 1990, as amended December 26, 1990 is reversed in part and affirmed in part. Claimant's attorney is awarded $1,000 for services regarding the insurer's recission of its denial, to be paid by the insurer. The remainder of the order is affirmed.

August 21, 1991 Cite as 43 Van Natta 1749 (1991)

In the Matter of the Compensation of
MONA L. ALLISON, Claimant
WCB Case No. 90-09628
ORDER ON REVIEW
Ronald A. Fontana, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

The insurer requests review of Referee Peterson's order which: (1) awarded temporary disability benefits; (2) assessed a penalty for unreasonable failure to pay time loss benefits; and (3) awarded an assessed attorney fee. On review, the issues are temporary disability benefits and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Temporary Disability Benefits

The Board adopts the Referee's opinion with respect to this issue.

Penalties and Attorney Fees

The Referee awarded a carrier-paid attorney fee of $3,000. The only apparent basis for an assessed fee is pursuant to ORS 656.386(1). However,

here, claimant did not finally prevail in a "rejected case." Instead, the Referee awarded increased temporary disability benefits. Accordingly, an attorney fee is appropriate under ORS 656.386(2) and OAR 438-15-045, and claimant's attorney is awarded an approved fee of 25 percent of the increased compensation made payable by the Referee's order. Additionally, pursuant to ORS 656.262(10)(a), the Referee assessed a penalty for unreasonable resistance to the payment of compensation of 25 percent of all temporary disability benefits made payable by his order. Pursuant to the applicable version of this statute, See Ida M. Walker, 43 Van Natta 1402 (1991), claimant's attorney is entitled to one-half of the penalty assessed by the Referee's order, in lieu of an attorney fee. Claimant shall receive the remainder of the penalty. See Harry E. Forrester, 43 Van Natta 1480 (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 temporary disability issue, is $800, 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 brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for defending against the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated January 4, 1991 is reversed in part and affirmed in part. That portion of the Referee's order which awarded a $3,000 assessed attorney fee is reversed. In lieu of that attorney fee, claimant's attorney is awarded an approved attorney fee of 25 percent of all benefits made payable by the Referee's order, in an amount not to exceed $1,050, payable directly to claimant's attorney. In lieu of a penalty-related attorney fee, claimant's attorney is awarded one-half of the penalty assessed by the Referee's order for an unreasonable resistance to the payment of compensation. For services on Board review concerning the issue of temporary disability benefits, claimant's attorney is awarded a reasonable assessed fee of $800, payable directly to claimant's attorney by the insurer.

In the Matter of the Compensation of
VASILE CHIRICEA, (Deceased), Claimant
WCB Case Nos. 90-19519 & 89-18748
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

The insurer requests review of that portion of Referee Menashe's order that directed it to pay claimant's July 6, 1990 Determination Order award of scheduled permanent disability, and the Referee's increased award of scheduled permanent disability, at the rate of $305 per degree. Claimant cross-requests review of that portion of the Referee's order that did not direct that claimant's April 19, 1989 Determination Order award of scheduled permanent disability be paid at the rate of $305 per degree. On review, the issue is rate of scheduled permanent disability. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable left thumb injury on October 16, 1987. The claim was closed by an April 19, 1989 Determination Order, which awarded claimant scheduled permanent disability of 63 percent loss of the left thumb, 10 percent loss of the left index finger, 10 percent loss of the left middle finger, 5 percent loss of the left ring finger, and 5 percent loss of the left little finger. In terms of degrees, claimant's award totalled 35.64 degrees.

Claimant sustained a second compensable injury on October 20, 1988. This injury involved claimant's left middle, ring and small fingers. The claim was closed by a July 6, 1990 Determination Order, which awarded claimant 52 percent scheduled permanent disability for loss of the left forearm. In terms of degrees, this award totalled 78 degrees.

Claimant requested hearings challenging the extent of his permanent disability as awarded by the two Determination Orders. Those hearing requests were ultimately consolidated for purposes of a single hearing before Referee Menashe. Following hearing, Referee Menashe increased claimant's total scheduled permanent disability award by 27.36 degrees by order dated January 7, 1991. This award represented an increase from both the April 19, 1989 Determination Order and the July 6, 1990 Determination Order.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's July 6, 1990 Determination Order award of 78 degrees permanent disability, as well as the Referee's increased award of 27.36 degrees of permanent disability, should be paid at the rate of $305 per degree. We agree.

In Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), we held that the 1990 Oregon Laws, Chapter 2, section 7 amendment to ORS 656.214(2), which increased the value per degree of scheduled permanent disability from $145 to $305, applied to all awards of scheduled disability made on or after May 7, 1990, regardless of the date of injury.

Accordingly, because the July 6, 1990 Determination Order award of scheduled permanent disability, and the Referee's increased award of permanent disability, were made after May 7, 1990, the Referee correctly concluded that the awards should be paid at the rate of $305 per degree.

The Referee expressly limited his conclusion regarding payment at $305 per degree to the July 6, 1990 Determination Order and the Referee's own increased award. Claimant contends that all of his awards should be paid at the rate of $305 per degree. Presumably, claimant is asserting that the award made by the April 19, 1989 Determination Order should also be paid at the rate of $305 degrees. We do not agree. That award was made prior to May 7, 1990, and, therefore, is not subject to the 1990 amendment to ORS 656.214(2). Herron, supra.

Claimant did not file a brief on review. Accordingly, we do not award claimant an assessed attorney fee for successfully defending against the insurer's request for review concerning the rate of disability issue. ORS 656.382(2); Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated January 7, 1991 is affirmed.

In the Matter of the Compensation of
JOAN A. HADDIX, Claimant
WCB Case No. 90-08712
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Neidig and Crider.

Claimant requests review of Referee Thye's order which: (1) upheld the self-insured employer's denial of claimant's claim for gastritis and enterocolitis; and (2) affirmed a Determination Order which awarded no unscheduled permanent disability for claimant's psychological condition. On review, the issues are compensability and extent of disability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

Claimant has 5 percent impairment due to her psychological condition.

CONCLUSIONS OF LAW AND OPINION

Compensability of Gastritis and Enterocolitis

The Board adopts the Referee's "Conclusions and Opinion" with regard to this issue.

Extent of Unscheduled Permanent Disability

Claimant's compensable condition was medically stationary after January 1, 1988 but before July 1, 1990. The claim was closed by Determination Order dated April 3, 1990. Therefore, we rate permanent disability under the standards in effect at the time of claim closure. Former OR 438-10-010. The applicable standards are those effective January 1, 1989. (WCD Admin. Order 6-1988).

The parties have stipulated that claimant's age has a value of 1, education a value 0, training a value of 1, skills a value of 3, and adaptability a value of 1.

Claimant's treating psychologist, Dr. Myers, has diagnosed claimant as having a Class I permanent psychoneurosis which may need periodic treatment as symptoms wax and wane. He also stated that it was his judgment that she had a permanent state of psychoneurosis with a minimal impairment of 0 to 5 percent, although he was not specific as to the impairment. (Ex. 39). Because the treating psychologist has stated that claimant does have permanent impairment and because he anticipates waxing and waning that will require treatment, we conclude that claimant has a 5 percent impairment due to her psychological condition. Former OAR 436-35-400(3)(c)(A). See also John H. Bement, 42 Van Natta 2335 (1990).

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, 5, the result is 10 percent unscheduled permanent partial disability. Former OAR 436-35-280(7).

ORDER

The Referee's order dated November 27, 1990 is reversed in part and affirmed in part. That portion of the order which affirmed an Determination Order awarding no unscheduled permanent disability is reversed. Claimant is awarded 10 percent (32 degrees) unscheduled permanent disability for a psychological condition. Claimant's attorney is awarded an approved attorney fee of 25 percent of the increased compensation awarded by this order, payable directly to claimant's attorney, not to exceed $3,800. The remainder of the order is affirmed.

August 21, 1991 Cite as 43 Van Natta 1753 (1991)

In the Matter of the Compensation of
JACK H. GLUBRECHT, Claimant
WCB Case No. MS-91001
ORDER OF DISMISSAL
Bennett & Durham, Claimant Attorneys
Rick Dawson (Saif), Defense Attorney

The SAIF Corporation requests Board review pursuant to ORS 656.327(1)(b) of a Director's "order." Contending that the Director refused to take action on a matter referred to him under ORS 656.327, SAIF asks that this case be returned to the Director for the issuance of a reviewable order. We dismiss the request for Board review.

FINDINGS OF FACT

On September 19, 1990, the Workers' Compensation Division (Medical Review and Abuse Section) of the Department of Insurance and Finance (hereafter referred to as "MRAS") received a petition from SAIF. The petition was entitled "Request for Order Declaring Home Remodel Request Noncompensable under ORS 656.245 and 656.327. Fee Dispute Pursuant to ORS 656.248."

Asserting that claimant was seeking in excess of $21,000 in home remodeling reimbursement for construction services and materials to improve his residence under ORS 656.245, SAIF asked that the Director render the following alternative decisions: (1) declare the requested services not to be included within the coverage of ORS 656.245; (2) declare the services noncompensable under ORS 656.327; or (3) determine the amount, if any, of reimbursement under ORS 656.248.

On October 18, 1990, MRAS, on behalf of the Director, acknowledged SAIF's petition. In addition, claimant was requested to submit a response to SAIF's petition within 10 days of the acknowledgment letter.

On October 25, 1990, through his attorney, claimant responded to SAIF's petition by enclosing copies of a hearing request filed with the Hearings Division of the Workers' Compensation Board. Noting that the hearing request raised as an issue SAIF's "de facto" denial of the compensability of claimant's home remodeling reimbursement claim, claimant moved for dismissal of SAIF's petition to the Director for lack of jurisdiction. Alternatively, claimant requested the opportunity to actively participate in the review process by submitting "testimony, oral argument, depositions, affidavits and other applicable documentation."

On November 19, 1990, SAIF filed a motion for dismissal of claimant's hearing request with the Hearings Division of the Board. Contending that the Director had assumed jurisdiction over the home remodeling reimbursement issue

by acknowledging its petition for relief, SAIF argued that the hearing request should be dismissed until the administrative remedies were exhausted.

On November 20, 1990, MRAS directed a letter to the Presiding Referee for the Workers' Compensation Board, Hearings Division. Reasoning that the dispute presently at issue was a "matter concerning a claim" and should be resolved by the Board's Hearings Division, MRAS' letter concluded that the Director lacked jurisdiction to resolve the dispute pursuant to ORS 656.704 and 656.327. Consequently, by the letter, MRAS notified the parties, Hearings Division and the Board that further action on SAIF's petition would be deferred pending the outcome of the hearing before the Hearings Division.

On November 30, 1990, SAIF directed a letter to MRAS. Noting that claimant had not submitted any additional information in response to MRAS' acknowledgment letter, SAIF requested guidance on when it could expect a Director's order.

On December 10, 1990, Referee McCullough denied SAIF's motion to dismiss claimant's hearing request. Reasoning that the home remodeling reimbursement dispute did not constitute "medical treatment that is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services", Referee McCullough concluded that ORS 656.327 was not designed to address the parties' dispute. Determining that no procedure for resolving the dispute was otherwise provided in Chapter 656, the Referee held that the Hearings Division had jurisdiction to consider the matter. See ORS 656.704(3).

On December 17, 1990, SAIF responded to MRAS' November 20, 1990 "deferral" letter. Arguing that the Director was without authority to "defer" further action on its petition, SAIF requested that the Director issue an appealable order. On January 22, 1991, SAIF renewed its request for the issuance of a final, appealable order.

On February 12, 1991, MRAS replied to SAIF's requests. Reasoning that the issues involved in the current dispute did not qualify for review under ORS 656.327, MRAS responded that it did not intend to issue either a "Bona Fide Dispute" or a "No Bona Fide Dispute" order. Reminding SAIF of Referee McCullough's order finding that the Board's Hearings Division had jurisdiction over the dispute, MRAS expressed its desire that the matter could be satisfactorily resolved in that forum.

On February 27, 1991, SAIF requested Board review under ORS 656.327 of the Director's February 12, 1991 "order." The request included a certificate of service by mail stating that copies had been directed to claimant and the Director. On March 6, 1991, the Board acknowledged the request for review, mailing copies of its acknowledgment to claimant, claimant's attorney, SAIF's attorney and MRAS and its attorney.

CONCLUSIONS OF LAW

To begin, claimant seeks dismissal of SAIF's request for review, contending that SAIF untimely appealed the Director's "order" of November 20, 1990. We disagree.

The "order" to which claimant is referring was a letter from MRAS to the Presiding Referee of the Hearings Division stating that the Director was deferring action on SAIF's petition. The letter was not addressed to SAIF and to claimant, although each received a copy. Moreover, the letter did not reach a final decision concerning SAIF's petition. Instead, the letter merely announced the Director's intention to defer further action pending completion of the

forthcoming hearing. Under such circumstances, we do not consider the November 20, 1990 letter to constitute an "order" pursuant to ORS 656.327(1)(b).

Claimant also moves for dismissal, contending that SAIF's request for review was defective in that it did not send a copy of its request to claimant's attorney. OAR 438-16-005(2) provides that copies of a request for Board review of a Director's order finding no bona fide medical services dispute exists should be mailed to the Director, all parties, and to their attorneys. Although the Board's rule strongly encourages service, the rule is drafted in exhortatory terms ("should"), not mandatory terms ("shall"). Therefore, SAIF's failure to serve claimant's counsel does not warrant dismissal of its request.

Notwithstanding these conclusions, we hold that we lack authority to consider this matter because the February 12, 1991 letter does not constitute an order finding that "no bona fide medical services dispute exists." See ORS 656.327(1)(b). We base our decision on the following reasoning.

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 the director, the injured worker, insurer, or self-insured employer shall so notify the parties and the director. ORS 656.327(1)(a). Unless the director issues an order finding that no bona fide medical services dispute exists, the director shall review the matter pursuant to ORS 656.327(2). See ORS 656.327(1)(b).

The appeal of an order finding that no bona fide medical services dispute exists shall be made directly to the board within 30 days after issuance of the order. Id. The board shall set aside or remand the order only if the board finds that the order is not supported by substantial evidence in the record. Id.

The Director has adopted the following rules regarding administrative review of Director actions. If the worker, insurer, or medical provider is aggrieved by an order of the director that no bona fide dispute exists, they may appeal the order directly to the Workers' Compensation Board within 30 days of the order. OAR 436-10-008(3). Any party aggrieved by an action taken by the director which does not involve orders concerning a palliative care dispute, bona fide dispute or no bona fide dispute order, may seek administrative review through the administrator or the administrator's designee. OAR 436-10-008(4). Such a review may result in a contested case hearing before the director or the director's designee. OAR 436-10-008(4)(b); 436-10-008(5).

Here, the Director has not issued an order finding that "no bona fide medical services dispute exists." See ORS 656.327(1)(b). Rather, the Director, through MRAS, has concluded that jurisdiction does not rest with the Director under ORS 656.327, relying upon the reasoning set forth in Referee McCullough's order finding that the appropriate forum for resolution of the dispute concerning claimant's reimbursement claim for home remodeling expenses is the Hearings Division.

SAIF objects to the Director's so-called "abdication" of authority, contending that the refusal to act constitutes a final order finding "no bona fide medical services dispute exists" under ORS 656.327(1)(b). Furthermore, asserting that the Director's "order" is not supported by substantial evidence, SAIF seeks remand to the Director for the issuance of a reviewable final order explaining the reasoning for the Director's decision.

As support for its position, SAIF relies upon the Supreme Court's reasoning in Forelaws on Board v. Energy Fac. Siting Council, 303 Or 541 (1987). In

Forelaws, the Siting Council had determined, following a contested case proceeding, that it lacked jurisdiction over an application because the level of radioactivity at the waste sites in question was such that the applicant did not need a permit. In response to the petitioners' petition for direct Supreme Court review under ORS 469.400(1) of a council's approval or rejection of an application for a site certificate, the Council contended that its order was neither an "approval" nor a "rejection" of the application because the Council had determined that it lacked jurisdiction. Consequently, the Council asserted that judicial review remained in the Court of Appeals under ORS 183.482, not the Supreme Court under the special provisions of ORS 469.400(1). The Supreme Court disagreed, reasoning that the Council's decision, which rested on a conclusion about facts disputed on the merits, was no less a "rejection of an application" in the words of ORS 469.400(1) because the Council had concluded that the application was not within its jurisdiction. Accordingly, the Court held that the petition for direct review under the statute of the Council's determination was properly before it.

The present case is readily distinguishable. In Forelaws, regardless of whether the application to the Siting Council was accepted or rejected, appellate jurisdiction rested with the Supreme Court. Here, our statutory authority to review the Director's decision is expressly contingent upon the issuance of an "order finding no bona fide medical services dispute exists." See ORS 656.327(1)(b).

Thus, whereas in Forelaws, the rejection of the site certificate application for lack of jurisdiction was clearly a "rejection" vesting jurisdiction in the Supreme Court, here the Director declined to act on SAIF's petition by issuing an order in the case under ORS 652.327 that would vest appellate jurisdiction in this Board. Indeed, the Director specifically expresses the intention not to issue such an order. In the absence of an order "finding no bona fide medical services dispute exists", the Board is without authority to review a Director's decision under ORS 656.327.

The Director's apparent refusal to comply with the review procedures of ORS 656.327(1)(b) may be grounds under ORS Chapter 34.105 et. seq., for issuance by a current court of a writ of mandamus which compels the Director to act, or to that same end, it may constitute a basis for circuit court review under ORS 183.484 and 183.490. However, the jurisdiction of this Board under ORS 656.327(1)(b) is dependent upon an act that the Director expressly refuses to take. That refusal to issue an order "finding no bona fide medical services dispute exists" does not satisfy the statute's requirement for our jurisdiction that such an order be issued. In short, we decline to treat the Director's refusal to issue an order as the order that the Director has refused to issue. The request for review must be dismissed.

IT IS SO ORDERED.

Board Chair Crider, dissenting

The Board has dismissed the SAIF Corporation's appeal of the Director's order which declined to review a dispute concerning the compensability of certain home remodel expenses on the ground that ORS 656.327 does not confer jurisdiction over the dispute. The Board has dismissed the appeal solely because the Director has not styled its order an order that no bona fide medical services dispute exists. I dissent.

ORS 656.327 clearly provides that if an insurer requests review by the Director, the Director shall do one of two things. He shall issue an order that no bona fide medical services dispute exists or he shall review the medical treatment in question and issue an order within 30 days of the request declaring the

treatment compensable or not compensable. If the Director actually reviews the dispute and finds the disputed services compensable or not compensable, an aggrieved party may obtain review via a request for hearing before the Hearings Division. If, on the other hand, the Director declines to review the dispute on the merits and issues an order finding that no medical services dispute exists, then an aggrieved party may appeal that decision to the Board itself; if the Board finds that there is a bona fide medical services dispute, then the board may remand the matter to the Director for further proceedings.

The Board recognizes that the Director must issue one of these two types of orders in each and every case brought to him under ORS 656.327. Nevertheless, it holds that because the Director issued an order declining jurisdiction over this dispute and did not call it an order finding that no bona fide medical dispute exists, then the order is reviewable under the Administrative Procedure Act rather than in the fashion established by the Legislature. I submit that a Director's order, declining to review on the merits because the procedure created by ORS 656.327 is not the appropriate avenue for resolving a dispute, is an order finding that no bona fide medical services dispute exists--whatever the Director calls it. Indeed, it is difficult to imagine any other kind of holding by the Director that would warrant issuance of an order that no bona fide medical services dispute exists.

The Legislature has established a scheme for review of the Director's decisions under ORS 656.327. It provides for review of orders on the merits by referees and review of orders declining to reach the merits by the Board. Read together with the balance of Chapter 656, it ensures that disputes over entitlement to workers compensation benefits shall continue to be reviewable by the Board and its Hearings Division. The Board's decision herein allows the Director to circumvent the statutory review procedure simply by refusing to use the statutory terminology and adopting a rule providing for appeal of orders not using the statutory terminology via a contested case procedure under the Administrative Procedure Act.

SAIF correctly requests that we take the Director's order for what it is in reality, and review it.

On review of the order, I would conclude that the Director correctly concluded that he did not have jurisdiction of the dispute over remodelling expenses. ORS 656.327 permits an insurer to seek review by the Director if the insurer "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..." The term "medical treatment" is nowhere defined in ORS Chapter 656 or the administrative rules promulgated thereunder. However, intrinsic and extrinsic indicia of legislative intent suggest that the Legislature meant the term to apply to services performed by practitioners of the healing arts and not to all "medical services" as defined in ORS 656.245(1).

"Medical services" include "medical, surgical, hospital, nursing, ambulances and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services." ORS 656.245(1)(c). In addition to the things specifically enumerated in the statute, services include such things as transportation costs related to doctor visits (see Francoeur v. SAIF, 17 Or App 37 (1974)) and removal of architectural barriers (see Stoddard v. Credit-Thrift Corp., 103 Or App 283 (1990)).

The term "medical treatment" is narrower. "Treatment" is defined as "The management and care of a patient for purpose of combatting disease or disorder." Dorland's Medical Dictionary (23rd ed.) The ability to "treat" is the essence of licensure in the healing arts. See e.g., ORS 677.285; ORS 677.755; ORS 678.010; ORS 659.025; ORS 684.010; ORS 675.010.

ORS 656.327 provides that review of treatment by the Director shall involve review of "medical information and records regarding treatment" and may involve review of medical treatment by a panel of physicians, which shall include at least one "practitioner of the healing art whose treatment is being reviewed".

Therefore, I conclude that ORS 656.327 was designed to provide for review by the Director to determine whether treatment which is being provided by a practitioner of the healing arts is excessive or otherwise inappropriate upon request. It was not designed to provide for review by the Director to determine whether an insurer is required, under ORS 656.245, to afford a worker other medical services.

SAIF has requested a Director's determination on the compensability of a worker's request for reimbursement of remodelling costs. The remodelling costs may or may not be compensable as medical services. They clearly are not treatment by a practitioner of the healing arts.

Consequently, substantial evidence exists to support the Director's finding that SAIF has raised no question of treatment which is allegedly excessive, inappropriate, ineffective or in violation of rules regarding the performance of medical services. Hence, no bona fide medical services dispute exists. Under such circumstances, we are not authorized to set aside or remand the Director's order. ORS 656.327(1)(b). The Director's order should be affirmed.

August 21, 1991 Cite as 43 Van Natta 1758 (1991)

In the Matter of the Compensation of
MICHAEL D. THOMAS, Claimant
WCB Case No. 90-08324
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Neidig and Crider.

The SAIF Corporation requests review of Referee Baker's order that granted claimant permanent total disability, whereas a Determination Order awarded claimant 48 percent (153.6 degrees) unscheduled permanent disability for his low back injury. On review, the issue is permanent total disability, and alternatively, extent of unscheduled and scheduled permanent disability. We reverse the award of permanent total disability and modify the extent of claimant's permanent partial disability.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact, with the exception of the Referee's finding that claimant cannot sell his services in a hypothetically normal labor market. We add the following supplementation.

Claimant has a high school degree and has taken a one-year advanced business management course. He has work experience as a millworker and as a motel manager. Claimant's highest SVP for the ten years prior to hearing was a 7 as a tennoner.

As a result of his compensable injury, claimant has undergone laminectomies and discectomies at the L4-5 and L5-S1 levels. Claimant has had fusions at the same levels. Claimant has loss of range of motion in the thoracolumbar region, as a result of his compensable back injury.

Claimant suffers from a chronic condition limiting repetitive use of his left leg.

CONCLUSIONS OF LAW AND OPINION

Permanent total disability

The Referee concluded that claimant had established that he is permanently and totally disabled. We disagree.

On review, SAIF argues that claimant is not permanently and totally disabled, based solely upon the medical evidence in the record. SAIF agrees with the Referee's assessment of claimant's physical capabilities with the exception of his finding that, on occasion, claimant needs to recline during the day. SAIF contends that this limitation is self-imposed and is not supported by the medical evidence. SAIF argues that Exhibit 42 (a questionnaire submitted to Dr. Kendrick) indicates that claimant does not need to recline during the day.

We do not agree that Dr. Kendrick has stated that there is no need for claimant to recline during a work day. Dr. Kendrick was asked whether, "after sitting the stated maximum of 40 minutes, is a mere change of position (e.g., standing) sufficient or may some form of rest (e.g., lying down) be required, at least on occasions and/or toward the end of an eight-hour work day?" Dr. Kendrick responded, "maybe - a change of position I would expect to be sufficient" (emphasis in original).

We conclude that claimant's testimony and the report of his treating physician are not inconsistent. Both indicate that claimant may be required to rest or recline during a regular work day. Accordingly, we agree that, in assessing claimant's work restrictions, the Referee could assign weight to the evidence regarding claimant's need to rest during the day.

Although claimant argues that he is severely disabled as a result of his surgeries, we agree with SAIF that claimant is not totally physically incapacitated. In March 1989, Dr. Kendrick reported that, given the amount of surgery claimant had undergone (and following additional recovery time) motel management would be the type of position that claimant might reasonably be expected to occupy. In August 1989, Dr. Kendrick signed a release for claimant to return to hotel management "without doing the maintenance work." Based upon the reports of claimant's treating doctor, we conclude that claimant has not established that he is permanently totally disabled solely upon a medical basis.

Permanent total disability, however, 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).

SAIF also contends that claimant is not permanently totally disabled under the odd-lot doctrine. SAIF notes that claimant has a high school diploma and has taken post-high school vocational training, a course in business management and a six week training seminar on supervisory skills.

Claimant's vocational counselor, Mr. Stones, testified that, even taking claimant's restrictions into account (including his testimony regarding a need to recline during the work day), there were jobs that claimant was capable of performing. Mr. Stones testified that claimant was both qualified and physically capable of performing work in motel management, night auditing, cashiering and unskilled assembly work. Although he acknowledged that the job of night

auditor would pay less wages than the motel management jobs claimant had been seeking, Mr. Stones testified that such positions did exist in the motel/hotel industry.

One of SAIF's vocational experts, Ms. Zuckerman, testified that, taking into account claimant's testimony regarding his limitations, she would question his capability (in regard to stamina) to work an eight-hour shift as a hotel or motel manager. However, she believed that claimant was capable of part-time employment and she testified that he would be qualified for positions such as night auditor, desk clerk, general clerk and collections clerk. She testified that there were such jobs available throughout the state of Oregon, although she could not identify specific employers.

Mr. Ridenour, SAIF's second vocational expert, testified that claimant could work as a motel manager, night auditor or night desk clerk. He agreed with Ms. Zuckerman's testimony that claimant would be capable of working on a part-time basis. He also testified that there were jobs available within the state labor market.

It is apparent that many motel management jobs will not be available to claimant because they require maintenance work also. Nevertheless, the expert evidence establishes that there are jobs - management and others - available in the lodging industry which claimant is capable of performing on a part-time basis. Although claimant may need to rest during the work day, the vocational testimony has established that there are part-time jobs that he is capable of performing. Inasmuch as claimant is capable of working on a part-time basis and such work is available, we must find that he is capable of remunerative, and therefore gainful, employment. See Tee v. Albertsons, Inc., 107 Or App 638 (1991).

Finally, although we acknowledge claimant's motivation, willingness to seek work and his unsuccessful attempts to obtain a position as a motel or restaurant manager, we conclude that the record establishes that, within his hypothetically normal labor market, there are jobs that claimant is physically and vocationally capable of performing. Accordingly, we conclude that claimant has not established that he is permanently totally disabled under the odd lot doctrine.

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). The "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. Accordingly, we apply the "standards" in effect on February 16, 1990, the date of the Determination Order.

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

Age

The appropriate value for claimant's age of 47 years is 1. Former OAR 436-35-290.

Formal education

The appropriate value for claimant's 12 years of formal education, including a high school diploma, 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 7 as a tennoner offbearer (DOT # 669.686-034). Therefore, the appropriate value for skills is 1. Former OAR 436-35-300(4).

Training

Claimant has acquired on-the-job training in various positions during his employment as a millworker, including experience as a tennoner operator and as a millwork and warehouse supervisor. In addition, claimant has several years of experience as a motel/hotel manager. We conclude that claimant has acquired sufficient experience and training to perform other than an entry-level position. Therefore, the appropriate training value is 0. Former OAR 436-35-300(5).

Adaptability

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

Claimant is unable to return to his usual and customary work and has not returned to, or been offered, regular, modified work since he became medically stationary (when permanent disability is rated). Claimant's physical capacity falls between the sedentary and light categories. Additionally, he is limited in his ability to sit, stand and walk. Thus, the appropriate adaptability value is the average of the values for the light (4), sedentary (8) and limited sedentary (10) categories. Claimant's adaptability value is 7.3. Former OAR 436-35-310(4).

Impairment

As a result of his compensable injury, claimant has loss of range of motion in the thoracolumbar region. For reduced thoracolumbar flexion (from 90 degrees to 10 degrees), claimant is entitled to an impairment value of 8 percent. Former OAR 436-35-360(6). For reduced thoracolumbar extension (from 30 degrees to 5 degrees), claimant is entitled to an impairment value of 2.5 percent. Former OAR 436-35-360(7). For reduced thoracolumbar flexion to both the right and left (from 30 degrees to 5 degrees), claimant is entitled to an impairment value of 5 percent each. Former OAR 436-35-360(8). For reduced right and left rotation (from 30 degrees to 15 degrees), claimant is entitled to

an impairment value of 3 percent each. Former OAR 436-35-360(9). For a total rating of the lost range of motion in the thoracolumbar area, the values are added. Former OAR 436-35-360(10). Claimant's total value for loss of motion is 26.5.

In addition to reduced spinal motion, claimant is entitled to a value for his surgeries and the resulting impairment. We find claimant is entitled to a value of 5 percent for a laminectomy and discectomy at the L4-5 level. Claimant is also entitled to a value of 5 percent for a laminectomy and discectomy at the L5-S1 level. For a fusion at the L4-5 level, claimant is entitled to a value of 3 percent. For a fusion at the L5-S1 level, claimant is entitled to a value of 5 percent. Former OAR 436-35-350(2). Claimant's general spinal findings are combined for a total of 16.8 percent. Former OAR 436-35-360(11).

To arrive at a total impairment finding, we combine (not add) the impairment value for claimant's lost range of motion (26.5) with the impairment value for his surgeries (16.8). The result of this combination is 38.87 percent. This value represents claimant's total impairment value.

Computation of unscheduled disability.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 1, is added to his education value, 1, the sum is 2. When that value is multiplied by claimant's adaptability value, 7.3, the product is 14.6. When that value is added to claimant's impairment value, 38.87 percent, the result is 53.47 percent 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, 54 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 sustained 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).

Here, claimant's treating doctor opined that claimant has a relatively severe permanent disability which limits his ability to perform work outside the very light to sedentary range. Dr. Kendrick recommended that if claimant were to seek employment as a motel/hotel manager, it should be limited to positions that did not require maintenance work. Claimant's vocational counselor indicated that a training program was not suggested for claimant because of his previously acquired skills in the motel industry. However, the counselor also reported that, because of his injury, the competition within the industry and a trend in hiring husbands and wives as team managers, claimant was having difficulty in obtaining such employment. Finally, claimant has credibly testified in regard to his need to occasionally rest during the day and his left leg "giveway". The vocational counselors have testified that such limitations would restrict him to part-time employment. This evidence is unrebutted.

Under the circumstances, we find it highly probable that claimant's loss of earning capacity exceeds the 54 percent unscheduled permanent disability allowed under the standards. We conclude that the evidence clearly and

convincingly demonstrates that claimant has suffered an 80 percent loss of earning capacity due to his compensable injury.

Extent of scheduled disability

Claimant argued at hearing that he was entitled to an award of scheduled permanent disability for loss of use or function of his left leg. We are unable to find evidence on the record of medically verified impairment of the left leg. Dr. Kendrick noted claimant's complaints of left leg pain and occasional "giveway", however, he reported on February 1990 that range of motion and muscle strength of the lower extremities was equal and symmetrical. Dr. Kendrick further noted that claimant's reflexes were "1+ bilaterally with the exception of the left knee jerk, which is trace". Straight leg raising was "positive bilaterally at 30 degrees for back and leg pain."

We conclude that claimant has not shown a decrease in the function of his left leg as measured by a physician. Accordingly, we conclude that claimant has not shown entitlement to an award of scheduled permanent impairment under the "standards", except to the extent that he suffers from a chronic condition limiting repetitive use of his leg. See former OAR 436-35-320(4). We accept the Referee's finding that claimant was a credible historian with respect to his limitation of repetitive use of his leg. Further, claimant's attending physician found him medically stationary with such limitations. Because the limitation in issue is not subject to measurement pursuant to AMA guidelines, we may make such an award without medical measurements. Claimant is entitled to 5 percent unscheduled permanent disability for loss of use of his left leg.

Finally, we do not find clear and convincing evidence that claimant sustained permanent loss of use or function of his left leg in excess of that calculated under the standards.

ORDER

The Referee's order dated January 2, 1991 is reversed. That portion of the Referee's order which granted permanent total disability is reversed. The Determination Order is reinstated and modified. In addition to the Determination Order award of 48 percent (153.6 degrees), claimant is awarded 32 percent (102.4 degrees), for a total award to date of 80 percent (256 degrees) unscheduled permanent disability. Claimant is also awarded 5 percent (7.5 degrees) scheduled permanent disability for the left leg. The Referee's attorney fee is modified. In lieu of the Referee's award, claimant's counsel is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's counsel by the SAIF Corporation. However, the total attorney fee award shall not exceed $3,800.

In the Matter of the Compensation of
TAMMI L. BRYANT, Claimant
WCB Case No. 90-09241
ORDER ON REVIEW (REMANDING)
Aller & Morrison, Claimant Attorneys
Darryl Nelson, Defense Attorney

Reviewed by Board Members Crider and Neidig.

Liberty Northwest Insurance Corporation (Liberty) requests review of Referee Brown's order that set aside its denial of claimant's bilateral shoulder and back condition. In its brief, Liberty contends that the Referee improperly denied its motion for joinder of the SAIF Corporation. Liberty also requests that this matter be remanded to the Referee for evidence on the issue of whether a hearing was convened before July 1, 1990. On review, the issues are remand, joinder and responsibility. We remand.

FINDINGS OF FACT

Claimant worked for Temporary Source (Liberty's insured) from December 7, 1989 through January 3, 1990. She began work for Creative Catering (SAIF's insured) on January 25, 1990.

On January 27, 1990, claimant filed an injury claim against Temporary Source for a shoulder injury sustained while working in a nursery as a tree grader. On a Form 827, claimant listed her date of injury as December 28, 1989. Dr. Russo, D.O., diagnosed thoracic and trapezius muscle strain.

On March 22, 1990, Liberty denied responsibility for claimant's bilateral shoulder and back problems. Liberty conceded that claimant's injury was compensable but stated that medical records indicated she did not seek treatment for her condition until she had begun her employment with Creative Catering. Liberty also stated, "By copy of this letter, we are informing all parties concerned and putting them on notice to process this claim under their Workers' Compensation coverage." Liberty's letter indicated that copies of the letter were sent to claimant, Creative Catering, SAIF and Compliance.

On April 30, 1990, claimant filed a request for hearing on Liberty's denial and a hearing was set for July 25, 1990.

On July 16, 1990, Liberty filed a motion to join SAIF as a party.

CONCLUSIONS OF LAW AND OPINION

The Referee denied Liberty's motion to join SAIF to the proceeding. He concluded that, because Liberty's motion was not filed until after July 1, 1990, the new law applied; he further held that joinder was barred due to claimant's failure to file a claim against SAIF's insured. We disagree.

As a preliminary matter, we address Liberty's argument that there is no evidence that the Referee attempted to determine if the statutory requirements for convening a hearing before July 1, 1990, were met. The notice of hearing provides that, pursuant to the April 30, 1990 request for hearing, the case was set for hearing on July 25, 1990. The Referee's opinion and order notes that the hearing convened and closed on July 25, 1990. We conclude that Liberty has not pointed to any evidence that the hearing was convened before July 1, 1990. We, therefore, find that no hearing was convened before July 1, 1990.

Liberty contends that it complied with the rules for joinder which were in effect at the time. Liberty notes that it filed a claim against SAIF (on behalf of claimant) but that SAIF did not respond to the claim. Liberty contends that SAIF's failure to respond allowed claimant an opportunity to file a request for hearing on a "de facto" denial and claimant's failure to either request a hearing or obtain consolidation of the claim resulted in SAIF not being joined in the proceeding. Liberty argues that claimant's inaction should not preclude it from pointing to potential contribution by her subsequent employment with SAIF's insured.

Claimant and SAIF contend that, because the hearing was held after July 1, 1990, the amendments to ORS Chapter 656, as enacted by Senate Bill 1197, are applicable. They argue that Liberty's July 11, 1990 Motion to Join was improper because, effective July 1, 1990, the new law provides that joinder can only be accomplished if the worker first files a claim with the insurer or employer to be joined. In this case, claimant did not file a claim with SAIF or its insured.

We conclude that, although a hearing was convened after July 1, 1990, and Liberty did not move for joinder until after that date, the new law does not apply in this case. Prior to enactment of SB 1197, the rules for joinder provided that an insurer with knowledge of a situation involving more than one potentially responsible insurer or employer was required to immediately notify other affected insurers and provide them with a copy of medical reports and other information. Former OAR 436-60-180(5). The rules further provided that such notice, received from another insurer, was notice of a claim as provided by ORS 656.265(3). Former OAR 436-60-180(6). See also former OAR 438-06-065(2).

The legislature significantly altered the rules for joinder through its enactment of SB 1197, passed during a special session on May 7, 1990. The new law pertaining to joinder provides that:

> "(2) No employer or insurer shall be joined in any workers' compensation proceeding unless the worker has first filed a timely written claim for benefits against that employer or insurer, or the employer or insurer has consented to the issuance of an order designating a paying agent under ORS 656.307. Any employer or insurer which intends to disclaim responsibility for a given injury or disease claim on the basis of an injury or exposure with another employer or insurer shall mail a written notice to the worker as to this position within 30 days of actual knowledge of being named or joined in this claim. The notice shall specify which employer or insurer the disclaiming party believes is responsible for the injury or disease. The worker shall have 60 days from the date of mailing of the notice to file a claim with such other employer or insurer. Any employer or insurer against whom a claim is filed may assert, as a defense, that the actual responsibility lies with another employer or insurer, regardless of whether or not the worker has filed a claim against that other employer or insurer, if that notice was given as provided in this subsection." (emphasis added) Or Laws 1990 (Special Session), ch 2 49.

We have recently concluded that the 1990 Act generally applies retroactively to existing claims, with the exception of those "saved" by litigation or provided for in other sections. Ida M. Walker, 43 Van Natta 1402 (1991). However, we noted that, because the parties governed by the workers' compensation law must conform their conduct to the law in effect at the time they act, it would be unfair to retroactively alter the rights and obligations of those who correctly relied upon the law in effect at the time of their actions. We concluded that the the legislature did not intend the provision of the new law to be applied retroactively when such construction would produce an absurd or unjust result and would clearly be inconsistent with the purposes and policies of the workers' compensation law. Walker, supra.

The new law provides that an insurer which intends to disclaim responsibility on the basis of an injury or exposure with another employer or insurer must mail a written notice to the worker within 30 days of knowledge of being named or joined in the claim. If the insurer properly disclaims responsibility, then it may defend on the basis of responsibility -- even if the second insurer is not joined in the proceeding. It further requires that the worker, having received the notice, must directly file a written claim for benefits. Only under those circumstances may the second insurer be joined.

In this case, claimant filed an injury claim against Liberty's insured on January 27, 1990. If the new law were applied retroactively, Liberty would have been required to mail written notice to the worker within 30 days of its knowledge of the claim or be precluded from asserting, as a defense, that responsibility lies with another employer or insurer. Here, a retroactive application of the statute would mean that the final day on which Liberty could have mailed written notice to claimant would have fallen before the May 7, 1990 effective date of the Act. In other words, Liberty would have been required to comply with a law that was not yet in existence and would have been penalized for its noncompliance by being precluded from arguing that another insurer was responsible for claimant's condition.

Under the circumstances, we conclude that retroactive application of the new law would be unreasonable and would result in prejudice to Liberty. Accordingly, we conclude that the new law does not apply.

The Referee expressly declined to consider Liberty's motion for joinder under the prior law. Under such circumstances, we deem it appropriate to remand this matter to Referee Brown to determine whether joinder was appropriate under the law in effect prior to July 1, 1990. If joinder is appropriate, the Referee shall conduct further proceedings consistent with this order in such manner as will achieve substantial justice.

ORDER

The Referee's order dated August 7, 1990 is vacated. The matter is remanded to Referee Brown for further proceedings consistent with this order.

In the Matter of the Compensation of
LLOYD L. CROCKETT, Claimant
WCB Case Nos. 90-05762 & 90-12356
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Crider.

The self-insured employer requests review of Referee Holtan's order that: (1) set aside its medical services denial of claimant's chiropractic care; and (2) awarded 35 percent (52.5 degrees) scheduled permanent disability for loss of use or function of the right forearm (hand), whereas a Determination Order awarded 8 percent (12 degrees) scheduled permanent disability. On review, the issues are medical services and extent of scheduled permanent disability. 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

Medical Services

At hearing, the Referee allowed the employer to amend its denial in order to remove language which the employer conceded was prospective. However, in his opinion and order, the Referee concluded that the employer should not be allowed to amend the denial at hearing without first rescinding the entire denial in writing before the date of hearing.

The employer argues that its ultimate denial was valid as it reflected a factual basis (lack of causation) that was appropriate under the law. The employer also contends that its amendment at hearing did not invalidate the denial, as amendments of issues are liberally permitted under OAR 438-06-031. The employer argues that, because there was no objection at hearing, the amended denial should have been allowed and then considered on its merits without the prospective language. We agree.

In Donna J. Wilson, 42 Van Natta 1026 (1990), we concluded that the Referee should have considered an amended denial on its merits as there was no objection or surprise asserted by claimant at hearing. We reasoned that, in such a case, claimant's remedy was to move for a continuance, rather than for the denial to be set aside. Donna J. Wilson, supra.

In the present case, claimant did not object to amendment of the denial. Additionally, he neither asserted surprise nor requested a continuance. See OAR 438-06-031. Accordingly, we conclude that amendment of the denial should have been permitted, and on review, we consider the denial as amended.

Without the prospective language, the denial states that the employer denies "current chiropractic care as not related to this claim or your employment.....". Under the circumstances, we conclude that the denial, as amended, is a permissible denial of current care. See Green Thumb, Inc. v. Basl, 106 Or App 98 (1991). We therefore proceed to address the merits of the employer's denial.

The employer contends that, under either the written denial (which issued February 16, 1990) or the "de facto" denial of two treatments received after the

date of the written denial, the Referee erred in ruling that the treatments were reasonable and necessary. The employer argues that there is no connection between claimant's work and his arthritis condition. The employer also contends that claimant has not shown that his chiropractic care is for his compensable strain condition, rather than his degenerative condition. We disagree.

Claimant was examined by Western Medical Consultants in December 1989. The Consultants diagnosed right shoulder strain superimposed upon preexisting arthritis. They found claimant to be medically stationary (in regard to his strain injury) and recommended no further care. The Consultants suggested that arthritis was more likely than not the major factor in the slow resolution of claimant's cervical symptoms. They believed that the most reasonable explanation for claimant's continuing symptoms was his strain superimposed upon some rather severe degenerative change.

Claimant's treating doctor, Dr. Clifford, initially agreed with the Consultants' report. However, he later retracted his concurrence and wrote that he disagreed that claimant had recovered without symptoms or findings. Dr. Clifford based his opinion upon his findings of significantly reduced range of motion and palpation findings. He recommended treatment on a "prn" basis.

Dr. Clifford also referred claimant to Dr. Lewis for a second opinion. Dr. Lewis reported that claimant seemed to be medically stationary relative to his strain injury. He wrote that claimant may be having some persistent symptoms from this (the strain) or they "may be from his degenerative cervical condition." Dr. Lewis recommended continuing palliative care on an infrequent basis. In a second report, Dr. Lewis wrote that he felt that most of claimant's symptoms were related to his cervical arthritis; however, he further stated that he did not mean to say that his work-related activities did not cause the areas to flare up.

Under the circumstances, we agree with the Referee's conclusion that claimant's then current need for treatments was reasonable and necessary. We base our conclusion upon the opinion of claimant's treating doctor, Dr. Clifford. We find his opinion to be persuasive and supported by his objective findings which he has related to claimant's compensable condition and current need for treatment. In addition, we adopt the Referee's opinion and conclusions regarding the effectiveness of claimant's treatments and the fact that claimant seeks care only on an "as needed" basis. We, therefore, affirm the Referee on the issue of medical services.

Attorney fees

The employer argues that its amendment of the written denial of chiropractic care should be reflected in the amount of attorney fees awarded to claimant. The employer contends that, to the extent that the inoperative portion of its written denial was rescinded before the hearing began, no fee should have been awarded.

We conclude that the employer's amendment of the prospective language of the denial does not affect the amount of attorney fees awarded to claimant's counsel for his efforts in setting aside the denial. Although the employer deleted a sentence from the denial, the denial itself remained in effect and claimant was required to defend his case on the merits. Under the circumstances, we conclude that the attorney fee awarded to claimant's counsel is reasonable and should not be modified. ORS 656.386(1); OAR 438-15-010(4).

Extent/scheduled disability

The Referee found that claimant was entitled to impairment values for loss of repetitive motion, lost range of motion and loss of grip strength in the right hand. The employer disagrees only with the Referee's assignment of an impairment value for claimant's loss of grip strength.

The employer argues that, under former OAR 436-35-110(3)(d), lost grip strength may not be rated unless it is attributed to either atrophy or other anatomical changes. Although the Referee determined that claimant's bone graft and fracture plate and pins constituted anatomical changes, the employer contends that none of Dr. Warren's reports relate claimant's loss of grip strength to either the graft or plates.

Claimant argues that he sustained a crush injury to his hand and the multiple disclocations and fractures created an anatomical change because of the graft and plate required to repair the fractures. Claimant testified that he has lost grip strength in his right hand following the injury and surgeries. This evidence is supported by Dr. Warren's July 1990 report which stated that claimant had approximately 50 percent loss of grip strength on the right. Dr. Warren also noted that claimant had no peripheral nerve injury and no paralysis or partial paralysis of the hand. However, he did not attribute claimant's loss of grip strength to atrophy or anatomical changes.

The "standards" require that decreased grip strength be attributable to atrophy or other anatomical changes before a value can be assigned. In this case, we are unable to find expert medical evidence that establishes that claimant's loss of grip strength is due to either atrophy or anatomical change. See Clark D. Griffith, 42 Van Natta 1112 (1990). We, therefore, reverse the Referee's award of 25 percent impairment value for loss of grip strength due to anatomical changes.

Nevertheless, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability sustained 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, the 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, Dr. Warren has reported claimant's loss of grip strength at approximately 50 percent. This evidence is unrebutted. Claimant testified that he had difficulty using tools at work. He is unable to make a fist with his hand and if pressure is put on his hand, he is unable to grip objects. Claimant testified that he often drops his tools now and he cannot use them as well as he could before the injury.

Under the circumstances, we find it highly probable that claimant's loss of use or function of the right hand exceeds the 13 percent allowed under the standards. Accordingly, we conclude that claimant has sustained 25 percent permanent loss of use or function of his right hand. Therefore, we modify the Referee's 35 percent award.

Claimant is entitled to an assessed attorney fee for successfully defending against the employer's request for review on the issue of medical services. 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 is $500, to be paid by the employer. In reaching this conclusion, we have particularly considered the complexity of the issue, 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 September 28, 1990 is modified in part and affirmed in part. In lieu of the Referee's increased award and in addition to the Determination Order award of 8 percent (12 degrees) scheduled permanent disability, claimant is awarded 17 percent (25.5 degrees), giving him a total of 25 percent (37.5 degrees) scheduled permanent disability for loss of use or function of his right forearm (hand). The remainder of the Referee's order is affirmed. Claimant's attorney is awarded a reasonable attorney fee of $500 for services on Board review, to be paid by the self-insured employer.

In the Matter of the Compensation of
MARK S. RANDOLPH, Claimant
WCB Case No. TP-91015
THIRD PARTY DISTRIBUTION ORDER
Stebbins & Coffey, Claimant Attorneys
William E. Brickey (Saif), Defense Attorney

The SAIF Corporation, as a paying agency, has petitioned the Board to resolve a conflict concerning a "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Contending that most of SAIF's claim costs for which it seeks reimbursement were not attributable to his February 6, 1989 compensable injury, claimant contests SAIF's entitlement to recover all of its $19,356.22 lien. We conclude that SAIF is entitled to recover $17,981.72 as its "just and proper" share of the third party settlement.

FINDINGS OF FACT

In February 1989, while performing his employment duties as a sanitation worker, claimant was involved in a motor vehicle accident when the sewer pump truck in which he was riding as a passenger collided with another vehicle which had skidded out of control on an icy road. As a result of the impact, the tank which was on the back of claimant's truck pushed forward, crushing the cab and pinning claimant.

Claimant's injury claim was accepted by SAIF, as the insurer for his employer. His initial complaints involved some pain, bruises, and contusions to the right knee, chest, and right shoulder. However, shortly after the accident, he began experiencing persistent low back and upper right back pain. Dr. Hill, claimant's family physician, noted that claimant had previously suffered a low back herniated disc for which he had received a chymopapain injection. Hill diagnosed lumbosacral strain and right back contusion secondary to the February 1989 motor vehicle accident.

Claimant had sustained another compensable low back injury in October 1984, while working for an earlier employer. SAIF had accepted and processed that claim on behalf of the earlier employer. As a result of that injury, Dr. Whitney, orthopedist, had performed a L4-5 chemonucleolysis in February 1985. Evaluating the results of the procedure as "excellent," Whitney had found claimant medically stationary in December 1985, with a mild restriction due to the loss of a disc.

A January 1986 Determination Order had closed the October 1984 injury claim with a 15 percent unscheduled permanent disability award. Thereafter, claimant had sought treatment from Dr. Whitney for periodic back complaints on three occasions (May 1986, March 1988, and April 1988).

In April 1989, claimant returned to Dr. Whitney, complaining of increasing low back and left leg symptoms since the February 1989 motor vehicle accident. A May 1989 MRI study demonstrated a "L4-5 left posterior lateral disc herniation, recurrent," which was "compatible with his symptoms." Whitney prescribed a back brace and physical therapy. Released from working, claimant pursued his physical therapy program and continued his treatments with Dr. Whitney. In September 1989, claimant returned to modified work as a utility person for the employer.

On October 20, 1989, at SAIF's request, the Western Medical Consultants performed an independent medical examination. Noting the MRI evidence of some derangement in the L4-5 level, the Consultants predicted that claimant might require future treatment. However, in light of claimant's successful return to work and his lack of specific treatment needs, they found him medically stationary. SAIF paid the Consultants' $729.50 bill for the examination and report.

On November 27, 1989, Dr. Whitney essentially agreed with the Consultants' report. However, he recommended that claimant limit his operation of heavy equipment to short hauls, rather than long hauls.

On December 28, 1989, SAIF submitted its request for a determination order. Acknowledging its acceptance of claimant's February 6, 1989 disabling injury claim, SAIF sought closure of the claim. The request listed $2,511.34 in medical costs and $6,864.01 in temporary disability benefits. No Determination Order was forthcoming.

In February 1990 claimant returned to Dr. Whitney, reporting that he had been "doing quite well" until a recent off-the-job slip and fall on some ice. Since the fall, claimant's low back and left leg pain had become nearly continuous. A MRI study revealed "very little change" since the May 1989 study. Releasing claimant from work, Whitney diagnosed a recurrent back injury with a previous L4-5 disc herniation and L3-4 mild stenosis. Thereafter, claimant continued to receive conservative treatment for his persistent back complaints from Dr. Whitney.

On April 23, 1990, with "some reservations," Dr. Whitney released claimant to return to work. This release proved to be short-lived, since claimant's complaints became severe on May 14, 1990, following a weekend tree-cutting excursion. Whitney again took claimant off work and prescribed a work-hardening program. On July 20, 1990, following the completion of the program, Dr. Whitney released claimant to his prior modified work.

On August 10, 1990, at SAIF's request, the Western Medical Consultants performed another independent medical examination. The Consultants diagnosed: (1) degenerative disc disease (L4-5), with an asymmetric bulge to the left and a history of intermittent left leg symptoms; and (2) status post 1985 chemonucleolysis. Assuming that the chemonucleolysis had been performed at the L4-5 level, the Consultants considered the February 1989 injury to have been a temporary exacerbation of claimant's underlying condition which had resolved without residuals. Furthermore, the Consultants attributed claimant's subsequent exacerbations to the underlying condition and not the February 1989 injury. SAIF paid the Consultants' $645 bill for the examination and report.

Dr. Whitney concurred with the Consultants' August 10, 1990 report. Although noting that claimant remained at risk for recurrent injuries, Whitney agreed that claimant's condition was medically stationary.

An October 15, 1990 Determination Order closed claimant's February 6, 1989 injury claim. Claimant was awarded, less time worked, temporary total disability from March 15, 1989 through October 8, 1989 and temporary partial disability from October 9, 1989 through July 23, 1990. Finding claimant's condition to be medically stationary on August 10, 1990, the Determination Order granted claimant 2 percent unscheduled permanent disability.

Claimant had engaged legal counsel to pursue a third party cause of action for negligence against the driver of the other vehicle involved in the February 1989 accident. On February 1, 1991, with SAIF's approval, claimant and the third party agreed to settle claimant's cause of action for $55,000.

Following disbursements for attorney fees and litigation costs ($18,371.33), a balance of $36,628.67 remains. When claimant's statutory 1/3 share is deducted ($12,209.56), the remaining balance becomes $24,419.11.

In processing claimant's accepted February 1989 injury claim, SAIF has incurred $19,356.22 in expenses. These costs are composed of the following items: (1) $11,462.15 in temporary disability benefits; (2) $640 in permanent disability benefits; and (3) $7,254.07 in medical bills. $1,374.50 of the medical bills are attributable to the October 1989 and August 1990 Western Medical Consultant exams / reports, which were conducted for claim evaluation purposes.

SAIF has asserted its entitlement to receive its entire $19,356.22 in actual claim costs for reimbursement from the remaining balance of proceeds from the third party settlement. Claimant has responded that SAIF is only entitled to recover $60, the amount of a February 1989 medical bill, which claimant contends is the only expenditure attributable to claimant's compensable February 1989 injury. Alternatively, claimant argues that SAIF is not entitled to receive reimbursement for its $1,374.50 in claim expenses resulting from the two independent medical examinations.

A distribution of the remaining balance of third party settlement proceeds in which SAIF receives reimbursement for $17,981.72 of its claim costs is "just and proper." Such a distribution represents the recovery of all SAIF's claim costs resulting from the accepted February 1989 injury claim, less the expenses attributable to the independent medical examinations.

CONCLUSIONS OF LAW

If the worker or beneficiaries settle 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). Finding no persuasive reason to depart from our general approach of distributing third party settlement proceeds in accordance with ORS 656.593(1), we proceed with our analysis.

Pursuant to ORS 656.593(1)(a), cost and attorney fees incurred shall be initially disbursed. Then, the worker shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b).

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. See ORS 656.593(1)(c). Such other costs include assessments for reserves in the Insurance and Finance Fund, but do not include any compensation which may become payable under ORS 656.273 or 656.278. Following the aforementioned distribution of a third party recovery, any remaining balance shall be paid to the worker. ORS 656.593(1)(d).

Here, claimant contends that all but $60 of SAIF's asserted lien is not recoverable because the expenses incurred by SAIF were not attributable to claimant's compensable February 1989 injury. Specifically, he argues that SAIF's claim costs were actually related to claimant's 1984 compensable injury or to his subsequent off-the-job exacerbations. Relying upon former and current statutory definitions of "compensable injury," claimant asserts that most of SAIF's claim costs do not constitute "compensation" because such expenditures were not provided for the February 1989 compensable injury which is the basis of the third party settlement.

Claimant's argument might have had some appeal had the compensability of either claimant's February 1989 injury claim or his subsequent claims for disability and/or medical services allegedly arising from that claim been challenged. However, the initial February 1989 injury claim was accepted. Disability and medical services have been processed and paid under the February 1989 claim. Neither party has objected to the processing of the accepted February 1989 claim. Inasmuch as SAIF has established that it incurred expenditures for compensation, first aid or other medical, surgical, or hospital services; those expenditures have been provided for claimant's accepted February 1989 injury; and claimant has not challenged the payment of those benefits under the February 1989 claim, we conclude that SAIF is entitled to receive reimbursement from a third party recovery arising from that injury pursuant to ORS 656.593(1)(c). See Robert E. Greer, 43 Van Natta 650 (1991).

We also disagree with claimant's suggestion that SAIF is prohibited from recovering reimbursement for any compensation that has actually been provided following the submission of the claim for closure in December 1989. ORS 656.593(1)(c) states that a paying agency is entitled to recover reimbursement for its actual claim costs. Specifically, the statute provides for such reimbursement to the extent that the paying agency is compensated for its expenditures for compensation, first aid, or other medical, surgical or hospital service.

"Compensation" includes all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to ORS Chapter 656. ORS 656.005(8). Inasmuch as benefits paid as a result of the reopening of claimant's accepted February 1989 injury claim would satisfy the definition of "compensation," we conclude that SAIF would have been entitled to recover such benefits from the third party settlement even if the claim had been closed and subsequently reopened. In any event, since the expenditures for which SAIF seeks reimbursement were actually incurred during the processing of claimant's accepted February 1989 injury claim, SAIF is entitled to share in the third party recovery.

Notwithstanding our prior conclusions, we agree with claimant's alternative argument that SAIF is not entitled to recover reimbursement for its claim costs resulting from the two independent medical examinations conducted by the Western Medical Consultants. We have consistently held that claim evaluation reports are analogous to litigation reports and, as such, are not properly includable in a paying agency's lien against a third party recovery. David G. Payne, 43 Van Natta 918 (1991); Cleo Riggs, 42 Van Natta 377 (1990); Carolyn J. Gant, 39 Van Natta 471 (1987).

Here, other than to reassert its entitlement to its entire lien, SAIF has not rebutted claimant's characterizations of the Consultants' examinations as independent medical examinations. Our review of the record confirms that the examinations and resulting reports were conducted for claim evaluation reports. Consequently, we hold that SAIF's lien should be reduced by the total costs for the two examinations and reports ($1,374.50).

Accordingly, claimant's counsel is directed to forward to the SAIF Corporation, as its just and proper share of the third party settlement under ORS 656.593(3), $17,981.72. The remaining balance of the settlement proceeds shall be distributed to claimant in accordance with ORS 656.593(1)(d).

IT IS SO ORDERED.

In the Matter of the Compensation of
ISMEAL M. BARAJAS, Claimant
WCB Case No. 88-10277
ORDER ON REMAND
Bischoff & Strooband, Claimant Attorneys
Jim Dodge (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Barajas, 107 Or App 73 (1991). The court has concluded that our prior order, Ismeal M. Barajas, 42 Van Natta 479 (1990), which had affirmed a Referee's order setting aside a denial of claimant's injury claim, lacked findings as to how or why claimant became involved in an altercation while his assailant was armed with a knife. Consequently, the court has remanded to make findings necessary to determine whether claimant was an active participant in an assault. Accordingly, we proceed with our reconsideration.

FINDINGS OF FACT

The Board adopts the Findings of Fact in our earlier order with the following supplementation.

Claimant had known Gomez for about eight years and knew that Gomez had an extremely bad temper when he was drinking. (Tr. 25, 26). During the afternoon of the assault, both Gomez and claimant were drinking over a period of at least six hours. Gomez was upset with claimant because he was no longer claimant's supervisor and claimant made it clear to Gomez that Gomez had been demoted and could no longer tell claimant what to do. At least one time, Gomez threatened claimant with a bottle. (Ex. 9-21).

After claimant and Gomez returned to the motel, claimant went to his cabin. Shortly thereafter, claimant left his cabin and went outside to where Gomez was, knowing that Gomez wanted to fight, but not wanting others who were in the cabin to get into trouble with Gomez. Outside, Gomez indicated that he

was still upset about his demotion and wanted to fight. Claimant said that he was not afraid of Gomez and did not want to fight but, if that was what Gomez wanted, he would oblige because by that time he had "had his fill" of Gomez' harassment. (Ex. 7A-5, 9-22).

Gomez went into his cabin, obtained a knife, and returned to where claimant was waiting. (Exs. 7A-5, 9-22, 23). Claimant did not know that Gomez was getting a knife until Gomez returned and began approaching claimant. (Ex. 7A-5). Claimant did not hit Gomez before he was stabbed. (Tr. 25). He did kick at Gomez' hand that held the knife.

Claimant was an active participant in an assault or combat that was not an actual part of his job.

CONCLUSIONS OF LAW AND OPINION

The court agreed with our prior conclusion that claimant's injury was incurred in the course of his employment. It found, however, that former ORS 656.005(7)(a)(A) necessitates further inquiry because the statute's criteria relate to compensability. SAIF v. Barajas, supra at 76. (Emphasis in original). The court reasoned that the statute states, in part, that a compensable injury does not include injury to an active participant in assaults or combats which are not connected to the job. (Emphasis added). Thus, although an aggressor is clearly an active participant, the court concluded that aggressiveness is not the only criterion. In remanding the case for findings as to how or why claimant became involved in an altercation with Gomez, the court stated that if an injury is incurred by an active participant in an assault or combat that is not part of the job, it is not compensable. SAIF v. Barajas, supra at 76.

Here, the facts indicate that claimant was not the aggressor in the fight with Gomez and, in fact, initially indicated that he did not want to fight. Nonetheless, we are persuaded that he was an active participant in an assault or combat that was not an actual part of his job.

Gomez had been drinking a great deal of beer on the day of the assault and had incessantly harassed claimant, who finally had "had his fill" of Gomez. Claimant left his cabin and went out to where he knew he would encounter Gomez. Claimant waited while Gomez went into Gomez' cabin, although claimant did not know that Gomez was going for a knife. Claimant's actions, by waiting outside for Gomez to return, in conjunction with claimant's admitted intention to give Gomez a fight if that was what Gomez wanted, demonstrate that claimant anticipated an assault or combat and was willing to participate. Under such circumstances, we conclude that claimant was an active participant in an assault or combat that was not an actual part of his job. Therefore, his injury is not compensable. See former ORS 656.005(7)(a)(A); SAIF v. Barajas, supra.

Accordingly, on reconsideration, we reverse the Referee's order dated September 23, 1988. The SAIF Corporation's denial is reinstated and upheld. The Referee's $1,600 attorney fee award is reversed. Our prior award of a $1200 attorney fee for services on Board review is also reversed.

IT IS SO ORDERED.

In the Matter of the Compensation of
DENA L. BARNETT, Claimant
WCB Case No. 88-22382
ORDER ON REMAND
Flaxel, et al., Claimant Attorneys
Foss, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Barnett v. Liberty Northwest Insurance Corporation, 106 Or App 175 (1991). The court has reversed our order which affirmed and adopted a Referee's order that concluded claimant's temporary total disability (TTD) rate should be calculated based on an average weekly wage of $73. In remanding this case for consideration, the court has instructed us to determine whether breaks in claimant's work qualify as "extended gaps" under former OAR 436-60-020(7) for the purposes of computing claimant's TTD. We proceed with our reconsideration.

FINDINGS OF FACT

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

Claimant began working for the insured, a seafood processing plant, in July 1986. She worked irregular hours and shifts. From July 21, 1986 through September 6, 1986 she worked between 21.75 hours per week and 47.75 hours per week. Between September 7, 1986 and October 23, 1986 she did not work for the insured. This approximately 6 week period is an extended gap in claimant's employment with the insured.

Claimant was "rehire[d]" on October 23, 1986, working 50.75 hours between that date and November 1, and 51 hours between November 2 and November 15. (Ex 1D). From November 16 through November 29 claimant worked 4 hours. Her work hours were reduced during this period due to an arm injury. From November 30, 1986 through January 17, 1987, claimant worked between 61.5 hours per week and 14.75 hours per week.

Claimant's compensable low back injury occurred on January 17, 1987. Between claimant's October 23, 1986 return to work and her injury, she worked 13 weeks, consisting of 251.50 hours. Claimant averaged 18.346 hours per week of regular time and 1 hour per week of overtime during this 13 week period. At $5 per hour for regular time and $7.50 for overtime, claimant's average weekly wage was $99.23. ($91.73 + $7.50). The insurer paid claimant TTD based on a weekly wage of $152.48.

CONCLUSIONS OF LAW

Applying former OAR 436-60-020(7)(c), the Referee calculated claimant's average weekly wage by averaging her weekly earnings over the 26 weeks preceding her January 17, 1987 injury. According to the Referee's calculations, claimant's TTD rate should be based on a $73 average weekly wage. The Referee's order did not discuss whether claimant's employment included an "extended gap." We affirmed and adopted the Referee's order.

The court has reasoned that the 26 week average is applied, unless there are "extended gaps" in that period when claimant was not working. Inasmuch as our order did not consider that issue, the court has remanded to determine whether the breaks in claimant's work qualify as "extended gaps" for purposes of calculating her TTD under former OAR 436-60-020(7).

To begin, claimant seeks remand to the Referee for further development of the record. Remand is an appropriate action when the record has been improp

erly, incompletely, or otherwise insufficiently developed. ORS 656.295(5). To merit remand, it must be shown that the evidence was not obtainable with due diligence before the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986).

Claimant has made no showing concerning why the "evidence" which she wishes to present was unobtainable with due diligence at the prior hearing. Moreover, we note that the parties chose to present their dispute to the Referee based on the documentary record without the taking of testimony. Under such circumstances, we are not persuaded that the "evidence" claimant wishes to submit on remand was unobtainable with due diligence at the original hearing. In any event, we do not consider the record improperly, incompletely, or otherwise insufficiently developed. Consequently, the motion for remand is denied.

We turn to the merits. In determining what is an "extended gap" we have considered such factors as the length of the break in work and whether the break has caused a change in the work relationship between the claimant and the employer. See Craig E. Hobbs, 39 Van Natta 690 (1987). Such a determination is made on a case-by-case basis, considering such additional factors as whether the work was steady or seasonal. See Sally M. Turpin, 37 Van Natta 924 (1985).

Here, the payroll records regarding claimant's employment establish that her work for the 26 weeks preceding her January 17, 1987 injury was steady with two possible exceptions. The roughly six-week period between September 7, 1986 and October 23, 1986 (when she did not work) and the two-week period between November 16 and November 29 (when she worked 4 hours).

The payroll records describe claimant's October 23, 1986 return to work after the approximately 6 weeks of inactivity between September 7 and October 23 as a "rehire." Considering the length of claimant's inactivity and the description of her return to work ("rehire"), we conclude that the September 7 to October 23 period constitutes an "extended gap" for purposes of former OAR 436-60-020(7). Consequently, that period will not be considered in calculating claimant's average weekly wages.

Claimant's time sheets and payroll records establish that she worked just 4 hours during the November 16 - November 29 time period. This lack of activity was attributable to an arm injury. (Ex 1A-8). Prior to this 2 week period of relative inactivity, claimant worked 50.75 and 51 hours during the two preceding 2-week pay intervals. Furthermore, after the 2 week period of relative inactivity, claimant worked 61.5 hours in the following two-week period and continued working between 24.5 hours and 35 hours for the ensuing two-week periods until her January 17, 1987 injury.

Considering such circumstances, we do not consider claimant's medical absence to have altered the work or wage expectations of either herself or her employer. See Craig E. Hobbs, supra. Therefore, we hold that claimant's 4 hours of work during the November 16 - November 29 time period does not constitute an "extended gap" for purposes of calculating claimant's TTD rate under former OAR 436-60-020(7).

Having determined which breaks in claimant's work constituted "extended gaps," we proceed with our calculation of her TTD rate. We average her weekly earnings for the 13 weeks following claimant's return to work after the September 7 - October 23 "extended gap" and before her January 17, 1987 compensable injury. During that 13 week period, she worked 251.50 hours, averaging 18.346 hours per week of regular time and 1 hour per week of overtime. At $5 per hour for regular time and $7.50 for overtime, claimant's average weekly wage is $99.23. ($91.73 + $7.50).

Inasmuch as the insurer paid claimant TTD based on a weekly wage of $152.48, an overpayment has been created. The insurer is authorized to recover this overpayment from claimant's future permanent disability awards. Notwithstanding these conclusions, we have increased claimant's compensation from that awarded by the Referee. Consequently, claimant's attorney is entitled to 25 percent of the increased compensation created by this order not to exceed $3,800. ORS 656.386(2); OAR 438-15-055. This attorney fee is not subject to any offset based upon prior overpayment of claimant's compensation. OAR 438-15-085(2).

Accordingly, on reconsideration, we modify the Referee's January 31, 1989 order. Claimant's TTD rate shall be based on a weekly wage rate of $99.23, rather than the Referee's calculation of $73. The insurer is authorized to recover any overpayment created by this order from claimant's future permanent disability awards. Claimant's attorney is allowed 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly from the insurer to claimant's attorney. This attorney fee shall not be subject to any offset.

IT IS SO ORDERED.

In the Matter of the Compensation of
RAYMOND E. CLONKEY, Claimant
WCB Case No. C1-01579
ORDER DENYING RECONSIDERATION
Royce, Swanson & Thomas, Claimant Attorneys
Alan Ludwick (Saif), Defense Attorney

By order dated August 8, 1991, the Board disapproved the parties' Claim Disposition Agreement (CDA) on the basis that the agreement provided for an attorney fee in excess of the limit set by OAR 438-15-052, without an indication of extraordinary circumstances. The parties have jointly requested reconsideration of our order contending that claimant's attorney fee is not excessive.

The parties argue that OAR 438-15-085(2) applies to CDAs. This rule provides:

> "2) An attorney fee which has been authorized under these rules to be paid out of increased compensation awarded by a referee, the Board or a court shall not be subject to any offset based upon prior overpayment of compensation to the claimant."

Thus, we assume it is the position of the parties that the propriety of claimant's attorney fee must be gauged based upon a total consideration amount which includes SAIF's overpayment. We disagree.

Entitlement to an attorney fee in connection with a CDA is expressly subject to OAR 438-15-052. That rule establishes limitations on attorney fees based upon percentages of the "agreement proceeds." Here, the parties request that we include the amount of SAIF's overpayment when calculating the "agreement proceeds." We conclude that it would be improper to do so.

Although the parties have not described the nature of the overpayment in their agreement, we presume the overpayment alluded to refers to overpaid temporary disability for which the insurer was legally obligated to pay under ORS 656.210 and/or 656.212. Inasmuch as the overpayment was apparently made pursuant

to prior claims processing obligations, that overpayment cannot logically qualify as "proceeds" of the parties' CDA.

Moreover, although SAIF is precluded, as a practical matter, by the parties' agreement from recovery by future offset of its overpayment, such preclusion does not convert the overpayment into "agreement proceeds." In this regard, a carrier may only recoup an overpayment from a future award, if any, of permanent disability. Therefore, a carrier's recovery of an overpayment is always speculative in that it is dependent upon a condition subsequent. For this reason, we conclude that a carrier's contractual forbearance of its speculative right to pursue an offset in the future cannot qualify the amount of the overpayment as "agreement proceeds" for purposes of OAR 438-15-052. Accordingly, here we find that the agreement proceeds, upon which the calculation of the attorney fees is based, is $6,306.63, not $8,000 as represented by the parties. Because of the express limitations contained in OAR 438-15-052, we do not find OAR 438-15-085(2) applicable.

Accordingly, where the parties include an overpayment of compensation within the stated sum of the claims disposition agreement, the approved attorney fee is calculated on the actual consideration claimant receives under the agreement rather than the stated sum. Inasmuch as the attorney fee in the present case exceeds the strictures of OAR 438-15-052 without an indication of extraordinary circumstances, the proposed agreement remains unreasonable as a matter of law. Accordingly, claimant's request for reconsideration is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
ANITA J. DOUGLAS, Claimant
WCB Case No. 89-22587
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Crider and Westerband.

Claimant requests review of that portion of Referee Michael Johnson's order which declined to grant permanent total disability. Alternatively, claimant contends she is entitled to 100 percent (320 degrees) unscheduled permanent partial disability. The insurer cross-requests review of that portion of the Referee's order which: (1) increased claimant's scheduled permanent disability award for loss of use or function of the left foot from 5 percent (6.75 degrees), as awarded by Determination Order, to 10 percent (13.5 degrees); and (2) increased claimant's unscheduled permanent disability for a low back injury from 53 percent (169.6 degrees) as awarded by Determination Order, to 75 percent (240 degrees). On review, the issue is permanent total disability and alternatively, extent of scheduled and unscheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant experienced low back problems in 1976. At that time, a myelogram revealed an extradural defect on the left at L5-S1. As a result of this finding, claimant underwent a L5-S1 laminotomy with removal of several extruded disc fragments. Claimant did well following the surgery and was able to return to her regular work as a salesperson. Claimant remained relatively symptom-free for approximately the next six years.

In January 1983, claimant sustained a compensable injury to her low back. Her claim was initially closed by an October 1983 Determination Order which awarded 10 percent unscheduled permanent disability. Claimant continued to experienced low back and left lower extremity pain. As a result, she underwent an exploratory lumbar laminectomy, foraminotomy, neurolysis and decompression of the left S1 root. The October 1983 Determination Order was set aside as premature. Thereafter, an August 1985 Determination Order closed her claim with an award of 25 percent unscheduled permanent disability. This award was increased to 35 percent by stipulation of the parties.

Claimant continued to experience low back pain. Diagnostic tests performed in March 1987 revealed marked bulging of the L4-5 and L5-S1 discs, with no evidence of nerve encroachment. An aggravation claim was filed and initially denied by the insurer. However, the insurer later rescinded its denial. In September 1988, claimant underwent a third surgical procedure. At that time, she underwent a tertiary laminectomy at L4-5 with extension of the laminotomy and facetectomy with foraminotomy and neurolysis left as well as a hemilaminectomy at L5-S1 with neurolysis.

Claimant continued to experience low back and lower extremity symptoms. In July 1989, she underwent a lumbar MRI. That study revealed degenerative desiccation of the L4-5 and L5-S1 discs. The discs were moderately narrowed with minimal bulging at L4-5 and mild bulging at L5-S1. The MRI further showed that the epidural fat surrounding the S1 nerve root toward its lower margin on the left was obliterated due to post-operative scarring. Claimant's claim was closed by a November 1989 Determination Order which increased her unscheduled permanent disability award to 53 percent. The Determination Order also awarded claimant 5 percent scheduled permanent disability for loss of use or function of the left foot.

Claimant is 47 years old and has a high school education. Her prior occupational experience consists of work as a retail sales clerk. As a result of her compensable injury, claimant can no longer work as a sales clerk. Following her second back surgery, claimant was certified as a manicurist and was able to perform this job for approximately 1-1/2 years. Claimant was unable to continue work as a manicurist, however, as her low back condition did not allow her to keep regular hours or appointments.

As a result of her compensable injury, claimant has chronic low back pain which fluctuates in intensity. Approximately 2 days per week, claimant's pain is so severe that she has to take pain medication and lie down to obtain any relief. She is limited to sitting for 30 minutes to two hours depending on the type of day she is having. Her standing limitation is 35 to 40 minutes on good days; however, on bad days she finds it difficult to stand for any length of time. She cannot lift over 5 pounds, and any bending or twisting causes pain. Claimant also is restricted from any repetitive work with respect to both lower extremities.

Following her injury, claimant made an effort to return to the work force. She attempted work as a manicurist but was unable to hold this employment due to her physical limitations. She is willing to work, but she is unable to do so as a result of her physical limitations.

FINDINGS OF ULTIMATE FACT

As a result of her compensable injury, resultant surgeries and relevant nonmedical factors, claimant is unable to obtain and hold gainful employment in the normal labor market.

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

Claimant is willing to seek work, but is unable to due so as a result of her physcial limitations.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was not permanently and totally disabled. We disagree.

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

The first step in determining whether claimant is permanently and totally disabled requires an evaluation of her physical condition.

Dr. Kuller, claimant's current treating physician, reported that claimant suffers from chronic pain which was severe and unremitting. She noted that claimant had failed back syndrome, having undergone several spinal surgeries without relief and with a progressive worsening of pain. She further reported that claimant was permanently restricted from repetitive work with respect to her lower extremities and was permanently restricted from repetitive bending, stooping, twisting, lifting, walking, sitting, sqatting or standing. Dr. Kuller opined that claimant was not capable of performing part-time light duty as she would have frequent episodes of severe pain which required bed-rest.

Dr. Damond, who has followed claimant since 1985, concurred with Dr. Kuller's assessment. He added that claimant's lower back and leg pain was always present although it varied from mildly moderate to severe. He opined that claimant might have days where she could perform sedentary work, but would also have days where she could not tolerate any work at all. He further opined that on her best days, claimant would be limited to sedentary work with no lifting, pushing, pulling, stooping, bending, twisting, crawling or climbing.

The Orthopaedic Consultants performed an independent medical examination in March 1990. The Consultants reported that claimant had multiple subjective complaints, but no objective findings. They opined that claimant had mild permanent impairment and felt that claimant could perform light duty work on a full-time basis. The Consultants also suspected a significant degree of secondary gain was involved in claimant's failure to return to work.

Claimant credibly testified that she has chronic low back pain which fluctuates in intensity. Approximately 2 days per week, claimant's pain is so severe that she has to take pain medication and lie down to obtain any relief. She is limited to sitting from 30 minutes to two hours depending on the type of day she is having. Her standing limitation is 35 to 40 minutes on good days; however, on bad days she finds it difficult to stand for any length of time. She cannot lift over 5 pounds and any bending or twisting causes pain. Claimant also is restricted from any repetitive work with respect to both lower extremities.

We are persuaded by the well-reasoned opinions of Dr. Kuller and Dr. Damond. Both Dr. Kuller and Dr. Damond have treated claimant and their opinions

are consistent with claimant's credible testimony. We are not persuaded by the opinion of the Orthopaedic Consultants. The Consultants examined claimant on only one occasion. Further, their opinion is inconsistent with claimant's credible testimony, her medical history and the degree of permanent disability she has been awarded in the past. Accordingly, we conclude that as a result of her physical restrictions, claimant is limited to performing sedentary work on an irregular part-time basis.

We next turn to the nonmedical factors. Claimant is 47 years of age and has a high school education. Her prior occupational experience consists entirely of work as a retail sales clerk. As a result of her compensable injury, she can no longer perform such work. Claimant is certified as a manicurist and did perform such work following her second back surgery. However, due to her physical restrictions, claimant cannot obtain and hold work as a manicurist.

Mr. Rees, a vocational expert, opined that claimant was not able to work in a competitive job on a reasonable and realistic basis. Rees testified that claimant would not be able to compete in the job market due to her chronic pain fluctuations which would preclude her from any type of consistency in her job performance. He noted that she was unable to maintain her job as a manicurist as her chronic pain fluctuations did not allow her to be reliable or dependable on a day-to-day basis. He opined that this inconsistency rendered claimant unable to perform even sedentary work on a competitive basis. There is no contrary vocational evidence.

Under these circumstances, claimant has established that she is permanently incapacitated from regulary performing work at a gainful and suitable occupation. Although claimant has established that she is presently permanently incapacitated from performing regular employment, she must also show that she is willing to seek work and has made reasonable efforts in this regard. See ORS 656.206(3).

Claimant has not actively sought work since late 1989. However, she has not been released to work by Dr. Kuller due to her physical restrictions. Further, Mr. Rees opined that claimant could not compete in the job market due to her physical condition. Rees also opined that due to her pain fluctuations, claimant would be unable to hold even part-time sedentary work. Under these circumstances, we find that it is futile for claimant to attempt to obtain employment. See Butcher v. SAIF, 45 Or App 313 (1980).

Despite our finding that efforts to obtain employment would be futile, we find that claimant is willing to work and has made reasonable efforts to obtain employment. Following her second back surgery, claimant was trained and certified as a manicurist. She performed this job for approximately 1-1/2 years until chronic pain fluctuations forced her to give up this position as she could not keep regular hours or appointments. Moreover, claimant credibly testified that she would like to work and is willing to seek work, but, her physical restrictions and chronic pain fluctuations preclude her from doing so. We conclude therefore, that claimant is willing to seek work and under the circumstances has made reasonable efforts to find work.

Accordingly, claimant has established that she is permanently and totally disabled. Inasmuch as we have found that claimant is permanently and totally disabled, we do not reach the issues of permanent partial disability.

ORDER

The Referee's order dated October 10, 1990 is reversed. Claimant is granted permanent total disability as of May 15, 1990. The insurer is permitted

to offset permanent disability payments paid subsequent to that date, if any, against claimant's permanent total disability benefits. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, except that the total out-of-compensation fees awarded by the referee and the Board shall not exceed $6,000.

August 26, 1991 Cite as 43 Van Natta 1783 (1991)

In the Matter of the Compensation of
HOMER K. DUNCAN, Claimant
WCB Case No. 90-04771
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Neidig and Crider.

Claimant requests review of Referee Black's order which: (1) declined to assess a penalty and associated attorney fee for an unreasonable denial; and (2) declined to award an assessed attorney fee because claimant did not prevail in a hearing before a Referee. On review, the issues are penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" and "Findings of Ultimate Fact" and makes the following additional findings.

Claimant's attorney solicited the physician's report from Dr. Freudenberg which clearly established the elements necessary to prove a compensable claim. Claimant's attorney was instrumental in obtaining rescission of a denial of compensation; no hearing was held on the compensability issue.

CONCLUSIONS OF LAW AND OPINION

Penalty and Attorney Fee for Unreasonable Denial

The Board adopts the Referee's opinion with respect to this issue.

Attorney Fee for Not Prevailing in a Hearing

The Referee, relying on Duane L. Jones, 42 Van Natta 875 (1990), concluded that no attorney fee was available if a compensability denial is rescinded prior to hearing. The Board's order in Jones was affirmed by the court. See Jones v. Oregon State Correctional Institution, 107 Or App 78 (1991). However, since the Referee's order, the legislature has effectively overruled Jones by amending ORS 656.386(1) to allow an attorney fee if an attorney is instrumental in obtaining compensation, even though a hearing is not held. See ORS 656.386(1); Senate Bill 540 (June 19, 1991). Based on this statutory revision, the court has reconsidered its decision in Jones and remanded. 108 Or App 230 (1991). Accordingly, because we find claimant's counsel to have been instrumental in obtaining compensation, we conclude that an attorney fee for services prior to the hearing is warranted.

After considering the factors set forth in OAR 436-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services prior to hearing in relation to the compensability issue is $1,500, to be paid by the self-insured employer.

ORDER

The Referee's order dated August 17, 1990 is affirmed in part and reversed in part. That portion which declined to award an attorney fee for services prior to hearing is reversed. For services rendered prior to hearing, claimant's attorney is awarded a reasonable assessed attorney fee of $1,500, payable by the self-insured employer. The remainder of the order is affirmed.

August 26, 1991 Cite as 43 Van Natta 1784 (1991)

In the Matter of the Compensation of
LAURA S. FREDERICK, Claimant
WCB Case No. 89-06916
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Crider and Neidig.

Claimant requests review of those portions of Referee Mills' order that: (1) upheld the self-insured employer's denial of claimant's aggravation claim for a current low back condition; and (2) affirmed a Determination Order award of 16 percent (51.2 degrees) unscheduled permanent partial disability for a low back injury. On review, the issues are aggravation and extent of unscheduled permanent partial disability. We affirm.

FINDINGS OF FACT

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

Claimant's claim was last closed by a March 28, 1989 Determination Order.

Claimant was 30 years old at hearing and she has some education beyond high school. During the ten years prior to hearing, she worked as a janitor and as a sales clerk. Claimant's job at injury was in the light range; she returned to modified work in the sedentary range.

Claimant has limited ability to bend or lift repetitively, due to her chronic back condition.

CONCLUSIONS OF LAW AND OPINION

Aggravation

We adopt the Referee's "Conclusions and Opinion" on this issue.

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. OAR 438-10-010.

Because claimant's condition became medically stationary on August 17, 1988, and her claim was closed by Determination Order on March 28, 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 appropriate value for claimant's age of 30 years is 0. Former OAR 436-35-290.

The appropriate value for claimant's 13 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). 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 sales clerk (DOT # 290.477-014). 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).

Claimant has no demonstrated competence in a specific vocational pursuit. Therefore, the appropriate training value is a 1. Former OAR 436-35-300(5).

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. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the "standards" generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

In this case, claimant's usual and customary work required the physical capacity to do light work. Claimant's modified work required a sedentary physical capacity. Therefore, the appropriate adaptability value is 2. Former OAR 436-35-310(3)(a).

The Referee decided that claimant is not entitled to a rating for her unoperated disc bulge at L5-S1, because the medical evidence indicates that the bulge, which preexisted the compensable injury, is not the cause of claimant's current symptoms. We agree.

The Referee also decided that claimant is not entitled to ratings for lost range of back motion or for a chronic condition limiting repetitive use of her back. In reaching this conclusion, the Referee was persuaded by evidence, including surveillance films, that claimant is capable of more physical activity involving her back than she admits. Although we agree that claimant has not established that she is entitled to an impairment rating for lost range of motion, we find that she is entitled to a rating for her injury-related chronic condition which limits repetitive use of her back. In this regard, we are persuaded by the limitations imposed by Dr. Frank, treating physician. (See Ex. 30). Consequently, claimant has established entitlement to a 5 percent impairment

rating for her chronic condition which limits repetitive use of her back. Former OAR 436-35-320(4).

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, the product is 8. When that value is added to claimant's impairment value 5, 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.

There is no evidence that claimant suffers more or less permanent disability than found under strict application of the standards. ORS 656.283(7) & 656.295(5); see Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 402 (1987).

We have found that claimant is entitled 13 percent unscheduled permanent disability. However, because the employer has not requested reduction of the amount awarded by the Referee, we affirm his award of 16 percent.

ORDER

The Referee's order dated October 24, 1990 is affirmed.

August 26, 1991 Cite as 43 Van Natta 1786 (1991)

In the Matter of the Compensation of
JAMES A. LOWE, Claimant
WCB Case No. 90-02632
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of Referee McGeorge's order which increased claimant's scheduled permanent disability award for a left wrist injury from 7 percent (10.5 degrees), as awarded by a Determination Order, to 21.5 percent (33 degrees). On review, the issue is extent of permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," with the exception of the second paragraph thereof, and with the following supplementation.

Claimant has a chronic condition that limits repetitive use of the left wrist.

CONCLUSIONS OF LAW AND OPINION

A Determination Order awarded claimant 7 percent scheduled permanent disability for loss of range of motion in the left wrist. The Referee increased the award to 21.5 percent scheduled permanent disability by finding reduced grip strength and finding that claimant has a chronic condition limiting repetitive use of his wrist. After de novo review of the record, we reverse the increased award of scheduled permanent disability.

In the absence of persuasive reasons to do otherwise, we generally assign greater weight to the opinion of a worker's treating physician. Weiland v. SAIF, 64 Or App 810 (1983). Here, because Dr. Beeson, D.C., has followed claimant's wrist injury since September 1988, over a year before his wrist

became medically stationary, we conclude that he is best able to evaluate claimant's permanent wrist impairment.

In rating claimant's wrist range of motion impairment, the Referee and the Evaluation Section relied on the report of a consulting examination by Dr. Lubcke which was conducted in November 1989. We rely instead on the more recent report of claimant's treating physician, Dr. Beeson.

Impairment for purposes of the applicable version of the "standards" is determined at the date of hearing. Gettman v. SAIF, 289 Or 609 (1980); Ronald G. Boehm, 42 Van Natta 1059 (1990). In this case, for the purpose of rating loss of range of motion in claimant's wrist, the Referee relied on a report made over a year before the time of hearing. Additionally, at the time of the examination performed by Dr. Lubcke, D.C., he noted that claimant had suffered an aggravation of his wrist injury sometime during the past 30 days while carrying wood into his house. (Ex. 20-1). Thus, for the above reasons, we do not rely on the results of Dr. Lubcke's consulting examination.

Instead, we rely on the examination done by claimant's treating chiropractor in June 1990. In that report, Dr. Beeson reported that wrist extension and flexion were within normal limits but produced pain. (Ex. 25-2). No additional impairment of the wrist was noted. Accordingly, we conclude that claimant has no permanent impairment due to loss of range of motion of the left wrist.

The Referee, relying on a report from May 1988, found that claimant has 17.5 percent impairment of the left forearm due to loss of grip strength. We disagree. At the time of the 1988 report, claimant was not medically stationary, nor did he become so until November 1989. Permanent disability should be rated at the time of hearing when claimant is medically stationary. See Gettman v. SAIF, supra; Kociemba v. SAIF, 63 Or App 577 (1987).

The Referee found that grip strength had not been tested since May 1988. Because claimant was not medically stationary when his grip strength was tested and because there are no other medical findings in the record, we conclude that claimant has not met his burden of proving that he has permanent impairment in his left wrist due to loss of grip strength.

Claimant testified that he could not climb ladders as well as before, that he is unable to crawl, and that he has pain in the wrist while gripping and with repetitive use. Accordingly, we agree with the Referee that claimant has established that he has a chronic condition that limits repetitive use of his left wrist and is entitled to 5 percent permanent disability. Former OAR 436-35-010(7).

We do not find clear and convincing evidence that claimant's disability exceeds that indicated by the "standards."

Because the insurer has requested only that we reverse the Referee's order, we do not modify the Determination Order award.

ORDER

The Referee's order dated January 4, 1991 is reversed. The Determination Order award of 7 percent (10.5 degrees) scheduled permanent disability for a left wrist injury is reinstated and affirmed.

In the Matter of the Compensation of
EMERY R. MILLER, Claimant
WCB Case No. 90-07390
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee McCullough's order which upheld the insurer's denials of claimant's right forearm tendinitis claim. In his brief on review, claimant argues that the Referee was in error to exclude those portions of Exhibits 1, 1A, 1B, 2, and 9 which contain/reflect factual assertions by claimant purported to connect his right forearm condition to his work-related activities. On review, the issues are evidence and compensability. We affirm.

FINDINGS OF FACT

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

Claimant requested a hearing. At the time set for hearing claimant appeared through counsel. He did not personally attend the hearing. The insurer moved for dismissal of the request for hearing. The motion was denied. The insurer objected to those portions of certain exhibits (Ex. 1, 1A, 1B, 2 and 9), which contain statements or are based upon statements by claimant regarding the cause of his right upper extremity condition. The insurer objected to this evidence on the grounds that it constituted inadmissible hearsay.

The Referee excluded portions of Exhibits 1, 1A, 1B, 2, 4 and 9 which were statements or which were based on statements by claimant regarding the connection between his right forearm condition and his work activities.

CONCLUSIONS OF LAW AND OPINION

Admissibility of Evidence

The Referee denied the insurer's motion to dismiss. He held, relying on the Court of Appeals' decision in Williams v. SAIF, 99 Or App 367 (1989) aff'd on other grounds, 310 Or 320 (1991), and the Board decision in Jose Arisqueta-Martinez, 42 Van Natta 2072 (1990), that claimant was entitled proceed through counsel and need not personally appear at hearing. Nevertheless, the Referee excluded portions of Exhibits 1, 1A, 1B, 2, 4 and 9 which constituted hearsay statements or which are based on hearsay statements by claimant regarding the connection between his right forearm condition and his work activities. The Referee did so because he concluded that because claimant was unavailable for examination at hearing, it would not be just to admit the exhibits portions which were necessarily created from or informed by claimant's out-of-court statements. We disagree that this evidence should have been excluded.

The parties agreed that claimant suffered from tendinitis. The Referee excluded all or portions of claimant's "801" claim form, the treating physician's "827" first medical report, the emergency room evaluation report, a second "827" physician's report, an interoffice memo from an investigator to the insurer which relates to statements claimant made to the investigator regarding where the injury occurred, and an August 3, 1990 letter from the treating physician, Dr. Knower, M.D.

The Board has determined that where a claimant proceeds through counsel and is not personally present at hearing, medical reports based on claimant's out-of-court statements to his physicians are admissible for the truth of

claimant's statements to the extent that those statements were reasonably pertinent to medical diagnosis. Froylan L. Zurita, 43 Van Natta 1382 (1991). In Zurita, the Referee excluded all medical reports due to claimant's unavailability for examination at hearing. We concluded that the reports could not be rejected simply because claimant was not available at hearing. Finding that the claim-ant's statements to the doctors that he hurt his back lifting and twisting were reasonably pertinent to the doctor's diagnoses and treatment, the Board determined that such statements constituted prima facie evidence that claimant so hurt his back. However, since the claimant's statements in the medical reports that the lifting and twisting happened at work were not reasonably pertinent to diagnosis or treatment, the Board accorded them little weight. The Board distinguished the indicia of accuracy in hearsay statements made to a physician for diagnosis purposes from the indicia of accuracy in hearsay statements regarding where the injury occurred.

We conclude that those excluded portions of Exhibits 1, 1A, 1B, 2, 4 and 9, which constitute out-of-court statements by claimant to a physician for the purposes of medical diagnosis, cannot be excluded simply because claimant was not available at hearing and are admissible evidence. However, they should be given little weight. Zurita, supra.

Compensability

The exhibits and those portions which had been excluded, are in the record and we may proceed to review the record de novo to determine whether claimant's tendonitis is compensable. Zurita, supra.

The Referee concluded that claimant had failed to establish that his condition arose in the course and scope of his employment. We agree. Just as in Zurita, supra, the medical reports in the present record constitute prima facie evidence that claimant has sustained tendinitis, most likely from repetitive hand and arm movement. However, because the only evidence of where claimant endured the repetitive hand and arm movement comes from claimant himself who was not present at hearing to testify, and his out-of-court statements regarding where the injury occurred are not pertinent to medical diagnosis and are not shown to be reasonably reliable, we conclude that there is insufficient evidence to establish a prima facie case that claimant's tendinitis was sustained in the course and scope of his employment.

ORDER

The Referee's order dated October 18, 1990 is affirmed.

August 26, 1991 Cite as 43 Van Natta 1789 (1991)

In the Matter of the Compensation of
RICHARD D. SESHER, Claimant
WCB Case Nos. 90-08211, 90-06146 & 90-08210
ORDER ON REVIEW (REMANDING)
Karen M. Werner, Claimant Attorney
Scheminske & Lyons, Defense Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

Claimant requests review of Arbitrator Miller's order which declined to award an assessed attorney fee for services before hearing. On review, the sole issue is attorney fees. We reverse and remand.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant argues that he should be awarded to a carrier-paid attorney fee pursuant to ORS 656.307(5). We have recently held that ORS 656.307(5) contemplates a fee for all services reasonably rendered respecting responsibility denials, not just for services rendered after issuance of a .307 order and its receipt by the Board. Kenneth Cage, 43 Van Natta 487 (1991). Here, claimant, through his attorney, has consistently taken the position that Aetna was the responsible insurer and claimant's attorney has participated in attempts to resolve the dispute without a hearing. Claimant's attorney also requested a hearing on each of the insurers' denials of responsibility and prepared for hearing by submitting exhibits. Accordingly, we conclude that claimant actively and meaningfully participated in the proceeding.

Nevertheless, because an award under ORS 656.307(5) is within the discretion of the arbitrator, we remand. Because Arbitrator Miller is not presently employed by the Board, this case shall be remanded to the Presiding Referee for assignment to a new Arbitrator. See Daniel J. Bergmann, 42 Van Natta 949 (1990). On remand, the assigned Arbitrator shall determine whether or not claimant should be awarded a fee in this case under ORS 656.307(5) and, if so, shall award a reasonable fee, payable by Aetna.

ORDER

The Referee's order dated September 24, 1990 is reversed. The case is remanded for further proceedings consistent with this order.

August 26, 1991 Cite as 43 Van Natta 1790 (1991)

In the Matter of the Compensation of
DELORES J. TELLEZ, Claimant
WCB Case No. 90-12991
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Stoel, Rives, et al., Defense Attorneys

Reviewed by Board Members Crider and Neidig.

Claimant requests review of Referee Bethlamy's order which upheld the self-insured employer's denial of her bilateral carpal tunnel syndrome claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, and supplement with the following findings.

Claimant's carpal tunnel condition is more severe in the non-dominant left hand.

Right wrist soreness increases with work activity; numbness and nighttime pain do not vary, whether or not claimant is working.

The major contributing cause of claimant's carpal tunnel syndrome is her obesity and fluid retention.

FINDING OF ULTIMATE FACT

Claimant's work activity was not the major contributing cause of either the onset or worsening of her bilateral carpal tunnel syndrome.

CONCLUSIONS OF LAW AND OPINION

The sole issue in this case is whether claimant has established a compensable occupational disease claim. Because claimant's work as a quality control inspector and shipping and packaging specialist involved repetitive arm movements, and she has been diagnosed as suffering from bilateral carpal tunnel syndrome (CTS), her claim is properly analyzed under ORS 656.802. See Sibley v. City of Phoenix, 107 Or App 606 (1991). To establish that her condition is compensable under ORS 656.802(1)(c) and (2) as amended, claimant must prove that her work exposure included a series of traumatic events or occurrences which were the major contributing cause of the onset or worsening of her bilateral wrist condition, requiring medical services or resulting in disability. Major cause means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening than all other activities or exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); Dethlefs v. Hyster Co., 295 Or 309-310 (1983).

A number of potential causes for claimant's CTS have been identified. Thus, the causation issue presents a complex medical question, the resolution of which must be established by medical experts. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

We are persuaded by the opinions of Drs. Button and Layman, rather than that of Dr. Bergquist, for several reasons. First, the former doctors are hand surgery specialists, with expertise relevant to evaluating claimant's condition. Dr. Bergquist is not. See Abbott v. SAIF, 45 Or App 657, 661 (1980). Second, Drs. Button and Layman each viewed a video of claimant performing her job tasks in addition to performing a thorough examination, reviewing relevant medical records and taking a complete history. Dr. Button concluded that claimant performed a light job with a variety of duties, and that the job was not "hand intensive." In a well-reasoned opinion, he also considered the role that claimant's documented obesity and hypertension played in the development of her carpal tunnel syndrome and explained how fluid retention and peripheral edema formation lead to fluid retention and compression within the carpal tunnel region. Dr. Layman concurred in Dr. Button's conclusion. Dr. Bergquist disagreed, stating that there is no evidence that hypertension is associated with CTS. He neither addressed nor refuted the link between fluid retention and peripheral edema occurring in obesity and CTS, but rather noted that sites of carpal tunnel compression are marked by the absence of fat deposits.

Finally, Dr. Bergquist twice indicated that claimant's work activities were a materially contributing cause of her CTS. Later, when asked whether work activity was the major contributing cause of claimant's condition, he responded that he did not know. Finally, ten months after he last saw claimant, when again asked for a statement on the causation of claimant's CTS condition, he indicated in a check-the-box reply that it was not the major contributing cause of the onset of the condition, but, was the major contributing cause of a "worsening/hastening/acceleration of any underlying/preexisting degenerative pathology." Although Dr. Bergquist is claimant's treating physician, we do not find his unexplained reversal of opinion to be persuasive. Raul A. Herrera, 40 Van Natta 1281 (1988).

Accordingly, on this record, we find that claimant has failed to carry her burden of proof.

ORDER

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

In the Matter of the Compensation of
DAVID J. DEERING, Claimant
WCB Case No. 90-00730
ORDER ON REVIEW
Douglas D. Hagen, Claimant Attorney
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The insurer requests review of Referee Lipton's order that: (1) found that claimant's request for hearing was timely filed; and (2) set aside its denial of claimant's medical services claim for his current low back condition. On review, the issues are jurisdiction and medical services. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact, with the exception of the Referee's findings that claimant did not receive his mail from his parents until after the Christmas holidays and claimant's request for hearing was timely filed.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The Referee concluded that claimant's request for hearing was timely filed. Alternatively, he concluded that, in the event claimant's request for hearing was not timely filed, claimant had shown good cause for his failure to timely file.

A hearing on a denial of a claim for compensation shall not be granted and the claim shall not be enforceable unless a request for hearing is filed within 60 days after the claimant is notified of the denial. ORS 656.319(1)(a). This is not an absolute time limit. If claimant files a request for hearing within 180 days, he may establish that there was good cause for failure to file by the 60th day. ORS 656.319(1)(b).

The Referee found that the denial was dated and mailed on November 7, 1989. Claimant's request for hearing has two date stamps and was either received by the Board on January 9 or January 10, 1990. The Referee concluded that, because the denial was received in Salem on January 10, 1990, it must have been mailed by January 8, 1990, which would mean that the request for hearing was mailed within the 60-day period and was, therefore, timely. We disagree.

If a request for hearing is not mailed by registered or certified mail and the request is actually received by the Board after the date for filing, it is presumed that the mailing was untimely unless the filing party establishes that the mailing was timely. See Richard S. Olson, 43 Van Natta 657 (1991); OAR 438-05-046(1)(b). We conclude that there is no evidence that claimant's request for hearing was mailed by registered or certified mail and there is no envelope or postmark indicating the date on which claimant mailed his request. Additionally, the parties agree that claimant's request for hearing was received by the Board either 63 or 64 days after the denial. Under the circumstances, we conclude that claimant has not overcome the presumption that the mailing of his hearing request from the insurer's denial was untimely.

Claimant has filed his request for hearing within 180 days and, therefore, he may establish that there was good cause for failure to file by the 60th day. "Good cause" has been defined as "mistake, inadvertence, surprise or excusable neglect" as those terms have been employed under ORCP 71B and former ORS 18.160.

Anderson v. Publishers Paper Co., 78 Or App 513 (1986). Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985).

Here, claimant contends that he failed to file his hearing request within 60 days because the insurer mailed its denial to his parents and he did not receive the denial until approximately January 6, 1990. Although the Referee found that claimant did not receive his mail (i.e., the insurer's denial) until sometime after Christmas, we do not agree that claimant has met his burden of proof in this regard.

The record shows that claimant last saw his treating doctor, Dr. Gemmer, on October 10, 1989. Ex. 39-12. At hearing, claimant testified that he received the denial approximately a month (three to four weeks) after he saw Dr. Gemmer. Tr. 17. Claimant also testified that, in terms of the holidays or other occasions, he was not certain when he received the denial. Tr. 17. Shortly after his statement indicating he could not relate receipt of the denial to a holiday, claimant testified that he was selling Christmas trees and, after the holidays, he went to his parents' house, picked up his mail and received the registered letter. Tr. 18.

In response to his attorney's question, claimant testified that he did not receive the denial until after the first of the year, and immediately afterward, he requested a hearing. Tr. 19-20. On cross examination, claimant testified that he received the letter on January 6th. Tr. 21. However, he then stated that he received the denial after seeing Dr. Gemmer, or approximately in the middle of November. Tr. 25. When the insurer pointed out the discrepancy in his testimony and asked again if claimant received the denial in November, claimant testified that he believed that was when he received it. Tr. 25. Finally, upon redirect, claimant testified that he thought he saw Dr. Gemmer in November of 1989, but he did not see him in December. Tr. 35.

We conclude that claimant has not met his burden of establishing that good cause existed for his failure to timely file his request for hearing. The only evidence on the record regarding when claimant received the denial is the testimony of claimant himself. Claimant has testified that he did not receive the denial until January 6, which was the 60th day from the mailing of the denial, and arguably, may have established that claimant had good cause for failing to timely file his request for hearing. However, claimant's final testimony on the subject was that he believed he received the denial in the middle of November. Claimant has not provided any explanation as to why he was unable to timely file his request for hearing if he received the denial shortly after it was mailed.

Because we are unable to find reliable evidence on the record of a date upon which claimant received the insurer's denial, we are also unable to find that good cause existed for his failure to timely file his request for hearing. Inasmuch as we have found that claimant has not established that good cause existed for his untimely request for hearing on the denial, the request for hearing on the November 17, 1989 denial is dismissed for lack of jurisdiction. The denial became final by operation of law.

Compensability

Because we have dismissed claimant's request for hearing, we are without jurisdiction in this matter and do not reach the issue of compensability.

ORDER

The Referee's order dated October 24, 1990 is reversed. Claimant's request for hearing is dismissed. The insurer's November 17, 1989 denial of claimant's medical services claim is reinstated. The Referee's attorney fee award of $2,000 for claimant's counsel's services at hearing is also reversed.

In the Matter of the Compensation of
ROBIN R. OLIVER, Claimant
WCB Case No. 90-15596
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of Referee Podnar's order that: (1) directed it to pay temporary total disability as ordered by a prior Referee; (2) assessed a penalty for its allegedly unreasonable failure to pay temporary disability; and (3) awarded an assessed fee for its failure to properly process claimant's claim. In its brief, the insurer contends that, if claimant is entitled to an assessed fee, the amount awarded by the Referee was excessive. On review, the issues are temporary total disability and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

We take official notice of the fact that an April 30, 1991 Order on Review reversed Referee Fink's order which found the insurer responsible for an aggravation of claimant's accepted psittacosis disease. The Board's order concluded that the subsequent insurer was responsible for claimant's condition. Robin R. Oliver, 43 Van Natta 1055 (1991).

CONCLUSIONS OF LAW AND OPINION

Temporary total disability

The Referee found that a prior Referee had ordered the insurer to pay temporary total disability beginning November 15, 1989. The Referee concluded that the insurer unreasonably refused to process claimant's claim. We agree that claimant has shown both a procedural and a substantive entitlement to temporary total disability benefits beginning November 15, 1989, and we adopt the Referee's "Conclusions" on the issue of temporary total disability.

Penalties and attorney fees

The Referee assessed a penalty and directed that one-half of the penalty be paid to claimant's counsel in lieu of an attorney fee as provided under ORS 656.262(10). Additionally, the Referee awarded an assessed fee pursuant to ORS 656.382(1). On review, the insurer contends that under current ORS 656.262(10), if a fee is awarded under that provision, an attorney fee pursuant to ORS 656.382(1) is not available.

We agree, and the parties do not dispute, that the law effective July 1, 1990, is applicable to the penalty and attorney fee issue in this case. Former ORS 656.262(10) authorized the assessment of an attorney fee if an insurer unreasonably refused to pay compensation. However, the legislature significantly amended ORS 656.262(10) during its 1990 Special Session. See Or Laws 1990 (Special Session), ch 2, 15. The legislature removed from ORS 656.262(10) the language expressly authorizing the assessment of an attorney fee. Furthermore, as amended, ORS 656.262(10)(a) now provides that the Director shall have exclusive jurisdiction over proceedings regarding solely the assessment of a penalty under that subsection. It further provides that, if the worker is represented

by an attorney, the attorney shall receive one-half the penalty "in lieu of an attorney fee." Additionally, ORS 656.262(10)(b) provides that, when the Director does not have exclusive jurisdiction over proceedings regarding the assessment of the penalty, "the provision for attorney fees provided in this subsection shall apply in the other proceeding."

The parties do not dispute that exclusive jurisdiction over this matter rests with the Board. See e.g. Harry E. Forrester, 43 Van Natta 1480 (1991) (Because claimant sought enforcement of a Board order awarding additional temporary disability benefits, the proceeding did not involve solely the assessment of a penalty and jurisdiction rested with the Board, rather than the Director). Nevertheless, pursuant to ORS 656.262(10)(b), the provision for attorney fees provided in ORS 656.262(10)(a) also applies here. Accordingly, we agree with the Referee's conclusion that claimant's attorney is awarded one-half of the penalty assessed by this order, in lieu of an attorney fee. Claimant shall receive the remainder of the penalty.

The Referee also awarded claimant's counsel an assessed fee for the insurer's refusal to pay compensation. We reverse the Referee in this case, because the factual basis asserted in support of the fee, i.e., the insurer's refusal to pay compensation as ordered by the prior Referee, is identical to the factual basis for which the Referee assessed a penalty under ORS 656.262(10)(a). See Nicolasa Martinez, 43 Van Natta 1638 (1991). Accordingly, the assessment of an attorney fee under ORS 656.382(1) would contravene the legislative intent expressed in ORS 656.262(10)(a) that claimant's attorney receive one-half the penalty, "in lieu of an attorney fee." See Harry E. Forrester, supra. We, therefore, reverse the Referee's award of an assessed fee.

For successfully defending against the insurer's appeal on the issue of temporary total disability, claimant's counsel is entitled to an assessed attorney fee. 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 fee for claimant's counsel's services on review concerning the temporary total disability issue is $400, to be paid by the insurer. 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. We note that claimant is not entitled to a fee for her counsel's efforts in successfully defending on the issues of a penalty and fee under ORS 656.262(10). See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, 80 Or App 233 (1986).

ORDER

The Referee's order dated January 8, 1991 is affirmed in part and reversed in part. That portion of the Referee's order that awarded an assessed fee of $4,370 is reversed. The remainder of the Referee's order is affirmed. For services on review concerning the issue of temporary total disability, claimant's counsel is awarded an assessed attorney fee of $400, payable by the insurer.

August 27, 1991 Cite as 43 Van Natta 1795 (1991)

In the Matter of the Compensation of
KAREN A. VEGA, Claimant
WCB Case No. 90-05674
ORDER OF ABATEMENT
Ginsburg, et al., Claimant Attorneys
Susan Ebner (Saif), Defense Attorney

The Board has received claimant's request for reconsideration of our July 30, 1991, Order on Review, which, inter alia, reversed the Referee's assessed fee award of $1,512 for overturning the SAIF Corporation's May 14, 1990 medical

services denial. Specifically, claimant contends that the assessed fee was not only for his attorney's services rendered in overturning the May 14, 1990 denial, but also for services regarding the February 2, 1990 and February 26, 1990 medical service denials that were withdrawn and rescinded by SAIF at hearing.

In order to allow sufficient time to consider the motion, the above noted Board order is withdrawn and SAIF is requested to file a response to the motion within ten days. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANNIE W. CRAWLEY, Claimant
Own Motion No. 91-0127M
OWN MOTION ORDER ON RECONSIDERATION
Dennis Henninger, Claimant Attorney
SAIF Legal Department, Defense Attorney
David L. Runner, Assistant Attorney General

On August 22, 1991, we filed with the Court of Appeals a Notice of Withdrawal of our March 15, 1991 Own Motion Order, which denied the SAIF Corporation's request for reimbursement from the Reopened Claims Reserve. See ORS 183.482(6); ORAP 4.35; Glen D. Roles, 43 Van Natta 278 (1991). We rarely exercise our authority to withdraw an appealed order. Ronald D. Chaffee, 39 Van Natta 1135 (1987). However, we took such an action in this instance to address SAIF's contention that we lack jurisdiction or authority to grant or deny an insurer's request for reimbursement from the Reopened Claims Reserve. We proceed with our reconsideration.

The relevant facts are as follows. SAIF sought Board authorization to receive reimbursement under ORS 656.625 for temporary total disability (TTD) it had voluntarily paid to claimant commencing in February 1987. We denied authorization for reimbursement because SAIF had reopened the claim prior to January 1, 1988, which was the date ORS 656.625 became effective. In reaching our conclusion, we relied upon our reasoning in Raymun B. Savalas, 43 Van Natta 38 (1991), which held that a claim reopened before January 1, 1988 does not qualify as an award made "pursuant to ORS 656.278 after January 1, 1988" as required by ORS 656.625.

ORS 656.278(4) authorizes an insurer to voluntarily reopen any claim to provide benefits or grant additional medical or hospital care to the claimant. To effectuate the legislative policy in favor of voluntary action by carriers, we stated in Savalas that we will authorize reimbursement from the reserve to carriers who voluntarily reopen claims after January 1, 1988, to the same extent as reimbursement is authorized when reopening is mandated by a Board order issued after January 1, 1988. However, we declined to extend that approach to pre-January 1, 1988 voluntary reopenings for several reasons.

First, a claim reopening effective before January 1, 1988, whether voluntary or Board-ordered, cannot qualify as an award made "pursuant to ORS 656.278 after January 1, 1988," as ORS 656.625 requires for reimbursement to be authorized. Furthermore, we noted that before the adoption of ORS 656.625 on January 1, 1988, the Reopened Claims Reserve did not exist. We declined to extend authorizations to pre-January 1, 1988 reopenings, for to do so would permit carriers to receive reimbursement for payments that they had no expectation of recovering from a source that did not exist at the time they decided to pay the

benefits. In short, we declined to apply the statute retroactively without specific statutory authorization.

Finally, we interpreted 1987 legislative revisions to ORS 656.278 which coincided with the adoption of ORS 656.625 as evidence of a legislative intent to allow reimbursement for only those awards made pursuant to the version of ORS 656.278 that became effective January 1, 1988. Inasmuch as the claim in Savalas had never been reclosed after an August 1987 reopening, we held that the carrier was not entitled to reimbursement from the Reopened Claims Reserve.

Here, SAIF challenges our authority to address either the amount of, or the entitlement to, reimbursement from the Reopened Claims Reserve under ORS 656.625. Specifically, it contends that the authority to decide such questions rests with the Director and not the Board. We disagree.

Section (1) of the statute provides that the Director "shall establish a Reopened Claims Reserve with 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(2). Section (3) of the statute provides that the Director, by rule, shall prescribe the form and manner of requesting reimbursement, the amount payable and such other matters as may be necessary for the administration of the section.

The aforementioned statutory sections describe a procedure in which the Director is required to establish and administer a Reopened Claims Reserve for the purpose of reimbursing compensation payable from Board awards pursuant to ORS 656.278 after January 1, 1988. ORS 656.625(1), (3). The Director is also required, by rule, to prescribe a mechanism for seeking and obtaining payment from the Reserve. ORS 656.625(3). However, this authority is not solely the province of the Director in that section (2) provides that any reimbursement from the Reserve shall be in such amounts as the board prescribes.

In accordance with this statutory authority, the Director and Board have promulgated rules. The Director's rules are applicable to "all awards ordered on claims reopened by the Board pursuant to ORS 656.278 on or after 1-1-88." OAR 436-45-002. To qualify for reimbursement from the Reopened Claims Reserve, the Director requires: (1) a Board order or award issued pursuant to ORS 656.278 and as provided by OAR Chapter 438, Division 12; and (2) verifiable compensation paid in accordance with that order or award. OAR 436-45-010(1). In response to these statutory and administrative directives, the Board has promulgated OAR 438-12-052, which provides that the Board may authorize reimbursement from the Reopened Claims Reserve upon the request of a carrier.

Relying upon the "normal division of labor between the Director and the Board", SAIF argues that since the reimbursement question does not impact a claimant's compensation in any manner jurisdiction over the question rests with the Director. See ORS 656.704(3); 656.708. Considering this traditional line of authority between the Director and the Board, SAIF suggests that the language in ORS 656.625(2), which provides that "any reimbursement from the Reopened Claims Reserve shall be in such amounts as the Board prescribes", should not be interpreted in a manner that would also bestow on the Board the power to grant or deny reimbursement. Instead, SAIF asserts that the statute should be read in a manner that would limit the Board's authority to awarding TTD payable under ORS 656.278, thereby leaving questions concerning reimbursement from the Reopened Claims Reserve solely to the Director.

SAIF's argument might have some appeal from a claim processing standpoint. Yet, by adopting such reasoning, we would be required to disregard the clear directive from ORS 656.625(2) that "[n]otwithstanding any other provision of law, any reimbursement from the Reopened Claims Reserve shall be in such amounts as the board prescribes . . ." However redundant the procedure may appear to be in requiring Board and Director approval of a reimbursement request, the statute expressly grants such authority to both entities.[1] It is not for this forum to attempt to modify by administrative edict the legislature's mandate.

Consequently, for the foregoing reasons, we conclude that the Board is authorized to consider SAIF's entitlement to, and the amount of, reimbursement from the Reopened Claims Reserve under ORS 656.625. Furthermore, we adhere to our prior reasoning and conclusions that SAIF is not entitled to reimbursement from the Reserve. Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our March 15, 1991 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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[1] We surmise, in fact, that there was a reason for the redundancy. The Board has general authority over own motion matters. In such matters, the Board performs functions performed by the Director in other cases. Those functions include but are not limited to, establishing the amount and duration of compensation and closing a claim. The Board is more familiar with the law governing own motion than is the Director. The Director on the other hand, is responsible for the liquidity of various funds, including the Reopened Claims Reserve. It is far better equipped then the Board to ensure that its funds are not overspent. By requiring approval of reimbursement by both the Director and the Board, the legislature has maximized the possibility that the Reserve will be utilized only as appropriate.

In the Matter of the Compensation of
PHYLLIS I. FULLER, Claimant
WCB Case No. C1-01492
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Kirkpatrick & Zeitz, Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

On August 19, 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.

In pertinent part, the agreement provides:

> "Claimant contends that she is permanently and totally disabled. The parties stipulate that the claimant's total disability is due to noncompensable conditions." (p. 4, ll. 12-14).

The above language appears to dispose of claim(s) in which there is a bona fide dispute over the compensability of the claim(s). Specifically, the

parties dispute whether claimant's total disability results from the compensable injury. The stipulation resolves the dispute against compensability. By so stipulating, the parties have essentially entered into a disputed claim settlement. See OAR 438-09-001(2). Inasmuch as the disputed claim settlement is in the same document as a claim disposition agreement, it impermissibly exceeds the bounds of OAR 438-09-020(1)(b).

Furthermore, by stipulating that "claimant's total disability is due to noncompensable conditions," it is not clear which of claimant's conditions are and are not compensable. Therefore, we are unable to determine the extent of medical services relinquished by claimant under the proposed claim disposition agreement. Any restriction on claimant's right to medical services for the compensable condition would exceed the bounds of ORS 656.236(1) and the rules promulgated thereunder. See Jean E. Nealy, 42 Van Natta 2378 (1990); Kenneth D. McDonald, 42 Van Natta 2307 (1990).

Because this agreement exceeds the bounds of existing statute and rules, we find the proposed disposition is unreasonable as a matter of law. See Louis R. Anaya, 42 Van Natta 1843, 1844 (1990). Accordingly, we decline to approve the agreement and return it to the parties. See ORS 656.236(1)(a).

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).

Following our standard procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

August 28, 1991 Cite as 43 Van Natta 1799 (1991)

In the Matter of the Compensation of
CHARLES H. HANSCOM, Claimant
WCB Case Nos. 90-19136, 90-15086 & 90-15087
ORDER ON REVIEW
Bennett & Durham, Claimant Attorneys
VavRosky, et al., Defense Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Crider and Westerband .

The Traveler's Insurance Companies requests review of Referee Otto's order that: (1) set aside its denial of claimant's binaural hearing loss condition; and (2) upheld Argonaut Insurance Companies' "de facto" denial of the same condition. On review, the sole issue is responsibility.

We affirm and adopt the order of the Referee.

We note that claimant submitted a brief on review. ORS 656.382(2) provides for attorney fees against a carrier who initiates review when the Board determines that "the compensation awarded claimant shall not be disallowed or reduced." See Bahler v. Mail-Well Envelope Co., 60 Or App 90 (1982). That statute is also applicable in "responsibility only" cases (cases where compensability was not litigated at hearing and not addressed in the Referee's order) where it is established that a claimant's temporary disability rate was at risk of disallowance or reduction. See Riley E. Lott, Jr., 43 Van Natta 209 (1991).

In this case, however, there is no evidence in the record that claimant's temporary disability rate with Travelers would be greater than that of the prior carrier, Argonaut. We therefore conclude that claimant's compensation was not at risk. Accordingly, claimant's attorney is not entitled to a fee for services on review. Lott, supra; Neil J. Hauser, 42 Van Natta 1016 (1990).

ORDER

The Referee's order dated January 4, 1991 is affirmed.

August 28, 1991 Cite as 43 Van Natta 1800 (1991)

In the Matter of the Compensation of
BRENDA M. HINKLE, Claimant
WCB Case No. 89-14395
ORDER ON RECONSIDERATION
Popick & Merkel, Claimant Attorneys
Carol Taaffe (Saif), Defense Attorney

Claimant requests reconsideration of our August 9, 1991 Order on Review which affirmed a Referee's order that upheld the SAIF Corporation's denials of her aggravation and medical services claims for a current low back condition.

On reconsideration, claimant contends, first, that her treating physicians' opinions support a conclusion that her current low back problems are related to her 1985 compensable injury. We remain unpersuaded by those opinions, for the reasons stated in our prior order.

Second, claimant correctly notes that the Western Medical Consultants' report does not explicitly state that there is no causal relationship between claimant's current problems and her compensable injury. However, inasmuch as the Consultants found no current condition and no need for medical services, their opinion does not support either of claimant's claims.

Accordingly our August 9, 1991 order is withdrawn, on reconsideration, as supplemented and amended herein, we adhere to and republish our August 9, 1991 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

August 28, 1991 Cite as 43 Van Natta 1800 (1991)

In the Matter of the Compensation of
PAUL L. HOLMSTROM, Claimant
Own Motion No. 87-0155M
OWN MOTION ORDER ON RECONSIDERATION
SAIF Legal Department, Defense Attorney
David L. Runner, Assistant Attorney General

On August 22, 1991, we filed with the Court of Appeals a Notice of Withdrawal of our January 29, 1991 Own Motion Order Reviewing Carrier Closure, which denied the SAIF Corporation's request for reimbursement from the Reopened Claims Reserve. See ORS 183.482(6); ORAP 4.35; Glen D. Roles, 43 Van Natta 278 (1991). We rarely exercise our authority to withdraw an appealed order. Ronald D. Chaffee, 39 Van Natta 1135 (1987). However, we took such an action in this instance to address SAIF's contention that we lack jurisdiction or authority to grant or deny an insurer's request for reimbursement from the Reopened Claims Reserve. We proceed with our reconsideration.

The relevant facts are as follows. Claimant requested review of SAIF's August 23, 1990 Notice of Closure which had closed a claim that had been

reopened pursuant to a March 1987 Own Motion Order. We set aside SAIF's Notice of Closure and directed SAIF to resume the payment of claimant's temporary total disability (TTD). However, we did not authorize reimbursement from the Reopened Claims Reserve because we concluded that the claim had been reopened prior to January 1, 1988.

Although not cited in our order, the general rationale for our conclusion is expressed in Raymun B. Savalas, 43 Van Natta 38 (1991), which held that a claim reopened before January 1, 1988 does not qualify as an award made "pursuant to ORS 656.278 after January 1, 1988" as required in ORS 656.625. In Savalas, we noted that ORS 656.625(1) required the Director to establish a fund to provide reimbursement of "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." In the interests of promoting the continuing practice of voluntary reopening of own motion claims pursuant to ORS 656.278(4), we stated that we had authorized reimbursement from the reserve to carriers who had voluntarily reopened claims after January 1, 1988. See also OAR 438-12-025(3). However, we declined to extend that approach to pre-January 1, 1988 voluntary reopenings.

Our conclusion in Savalas was based on the reasoning that carriers reopening claims prior to January 1, 1988 had no expectation that their payments would be reimbursed because no such reserve was in existence. Moreover, we interpreted 1987 legislative revisions to ORS 656.278 which coincided with the adoption of ORS 656.625 as evidence of a legislative intent to allow reimbursement for only those awards made pursuant to the version of ORS 656.278 that became effective January 1, 1988. Inasmuch as the claim in Savalas had never been reclosed after an August 1987 reopening, we held that the carrier was not entitled to reimbursement from the Reopened Claims Reserve.

Here, SAIF challenges our authority to address either the amount of, or the entitlement to, reimbursement from the Reopened Claims Reserve under ORS 656.625. Specifically, it contends that the authority to decide such questions rests with the Director and not the Board. This date, we have rejected such an argument. See Dannie W. Crawley, 43 Van Natta 1796 (1991). For the reasons articulated in our holding in Crawley, we disagree with SAIF's contention that we lack authority to consider its request for reimbursement from the Reopened Claims Reserve under ORS 656.625.

Having concluded that we are authorized to address ORS 656.625 reimbursement requests, we have reconsidered SAIF's request. We have determined that a portion of TTD payable under this claim satisfies the qualifications for reimbursement pursuant to ORS 656.625. In reaching this determination, we draw from the Savalas rationale.

In Savalas, we held that because a claim reopened in August 1987 had never been reclosed, the carrier was not entitled to reimbursement. Here, a claim reopened in 1987 was closed by an August 23, 1990, Notice of Closure with TTD terminated as of August 13, 1990. On review of that claim closure, we set aside the notice and directed SAIF to resume TTD effective the date it had previously stopped paying. Thus, we effectively found that the claim had been prematurely closed. Notwithstanding such a finding, the fact remains that the claim was reopened and we awarded compensation payable effective August 14, 1990, the date after SAIF had previously terminated claimant's benefits.

Based on such circumstances, we conclude that, to the extent that SAIF was directed to recommence TTD beginning August 14, 1990, we awarded compensation pursuant to ORS 656.278 after January 1, 1988. Thus, we hold that SAIF did

qualify for reimbursement to the aforementioned extent under the statutory and administrative requirements, as well as the Savalas decision.

In conclusion, based on the reasoning expressed above and articulated in Dannie W. Crawley, supra, we hold that the Board is authorized to consider SAIF's entitlement to, and the amount of, reimbursement from the Reopened Claims Reserve under ORS 656.625. Furthermore, after conducting our reconsideration, we modify our prior order to authorize reimbursement from the Reopened Claims Reserve to the extent allowed under ORS 656.625 and OAR 436, Division 45. This authorization shall only apply to TTD awarded by our January 29, 1991 order to commence August 14, 1990.

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our January 29, 1991 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

August 28, 1991 Cite as 43 Van Natta 1802 (1991)

In the Matter of the Compensation of
SHIRLEY A. ROTH, Claimant
WCB Case No. 90-21078
ORDER APPROVING STIPULATION
Carney, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

The self-insured employer has expressed disagreement with our July 23, 1991 refusal to approve the parties' proposed stipulation. We treat the employer's reaction as a motion for reconsideration of our disapproval of the agreement. On reconsideration, we approve the stipulation.

Claimant requested Board review of a Referee's order which held that claimant's scheduled permanent disability award payable under a July 17, 1990 Determination Order should be paid at a rate of $145 per degree. Prior to the expiration of the briefing schedule, the parties announced that they had settled their dispute. Thereafter, they submitted a proposed stipulation.

Pursuant to the proposed stipulation, the parties agreed to settle their current dispute by providing that claimant's 5 percent scheduled permanent disability granted by the Determination Order would be paid at the rate of $145 per degree. The parties further stipulated that, in the event a final unappealed order from either the Court of Appeals or Supreme Court affirms the Board's holding in Alan G. Herron, 43 Van Natta 1097 (1991), the employer would pay claimant's award at the higher rate of $305 per degree upon claimant's request. Finally, claimant agreed to waive any entitlement to penalties and attorney fees associated with the employer's payment of the award at $145 per degree.

We disapproved the proposed agreement. Relying upon our decision in Jeanette M. Rouse, 43 Van Natta 1618 (1991), we objected to that portion of the stipulation which conditioned claimant's recovery of his award at "$305 per degree" upon a final unappealed court decision affirming the Herron holding. In Rouse, we reasoned that "conditional" stipulations effectively place a dispute in a state of "suspended animation" for an indeterminate period and are not in accordance with the design of our legal system which provides for finality in the decision making process.

The employer disagrees with our disapproval, contending that nothing in the Workers' Compensation Act precludes such an agreement. Noting that the agreement provides claimant with "a definite and enforceable right premised on

the occurrence of a verifiable and inevitable event," the insurer argues that our disapproval will only result in "significantly and unnecessarily prolong[ed] litigation."

Upon further reflection on this stipulation, in light of the fact that claimant's entitlement under the agreement will be readily ascertainable when the Court's decision in Herron is final, we have decided to approve the proposed agreement. We do so mindful of the objectives of the Workers' Compensation Law: To provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings to the greatest extent practicable. ORS 656.012(2)(b). To the extent our decision in Rouse is contrary to our analysis herein, we disavow it.

In granting this approval, we wish to emphasize that we retain misgivings concerning approving stipulations which contain provisions that are contingent upon the occurrence of subsequent events. However, in this particular situation, the simplicity of the claim processing issue (i.e., $145 vs. $305) outweighed our concerns regarding the indefiniteness for the final resolution of this dispute. Thus, under these particular and unique circumstances, we have approved a stipulation containing a contingency provision. Such approval should not be interpreted as an indication that future stipulations regarding other contingent provisions shall receive a favorable response. Indeed, we will not approve stipulations designed to delay resolution of disputes during the pendancy of litigation in another case if it is not crystal clear that the entitlement and responsibilities of the parties will be clear based on the stipulation alone once the decision issues. We will not approve stipulations in which it is likely that further litigation will be necessary to resolve the dispute.

Accordingly, on reconsideration, the parties' stipulation has been approved. In accordance with their agreement, claimant's request for review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
NANCY R. SANTOS, Claimant
WCB Case No. 90-21316
ORDER DENYING MOTION TO DISMISS
Olson, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

The insurer has moved the Board for an order dismissing claimant's cross-request for review on the ground that it was untimely. We deny the motion.

FINDINGS OF FACT

The Referee's order was issued on July 8, 1991. On July 12, 1991, the insurer mailed, by certified mail, its request for review of the Referee's order to the Board. On July 29, 1991, the Board received claimant's cross-request for review of the Referee's order.

ULTIMATE FINDINGS OF FACT

Claimant's cross-request for Board review was received by the Board less than 30 days after the issuance of the Referee's order.

CONCLUSIONS OF LAW AND OPINION

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. When one party timely requests Board review, the other parties have at least the remainder of the 30-day period and, in any event, no less than 10 days within which to cross-request review. Thus, under the most extreme circumstances, a cross-request may be effective if submitted within 40 days of the Referee's order. Robert Casperson, 38 Van Natta 420 (1986).

Here, the insurer's request for review of the Referee's July 8, 1991 order was filed on July 12, 1991, when it mailed its request, by certified mail, to the Board. OAR 438-05-046(1)(b). Consequently, claimant had the remaining 26 days of the 30-day appeal period within which to file his cross-request. Inasmuch as claimant's cross-request was filed with the Board on July 29, 1991, within the statutory period, it is timely. See ORS 656.289(3).

Accordingly, the motion to dismiss is denied. A transcript has been ordered. Upon its receipt, copies will be distributed to the parties and a briefing schedule implemented.

We retain jurisdiction over this matter pursuant to the claimant's request for cross-review. This order shall be interim and will be incorporated into our final, appealable order once review is completed.

IT IS SO ORDERED.

August 29, 1991 Cite as 43 Van Natta 1804 (1991)

In the Matter of the Compensation of
CAROLE J. DAMM, Claimant
WCB Case No. 88-05479
ORDER ON REMAND
Vick & Gutzler, Claimant Attorneys
Darryl Nelson, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Liberty Northwest Insurance Corp. v. Damm, 107 Or App 764 (1991). In our prior order, we found claimant's occupational disease claim for her low back condition compensable because claimant had established that her work activity was a material contributing cause of her condition. However, in a recent case, the court held that a claimant must establish that her employment was the major contributing cause of her condition or the worsening of her underlying condition. See Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991). Consequently, the court has remanded this matter to us for reconsideration in light of Aschbacher.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had proven that her work activities were the major contributing cause of her low back condition or, if the condition preexisted her employment as a bus driver, work was the major contributing cause of an aggravation or worsening of that condition. We affirmed the Referee's

order; however, we concluded that, based upon our interpretation of former ORS 656.802, only a material contribution to claimant's condition need be shown.

The Court of Appeals recently held that to establish compensability of an occupational disease under former ORS 656.802, claimant must prove that her work activities were the major contributing cause of her condition or of the worsening of her underlying condition. See Aetna Casualty Co. v. Aschbacher, supra. In light of the court's decision, we review the record to determine compensability of claimant's occupational disease claim.

Because claimant's low back condition involved repetitive trauma and was gradual in onset, her claim is properly analyzed under former ORS 656.802(1)(c). To establish that her condition is compensable under subsection (1)(c), claimant must prove that her work exposure included a series of traumatic events which were the major cause of the onset or worsening of the low back conditions and required medical services or resulted in disability. See Aetna Casualty Co. v. Aschbacher, supra. Major cause means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening than all other conditions, explanations, or exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); Dethlefs v. Hyster Co., 295 Or 309-310 (1983); David K. Boyer, 43 Van Natta 561 (1991).

We find that the causation issue is a complex medical question. Resolution of the issue requires expert medical evidence. See Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Here, the record contains only two medical opinions on the issue of causation. Following x-rays and a CT scan, claimant's treating orthopedic surgeon, Dr. Peterson, M.D., opined that claimant's leg complaints were due to sciatica and caused by degenerative changes. He did not believe that claimant's osteoporosis was contributing to her back problem. Dr. Peterson reported that "the major contributing cause of the development of her degenerative disc disease is a combination of her industrial exposure and predisposition to degenerative changes." He concluded that, "(p)ercentage of contribution of each cannot be determined." Dr. Peterson did not believe that osteoporosis had anything to do with claimant's current complaints of pain and he thought that claimant's driving "did cause material worsening of the underlying condition."

The Orthopaedic Consultants examined claimant and diagnosed degenerative arthritis at L5-S1 with symptoms of left sciatica. The Consultants reported that "claimant's degenerative lumbar disease is primarily a natural process but we cannot state that 21 years of school bus driving has not contributed to this degenerative change." The Consultants concluded that it was impossible to state specifically what contribution, if any, her driving had upon the process, but in any event, they believed that work activity aggravated the process. The Consultants also noted that age and obesity were factors in development of degenerative arthritis, and they believed claimant's leg symptoms were directly related to her low back difficulties.

We are not persuaded that claimant has established that her work activity was the major contributing cause of her low back condition or a worsening of an underlying condition. The Consultants were unable to determine degree of contribution by claimant's driving activity. In addition, the Consultants reported that age and obesity were factors in development of claimant's arthritis condition. We conclude that the Consultants' report fails to prove that claimant's work activities, in comparison with nonwork-related conditions (i.e., age and obesity), were the major contributing cause of her current low back condition. See David K. Boyer, supra.

Finally, we conclude that Dr. Peterson's report does not establish that work was the major contributing cause of claimant's condition. Dr. Peterson first opined that work exposure was the major cause of claimant's condition; however, he later stated that the activity materially worsened an underlying condition. Moreover, Dr. Peterson also reported that he was unable to determine the degree of exposure contributed by claimant's work activity. Although "magic words" are not required, we conclude that the record, as a whole, does not satisfy claimant's burden of proof. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986).

Although we find that the record establishes that work-related activities did contribute materially to a worsening of claimant's condition, we are unable to find that her work exposure was the major contributing cause. Consequently, claimant has failed to carry her burden of proof. See Aetna Casualty Co. v. Aschbacher, supra.

Accordingly, the Referee's order dated August 5, 1988 is reversed. The insurer's denial is reinstated and upheld. The Referee's attorney fee award is also reversed.

IT IS SO ORDERED.

In the Matter of the Compensation of
ESTEBAN H. OSORIO, Claimant
WCB Case No. C1-01743
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Bottini, et al., Claimant Attorneys
H. Thomas Anderson (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

On August 21, 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). 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 claimant's claim for workers' compensation benefits and payments of any kind due or claimed for the past, the present and the future, except compensable medical services. The agreement then provides that:

> "SAIF Corporation agrees to not oppose a recommendation of the treating doctor . . . for surgery, as long as the following two conditions are met: First, there must be no intervening causational factors, and second, the surgical procedures proposed are limited to those procedures discussed in [the treating doctor]'s July 15, 1991 letter." (p. 3, ll. 9-14)(emphasis supplied).

The above language could reasonably be interpreted to limit claimant's right to medical services under ORS 656.245. Any limitation on that right exceeds the bounds of ORS 656.236 and OAR 436-60-145(1) and 438-09-001(1). Accordingly, we find that the proposed disposition is unreasonable as a matter of law and set it aside on this basis. 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 the submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

Following our standard procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

August 29, 1991 Cite as 43 Van Natta 1807 (1991)

In the Matter of the Compensation of
CHRISTINE J. STATON-STRICKLAND, Claimant
WCB Case Nos. 89-09951, 89-09667 & 89-08053
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee McCullough's order that: (1) set aside the SAIF Corporation's denial of her claim for medical services for a current back and neck condition; (2) upheld Liberty Northwest Insurance Corporation's (Liberty Northwest) denial of her "new" occupational disease claim for the same condition. In her brief, claimant requests an additional attorney fee for her counsel's services at hearing, under ORS 656.386(1). In its brief, SAIF also seeks reversal of the Referee's order finding it responsible for claimant's current condition. On review, the issues are compensability, responsibility 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

Compensability

Medical Services claim against SAIF

We affirm and adopt the Referee's "Opinion and Conclusions" regarding the compensability of claimant's claim for medical services against SAIF.

"New" occupational disease claim against Liberty Northwest

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 last worked for Liberty Northwest's insured on or about February 8, 1989. Therefore, the last work exposure with that employer which could have contributed to her back and neck condition occurred in February 1989. Accordingly,

the occupational disease law effective between January 1, 1988 and July 1, 1990 before its amendment is applicable. See Johnson, supra, at 146-48.

Claimant's work for Liberty Northwest's insured, selling advertising and designing and "laying out" adds, involved daily hours on the telephone, prolonged bending over a desk, and repetitive reaching and lifting of layout books. Considering these activities, we conclude that her occupational disease claim is for a condition resulting from a "series of traumatic events or occurrences" under former ORS 656.802(1)(c). To establish that her condition is compensable under subsection (1)(c), claimant must prove that these traumatic events at work were the major contributing cause of a worsening of her preexisting back and neck conditions. Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991). In determining whether claimant has met the burden of proving that work conditions were the major contributing cause of a disease or its worsening, we compare employment conditions to non-employment conditions, explanations or exposures. See McGarrah v. SAIF, 296 Or 145, 166 (1983); David K. Boyer, 43 Van Natta 561 (1991).

Considering the passage of time since the 1978 injury and the number of potential causes for claimant's current problems, we conclude that the causation issue is a complex medical question. The answer largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 424-26 (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).

Relying upon the Board's decision in Donna E. Aschbacher, 41 Van Natta 1272 (1989), the Referee determined that claimant's condition is compensable as to Liberty Northwest, based on the opinions of Drs. Maloney and Watts, who attribute claimant's increased symptoms to her work at Liberty Northwest's insured. However, the Court of Appeals has recently reversed our decision in Aschbacher. Under Aetna Casualty Co. v. Aschbacher, supra, in order to establish that her claim is compensable as an occupational disease, claimant bears the burden of proving that her work exposure was the major contributing cause of a worsening of her underlying condition.

Claimant and SAIF argue that the claim is compensable as to Liberty Northwest, based on 1989 x-ray changes which were not present in earlier x-rays, recent decreased range of motion measurements, and the fact that claimant's symptoms stabilized four or five years after the 1978 injury, but worsened about three months after she began working for Liberty's insured. We are not persuaded by these arguments, for the following reasons. First, in this medically complex case, a temporal relationship between work and a changed condition is not sufficient to establish causation. Second, although claimant has lost range of motion and x-rays do reveal abnormalities not previously present, (compare Exs. 8-3 & 9A-4 with Exs. 20A-2; 10 & 28), no medical opinion relates these changes to claimant's work exposure at Liberty's insured. Moreover, Dr. Maloney, claimant's former treating physician, stated that she was unable to relate claimant's objective findings (as opposed to her symptoms) to the latter employment. (Exs. 38A; 45.) In this regard, we also note that Maloney was unwilling to conclude that claimant's muscle cell structure had changed, despite her increased symptoms. (Ex. 46-29-30).

The medical evidence is divided regarding the relationship between claimant's advertising sales work and her current condition. In July 1989, Dr. Watts, treating chiropractor, opined that claimant's work "consistently aggravated her preexisting injury." (Ex. 40). He explained that claimant's earlier injury caused a chronic condition, such that the injured muscles are more susceptible to reinjury. (Id.) In June 1990, Watts opined that claimant's muscle

tissue would require time to "reheal." (Ex. 44-1). Although we conclude that Watts' opinion supports a finding of some degree of causal relationship between claimant's job activities and her condition, it is not sufficient to carry her burden under Aschbacher, supra.

Dr. Kendrick, neurologist, examined claimant, reviewed her history and opined in 1989 that claimant's "basic injury dates back to her old [1978] injury." (Ex. 38; see Ex. 28).

Dr. Maloney noted numerous possible causes for claimant's current problems, including pain, repetitive physical activities, and other physical and or psychological stressors. In her opinion, such stressors could lead to the reflexive muscle shortening which she believes causes claimant's complaints. However, Maloney declined to quantify the actual contribution by causal factors in claimant's case. In the absence of persuasive expert evidence in this regard, we are unwilling to conclude that claimant's work exposure was the major contributing cause of her current condition. Accordingly, we conclude that claimant has not carried her burden of proving that her claim is compensable as to Liberty Northwest's insured.

Responsibility

Inasmuch as we have concluded that claimant's claim is not compensable as to her later employment with Liberty Northwest's insured, responsibility remains with SAIF's insured.

Attorney fees

On review, claimant contends that the Referee improperly failed to award her an assessed attorney fee for prevailing against Liberty Northwest's denial insofar as it denied compensability. However, we have concluded that Liberty Northwest's denial should be upheld in its entirety. Accordingly, claimant has not prevailed on any aspect of Liberty Northwest's denial, and no assessed fee may be awarded against Liberty Northwest. ORS 656.386(1).

ORDER

The Referee's order dated November 6, 1990 is affirmed in part and reversed in part. That portion of the Referee's order that set aside Liberty Northwest Insurance Corporation's May 4, 1989 denial insofar as it denied compensability is reversed. Liberty Northwest's denial is reinstated and upheld in its entirety. The remainder of the Referee's order is affirmed.

August 29, 1991 Cite as 43 Van Natta 1809 (1991)

In the Matter of the Compensation of
DONALD A. WILLIAMS, Claimant
WCB Case No. 89-17142
ORDER ON OF ABATEMENT
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Claimant requests that we reconsider our July 30, 1991 Order on Reconsideration, which denied remand, reversed the Referee's July 3, 1990 order, and reinstated and upheld the insurers' August 28, 1989 denial of an occupational disease claim. Claimant contends the Board inappropriately considered the insurer's "de facto" denial for claimant's low back condition in its Order of Reconsideration. Further, claimant requests an assessed attorney fee for having prevailed on the "de facto" denial. In the alternative, claimant requests

remand for further evidence taking. The insurer filed a response to claimant's motion on August 26, 1991.

In order to allow sufficient time to consider claimant's motion, our prior order is abated and withdrawn. Following reconsideration, we shall issue a new order.

IT IS SO ORDERED.

August 30, 1991 Cite as 43 Van Natta 1810 (1991)

In the Matter of the Compensation of
TIMOTHY J. BOWEN, Claimant
WCB Case No. 90-05470
ORDER ON REVIEW
Gatti & Gatti, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Garaventa's order that: (1) upheld the insurer's denial of his aggravation claim for his current low back condition; (2) declined to assess a related penalty and attorney fee for an allegedly unreasonable denial; (3) upheld the insurer's denial of his headache condition claim; and (4) declined to assess a related penalty and attorney fee for an allegedly unreasonable denial. On review, the issues are aggravation, compensability and penalties and attorney fee. 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 conclusions and opinion on the issue of aggravation.

Compensability/Headache condition

The Referee concluded that, because claimant's request for hearing on the denial of his headache claim was not filed until July 6, 1990, and a hearing convened July 16, 1990, the matter should be analyzed under the Workers' Compensation Act as amended, effective July 1, 1990.

We agree that the Referee applied the correct law. See Ida M. Walker, 43 Van Natta 1402 (1991). We further agree that claimant did not prove that his original injury was the major contributing cause of a consequential headache condition, and we adopt the Referee's conclusions and opinion on that issue. See ORS 656.005(7)(a)(A); Julie K. Gasperino, 43 Van Natta 1151 (1991).

Penalties and Attorney Fees

We adopt the Referee's conclusions and opinion on the penalty and attorney fee issues.

ORDER

The Referee's order dated October 31, 1990, as amended November 5, 1990, is affirmed.

In the Matter of the Compensation of
HOWARD L. BURTIS, Claimant
WCB Case No. 90-19778
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The self-insured employer requests review of Referee Hoguet's order which set aside its partial denial of claimant's current treatment, need for surgery and disability. On review, the issue is compensability.

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

The employer contends, in part, that claimant's current condition requiring treatment is not compensable because that treatment is directed solely to claimant's preexisting degenerative condition. However, pursuant to ORS 656.005(7)(a)(B), the test does not turn upon whether the treatment is separately directed to either the "compensable injury" or the preexisting condition. Instead, the resulting condition (cervical strain superimposed upon degenerative cervical spine disease) is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment. We agree with the Referee that the medical evidence establishes that claimant's accepted cervical strain is and remains the major contributing cause of his disability and need for treatment.

Claimant is entitled to a reasonable, assessed attorney fee for successfully defending the employer's Board appeal of the Referee's order. 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 fee for claimant's counsel's services on review concerning the compensability issue 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 complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 18, 1991 is affirmed. For services on Board review, claimant's counsel is awarded a reasonable assessed attorney fee of $800, to be paid by the self-insured employer.

In the Matter of the Compensation of
TORRY R. CULP, Claimant
WCB Case No. 89-21819
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Robert Jackson (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Michael Johnson's order that: (1) increased his unscheduled permanent disability award for a right shoulder condition from 17 percent (54.4 degrees), as awarded by a Determination Order, to 22 percent (70.4 degrees); and (2) declined to award scheduled permanent disability

for loss of use or function of the right arm. On review, the issue is extent of unscheduled and scheduled permanent disability. We modify.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Unscheduled permanent disability

The Referee concluded that claimant was entitled to 22 percent unscheduled permanent disability for his right shoulder condition. We modify.

In the present case, the parties do not dispute the values assigned by the Referee for claimant's age, education and adaptability. We therefore accept those values and discuss only the issue of impairment.

Claimant agrees with the impairment values assigned by the Referee for his loss of range of motion and chronic right shoulder condition. However, claimant contends that the Referee should have assigned a value for loss of strength in the shoulder.

Claimant argues that in May 1989, his treating physician, Dr. Butters, M.D., reported that claimant has moderate weakness in his rotator cuff strength. In addition, a physical therapist reported that claimant had continued weakness of forward elevation power, and was able to withstand minimal resistance (although) external rotation power had increased. In October 1989, Dr. Butters stated that claimant had marked strength deficit of external rotation and moderate partial permanent medical impairment involving the left shoulder due to loss of strength. Finally, claimant argues that he testified that he had no strength in his shoulder and he demonstrated his difficulty lifting an object at hearing.

The SAIF Corporation contends that a physical therapist may not measure impairment for purposes of an award under the standards. See Linda F. Wright, 42 Van Natta 2570 (1990). SAIF also argues that Referees may not make range of motion findings based upon their observations at hearing and, consequently, the Referee may not rate claimant's loss of strength by observing his inability to lift certain weights at hearing. See Darcy M. Greene, 42 Van Natta 1372 (1990).

We agree with SAIF that the findings of a physical therapist may not be used to rate claimant's impairment, and additionally, there is no evidence that Dr. Butters reviewed and accepted the therapist's findings as his own. We also agree that a Referee may not rate a claimant's loss of strength by observing claimant at hearing, as the standards require such impairment to be rated by a physician. However, the record clearly shows that Dr. Butters has found that claimant has a moderate loss of shoulder strength as a result of his compensable rotator cuff tear.

Dr. Butters restricted claimant from returning to work that involved repetitive lifting of over 20 pounds. Claimant credibly testified that he was unable to lift the 50 pound bags of grass seed that he had previously been able to lift at work. Moreover, Dr. Butters has repeatedly reported that claimant has lost shoulder strength due to his compensable injury. Therefore, we conclude that an impairment value of 15 percent should be awarded for claimant's loss of shoulder strength. Former OAR 436-35-330(19); Herman H. Plaeth, 42 Van Natta 2507 (1990).

In arriving at an impairment value for claimant's shoulder condition, the Referee stated that claimant was entitled to a value for his chronic, disabling pain. He concluded, however, that claimant was entitled to a value of 5 percent under former OAR 436-25-320(4), for his chronic condition limiting repetitive use of an unscheduled body part. We agree that claimant is entitled to a 5 percent impairment value for his chronic shoulder condition which limits his ability to repetitively lift objects. However, under the applicable version of the standards, claimant would not be entitled to a value for disabling pain. See former OAR 436-35-320(1); Sheila A. Davison, 42 Van Natta 2350 (1990).

To arrive at a total impairment value for the shoulder, claimant's impairment values of 15 percent for loss of shoulder strength, 9 percent for lost range of motion and 5 percent for his chronic condition limiting repetitive use are combined (not added) for a total impairment value of 27. Former OAR 436-35-320(2).

To compute claimant permanent disability under the standards, claimant's age value, 0, is added to his education value, 4, for a sum of 4. When that value is multiplied by claimant's adaptability value, 2, the product is 8. When that value is added to claimant's impairment value, 27, the result is 35 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 35 percent.

Scheduled permanent disability

The Referee concluded that claimant had not demonstrated loss of use or function of the right arm and had not proven a loss of grip strength. We agree.

Claimant contends that at hearing, the Referee noted that claimant's left bicep appeared larger than his right bicep. Claimant also testified that he believed that his right hand grip strength was 20 percent stronger than his left, but before the injury, his right hand had been twice as strong as the left. Claimant contends that the standards provide for decreased grip strength due to atrophy and for a value for a chronic condition limiting repetitive use. Claimant argues that lay testimony is sufficient to establish his impairment and the fact that he has no medical evidence to support his claim is not fatal to his case.

We conclude that the Referee's observations of possible atrophy of claimant's upper extremity and claimant's testimony regarding his assessment of his lost grip strength are not sufficient to establish claimant's impairment under the standards. See Darcy M. Greene, supra. We agree with the Referee's conclusion that claimant has not proven entitlement to an award of scheduled permanent disability for loss of use or function of the right arm.

ORDER

The Referee's order dated October 15, 1990 is modified. In addition to the Referee's award of 22 percent (70.4 degrees), claimant is awarded 13 percent (41.6 degrees) unscheduled permanent disability for his right shoulder injury, giving him a total award to date of 35 percent (112 degrees). Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney. However, the total out-of-compensation fees awarded under the Referee and Board orders shall not exceed $3,800.

In the Matter of the Compensation of
ANNETTE M. KELLEY, Claimant
WCB Case No. 90-09709
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of those portions of Referee Davis' order that: (1) declined to award an assessed attorney fee for her counsel's services in obtaining the self-insured employer's rescission of its medical services denial prior to hearing; and (2) declined to assess a penalty and related fee for an allegedly unreasonable denial. On review, the 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.

CONCLUSIONS OF LAW AND OPINION

Attorney Fees

The Referee, relying on Duane L. Jones, 42 Van Natta 875 (1990), concluded that no attorney fee was available for a denial rescinded prior to hearing. However, since the Referee's order, the legislature has effectively overruled Jones by amending ORS 656.386(1) to allow an attorney fee if an attorney is instrumental in obtaining compensation, even though a hearing is not held. See ORS 656.386(1) (amended June 1991). That amendment applies retroactively to cases in which the order was not final on or before the effective date of the act. SB 540, 3. Such is the case here.

In an alternative finding, the Referee concluded that a modest attorney fee would be appropriate because the evidence showed that the primary reason the denial was withdrawn was due to a change in the law.

We conclude that claimant's counsel was instrumental in obtaining compensation for claimant without a hearing and, accordingly, an attorney fee for services prior to the hearing is warranted. However, we agree with the Referee that the employer's rescission was based primarily upon a change in the law, rather than efforts by claimant's counsel.

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 prior to the hearing concerning the medical services issue is $350, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case, and the relatively modest value of the interest involved to claimant.

Penalties and attorney fees

We adopt the Referee's opinion and conclusion on the issue of penalties and attorney fees.

ORDER

The Referee's order dated January 18, 1991 is reversed in part and affirmed in part. That portion which declined to award an assessed attorney fee for services concerning the self-insured employer's rescission of its denial prior to hearing is reversed. For services rendered in conjunction with the rescission of the denial, claimant's counsel is awarded an assessed attorney fee of $350, payable by the self-insured employer. The remainder of the order is affirmed.

In the Matter of the Compensation of
STEPHEN A. ROBERTS, Claimant
WCB Case No. 90-15200
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum and Crider.

The SAIF Corporation requests review of Referee Baker's order that increased claimant's scheduled permanent disability award for a right leg (knee) injury from 24 percent (36 degrees), as awarded by a Determination Order, to 42 percent (63 degrees). On review, the issue is extent of scheduled permanent disability.

We affirm and adopt the order of the Referee with the following supplementation.

SAIF argues that the Referee should not have used the range of motion testing performed at the Jennings Lodge facility to increase claimant's disability award. It contends that the Referee should have relied on the measurements made by the Western Medical Consultants, which were more contemporaneous with the date claimant became medically stationary and the claim was closed. We note, preliminarily, that under the applicable law, we rate disability as of the date of hearing, not as of the date of claim closure. The amendments to ORS 656.283(7) and 656.295(5), which create a different rating principle, do not apply because claimant became medically stationary before July 1, 1990. See Or Laws 1990, Ch. 2, Sec. 54(3).

We agree that measurements close in time to the date of determination are favored in rating the extent of an injured worker's disability. In this case, however, claimant credibly testified that the Western Medical Consultants' examination of his knee lasted a total of five minutes, whereas the Jennings Lodge examination lasted an hour and a half and included mechanical muscle testing on the Cybex machine. SAIF does not dispute those facts. Moreover, contrary to SAIF's assertion, there is no other evidence that claimant's knee condition improved after the testing performed at the Jennings Lodge. While a longer examination is not necessarily a more reliable examination, we conclude under these circumstances, that the Referee properly relied upon the Jennings Lodge testing results as the most reliable indicator of claimant's true range-of-motion findings.

On review, claimant's award of compensation has not been disallowed or reduced. Hence, his attorney is entitled to an assessed fee. OR 656.382(2). After considering the factors set forth in OAR 438-15-010(4), we find that $400 is a reasonable assessed fee for claimant's counsel's efforts concerning the issue of permanent disability. 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 presented, and the value of the interest involved.

ORDER

The Referee's order dated January 9, 1991 is affirmed. Claimant's attorney is awarded a $400 assessed fee, payable by the SAIF Corporation, for services on review regarding the permanent disability issue.

In the Matter of the Compensation of
JUAN L. TORRES, Claimant
WCB Case No. 90-20836
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Steve Cotton (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

The SAIF Corporation requests review of that portion of Referee Harri's order which assessed attorney fees under ORS 656.382(1) for its unreasonable denial. On review, the issue is penalty-related attorney fees. We reverse.

FINDINGS OF FACT

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

The Referee concluded that SAIF's denial constituted an unreasonable resistance to the payment of compensation and assessed a penalty pursuant to ORS 656.262(10). Additionally, the Referee awarded a penalty-related attorney fee of $200 pursuant to ORS 656.382(1).

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that ORS 656.382(1) provides a separate and additional basis for the award of penalty-related attorney fees when the carrier unreasonably refuses to pay compensation and there are amounts then due and owing. We disagree.

When the carrier unreasonably refuses to pay compensation and there are amounts then due upon which to assess a penalty pursuant to ORS 656.262(10), ORS 656.382(1) does not provide a separate and additional attorney fee award for the same conduct. See Nicolasa Martinez, 43 Van Natta 1638 (1991); Harry E. Forrester, 43 Van Natta 1480 (1991). In the present case, the Referee concluded that there were amounts then due upon which he assessed the penalty pursuant to ORS 656.262(10)(a). ORS 656.262(10)(a) provides that the attorney shall receive one-half the penalty "in lieu of an attorney fee." Accordingly, we conclude that claimant is not entitled to an additional attorney fee award under ORS 656.382. Instead, claimant's counsel is entitled to receive one-half the additional amount assessed under ORS 656.262(10).

ORDER

The Referee's order dated February 27, 1991, is reversed in part and affirmed in part. The Referee's $200 attorney fee award is reversed. Claimant's counsel is entitled to one-half of the penalty assessed by the Referee in lieu of an attorney fee. The remainder of the order is affirmed.

In the Matter of the Compensation of
PAULINE E. BINGHAM, Claimant
WCB Case Nos. 90-18212 & 91-00412
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Westerband and Moller.

Claimant requests review of those portions of Referee Neal's order which: (1) upheld the self-insured employer's partial denial of her current left foot condition; (2) found that her left foot claim was not prematurely closed; (3) affirmed a Determination Order that did not award any scheduled permanent disability for the left foot; (4) upheld the self-insured employer's denial of her aggravation claim for a cervical condition; and (5) upheld the self-insured employer's denial of her medical services claim for cervical surgery. On review, the issues are compensability, premature closure, extent of scheduled permanent disability, aggravation and reasonableness and necessity of medical services. We affirm in part and reverse in part.

FINDINGS OF FACT

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

In January 1990, claimant had full cervical range of motion and no significant muscle spasms. In October 1990, claimant experienced decreased cervical range of motion and paravertabral muscle spasms. She also experienced radicular symptoms in her upper extremities. The radicular symptoms were worse on the left.

ULTIMATE FINDINGS OF FACT

Claimant's compensable left foot condition was medically stationary on September 6, 1990.

Claimant's compensable injury did not result in a permanent loss of use or function of the left foot.

In October 1990, claimant's compensable cervical condition symptomatically worsened. As a result of this symptomatic worsening, claimant's earning capacity was diminished.

The proposed cervical surgery is reasonable and necessary as a result of claimant's compensable neck injury.

CONCLUSIONS OF LAW AND OPINION

Left Foot Condition

We adopt the conclusions and reasoning concerning compensability, premature closure and extent of disability of claimant's left foot condition as set forth in the section of the Referee's order entitled "Foot claim."

Cervical Condition

Aggravation

The Referee concluded that claimant did not establish a compensable aggravation of her cervical condition. We disagree.

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). To prove a compensable worsening of her unscheduled condition, claimant must show that increased symptoms or a worsened underlying condition resulted in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Further, the medical worsening must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

In September 1990, Dr. Voeller reported that claimant was experiencing worsened radicular symptoms related to her cervical injury and referred her to Dr. Brett. Dr. Brett reported that claimant had decreased cervical range of motion and paravertabral muscle spasms. Thereafter, claimant underwent a cervical myelogram and delayed CT scan which Dr. Brett interpreted as showing residual impingement on the left C5 root in the area of claimant's previous surgery. Dr. Brett indicated that claimant would require a decompressive laminectomy and released her from work.

Conversely, Dr. Rosenbaum opined that the abnormalities appearing on the myelogram and delayed CT scan had not changed since a myelographic CT scan performed in 1989. He further opined that although claimant experienced cervical symptoms, such symptoms were not compatible with the radiological findings. He concluded that claimant's underlying condition had not changed and that her symptomatology was residual cervical strain symptoms complicated by functional overlay.

We are persuaded by the opinion of Dr. Brett. Dr. Brett is claimant's treating surgeon and performed claimant's prior cervical surgery. By contrast, Dr. Rosenbaum examined claimant one time approximately three years after her compensable injury. Inasmuch as Dr. Brett has treated claimant and performed the prior cervical surgery, he is in the best position to offer an opinion regarding claimant's cervical condition and we therefore find his opinion persuasive. See Givens v. SAIF, 61 Or App 490 (1983). Accordingly, we conclude that claimant has established a symptomatic worsening of her compensable cervical condition which is supported by objective findings of decreased range of motion and muscle spasms. See Suzanne Robertson, 43 Van Natta 1505 (1991).

Although claimant has established a symptomatic worsening, she must also establish that this worsening has resulted in diminished earning capacity. Smith v. SAIF, supra. Prior to her last claim closure, Dr. Brett indicated that claimant would continue to experience cervical discomfort, but that she could perform modified work. At that time, he noted full cervical range of motion without muscle spasms. In October 1990, however, Dr. Brett indicated that claimant's cervical range of motion had decreased and that she was experiencing muscle spasms. Dr. Brett released claimant from all work and reported that her disability and need for time loss were related to the compensable cervical injury. We rely on Dr. Brett and conclude that claimant has established diminished earning capacity as a result of her worsened condition.

Finally, as claimant has previously been awarded unscheduled permanent disability, she must also show that the worsening is more than waxing and waning of symptoms contemplated by the previous permanent disability award. ORS 656.273(8).

Here, claimant's last arrangement of compensation was the July 1990 stipulation which increased her award of unscheduled permanent disability to 45 percent. The stipulation made no reference to the prognosis for claimant's cervical condition. Furthermore, there is no medical evidence at that time

which indicated that claimant would have future periods of waxing and waning. Prior to that time, in January 1990, Dr. Brett indicated that claimant would continue to experience cervical discomfort, but did not indicate that he anticipated future waxing and waning which would cause claimant to be disabled. We conclude, therefore, that claimant's last award of permanent disability did not contemplate future waxing and waning of her cervical condition. See Lucas v. Clark, supra.

Under these circumstances, we conclude that claimant has established a compensable aggravation.

Cervical Surgery

The Referee concluded that claimant had not established that the proposed cervical surgery was reasonable or necessary. We disagree.

Claimant is entitled to medical services so long as they are reasonably and necessarily incurred for the treatment of her compensable injury. ORS 656.245(1); McGarry v. SAIF, 24 Or App 883, 888 (1976).

In October 1990, Dr. Brett reported that claimant was experiencing decreased range of motion, muscle spasms and radicular pain in her upper extremities. A myelogram indicated amputation and non-filling of the left C5 nerve root; persistent ventral impression on the thecal sac at C3-4, C5-6 and C6-7; and, significant stenosis at C5-6. Based on these findings, Dr. Brett recommended a decompressive laminectomy to relieve residual impingement on the left C5 root in the area of the previous surgery.

Dr. Rosenbaum opined that claimant would not be improved by surgical intervention. He acknowledged that claimant had radiologic abnormalities, but opined that her symptoms were due to residual cervical strain symptoms complicated by functional overlay and not due to the radiologic abnormalities.

We find the opinion of Dr. Brett more persuasive than the opinion of Dr. Rosenbaum. Dr. Brett has followed claimant's condition since 1988 and performed the prior cervical surgery at the same site as the proposed surgery. Therefore, we conclude that claimant has established that the proposed cervical surgery is reasonable and necessary. In reaching this conclusion we are aware that Dr. Voeller, Dr. Silver and the Western Medical Consultants recommended against similar surgery in 1989. However, since that time, claimant's condition has worsened; therefore, their opinions are of little probative value with regard to the reasonableness and necessity of the current proposed cervical surgery.

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 aggravation and reasonableness and necessity of surgery issues is $3,500, 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 brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated February 11, 1991 is reversed in part and affirmed in part. That portion which upheld the self-insured employer's aggravation denial is reversed. The denial is set aside and the claim is remanded for pro-cessing according to law. That portion which upheld the self-insured

employer's denial of surgery is reversed. The denial is set aside and the claim is remanded to the self-insured employer for processing according to law. For services at hearing and on review concerning the aggravation and reasonableness and necessity of surgery issues, claimant's counsel is awarded an assessed attorney fee of $3,500, payable by the self-insured employer. The remainder of the order is affirmed.

September 5, 1991 Cite as 43 Van Natta 1820 (1991)

In the Matter of the Compensation of
HERB R. DAVIDSON, Claimant
WCB Case No. 90-14757
ORDER ON REVIEW
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant, pro se, requests review of Referee Brazeau's order that upheld the SAIF Corporation's denial of his bronchitis and right elbow conditions. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

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

The Referee concluded that, although various physicians had recorded claimant's complaints of pain, there were no objective findings in the record as defined by ORS 656.005(19). We disagree.

We have recently concluded that, where a physician performs a physical examination and determines that claimant does, in fact, suffer from a condition such as tenderness, the doctor's report will constitute medical evidence supported by objective findings. See Suzanne Robertson, 43 Van Natta 1505 (1991). Here, the record contains both claimant's subjective complaints of tenderness over the elbow region and reports by doctors that, upon examination, claimant demonstrates tenderness above the right elbow. Exs. 1, 2, 7, 8.

Although we have concluded that the record contains objective findings in regard to claimant's elbow condition, we nonetheless agree with the Referee's conclusion that claimant has not proven that his condition arose out of his employment. We, therefore, adopt the remainder of the Referee's conclusions and opinion on the issue of compensability.

ORDER

The Referee's order dated December 31, 1990 is affirmed.

In the Matter of the Compensation
DANIEL C. EBERT, Claimant
WCB Case No. 90-18788
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Janice M. Pilkenton, Defense Attorney

Reviewed by Board Members Moller and Neidig.

The insurer requests review of Referee Fink's order that increased claimant's unscheduled permanent disability award for his allergic dermatitis condition from 6 percent (19.2 degrees), as awarded by Determination Order, to 51 percent (163.2 degrees). On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact with the following supplementation. Claimant's highest SVP up until the time of hearing was 7 as a heavy equipment mechanic. Following his reaction to quintolubric oil, claimant was unable to return to regular work. Claimant is capable of performing heavy work.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was entitled to a total award of 51 percent unscheduled permanent disability. We agree that claimant has established a loss of earning capacity equivalent to 51 percent, but we base our conclusion upon the following reasoning.

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). The standards in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. We apply the standards in effect on May 22, 1990, the date of the Determination Order.

The appropriate value for claimant's age of 34 years is 0. Former OAR 436-35-290 (3).

The appropriate value for claimant's formal education, including an associate degree, is 0. Former OAR 436-35-300(3)(a).

Claimant's highest SVP during the ten years prior to the date of hearing was 7 as a heavy equipment mechanic (DOT #620.261-022). Therefore, the appropriate value for skills is 1. Former OAR 436-35-300(4).

Claimant's position as a fluid power technician, in addition to his ten to twelve years of experience as a heavy equipment mechanic, demonstrate that he has acquired sufficient experience and training to perform other than an entry-level position. See Larry L. McDougal, 42 Van Natta 1544 (1990). Therefore, the appropriate training value is 0. Former OAR 436-35-300(5).

Claimant is unable to return to his usual and customary work and has not returned to or been offered, regular, modified work since he became medically stationary. Claimant's physical capacity falls within the heavy category. The appropriate value for adaptability is 1. Former OAR 436-35-310(4)(a).

The Referee apparently concluded that, under former OAR 436-35-430(8)(c), claimant was entitled to an impairment value of 15 percent, as his exposure to

chemical agents resulted in the development of an allergic response and the reaction prevented most work-related activities. On review, the insurer contends that the Referee should have not found that claimant was prevented from most work-related activities, as he was only prevented from work involving exposure to hydraulic chemicals. The insurer argues that claimant is, therefore, entitled to only an impairment value of 10 percent under former OAR 436-35-430(b).

Claimant contends that he is restricted from all of his job activities and, although he attempted to return to work, once he was exposed to the hydraulic fluid and oil, his condition recurred. Claimant also argues that both parties have unsuccessfully attempted to find work within his field that he is capable of performing.

We conclude that the evidence shows that claimant is prevented from most of his work-related activities. We, therefore, agree with the Referee that claimant is entitled to an impairment value of 15 percent under former OAR 436-35-430(8)(c).

The insurer acknowledges, and claimant agrees, that claimant is also entitled to a value for impairment of the skin under former OAR 436-35-440. A Class 1 skin disorder exists when signs or symptoms of skin disorder are present and with treatment, there is no limitation, or minimal limitation, in the performance of the activities of daily living, although exposure to certain physical or chemical agents might increase limitation temporarily. Former OAR 436-35-440.

Here, Dr. Morello, M.D., reported that claimant was seen in the Contact Dermatitis Clinic on several occasions in late 1989 and early 1990. He noted that claimant had developed a rash requiring treatment with prednisone and ointment. Dr. Morello stated that claimant's allergy to quintolubric oil "was felt to be significant to his dermatitis at that time." He reported that there was no doubt that claimant's dermatitis "is 100% work related." Dr. Morello noted that at the time of the examination, claimant was medically stationary and he had done well without exposure to the oils at work.

Based upon the medical evidence, we agree with the parties that claimant is entitled to a value of 5 percent for a Class 1 skin disorder under former OAR 436-35-440.

To arrive at an impairment value, the value for claimant's development of an allergic response (15), is combined (not added) with the value for his skin disorder (5), for a total impairment value of 19.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 0, is added to his education value, 1, the sum is 1. When that value is multiplied by claimant's adaptability value, 1, the product is 1. When that value is added to claimant's impairment value, 19, the result is 20 percent unscheduled permanent disability. Former OAR 436-35-280(7). Claimant's permanent disability under the standards is, therefore, 20 percent.

Finally, the insurer contends that the Referee erred by basing an award outside the standards solely upon claimant's loss of access to the labor market. See Daniel Mercado-Nuno, 42 Van Natta 2814 (1990). The insurer argues that the Referee was also required to consider other factors, such as the number of jobs claimant remained capable of performing and the wages obtainable in those jobs. See Richard A. Gonsalves, 42 Van Natta 1787 (1990).

We agree with the insurer that several factors should be considered in determining whether claimant has established clear and convincing evidence of a greater loss in earning capacity than that provided under the "standards." However, we conclude that the Referee in this case considered more than just the factor of claimant's loss of access to the labor market.

In his Opinion and Order, the Referee noted that, in addition to his experience as a fluid power technician or mechanic, claimant also had previous experience as a heavy equipment mechanic. However, the Referee found that the same chemicals which prevented claimant from returning to his current employment would preclude him from returning to work as an equipment mechanic. The Referee concluded that although claimant's previous wages had ranged between $8.75 per hour and $13.50 per hour, claimant's only chance at work now was obtaining entry-level employment at, or near, minimum wage. The Referee also found that claimant would have the additional disability of avoiding hydraulic fluids and oil. Finally, the Referee found that claimant did not have any transferable skills that would accommodate his physical limitations.

We conclude that, in determining that claimant had shown clear and convincing evidence of an entitlement to additional permanent disability, the Referee properly considered several factors, including claimant's loss of access to the labor market, the jobs he remained capable of performing and the wages obtainable in those jobs. Under the circumstances, we agree with the Referee that claimant has sustained a greater loss of earning capacity than that provided for under the standards. Although we have increased claimant's award under the standards, we continue to agree with the Referee's total award of 51 percent unscheduled permanent disability for claimant's allergic dermatitis condition.

Because the insurer requested the reduction of claimant's permanent disability award as granted by the Referee, and we have affirmed the Referee's order, claimant is entitled to a reasonable attorney fee pursuant to ORS 656.382(2). See Kordon v. Mercer Industries, 308 Or 290, 295-96 (1989). 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 extent of disability is $700, 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 31, 1991 is affirmed. For services on review for successfully prevailing against the insurer's request for reduction, claimant's counsel is awarded a reasonable assessed fee of $700, to be paid by the insurer.

September 5, 1991 Cite as 43 Van Natta 1823 (1991)

In the Matter of the Compensation of
LELA M. FISHER, Claimant
WCB Case No. 90-14880
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Crider.

Claimant requests review of Referee Galton's order that upheld the insurer's denial of claimant's right knee condition. Claimant also filed a motion

to impose a penalty and attorney fees for unreasonable delay as a result of the insurer's filing a motion to dismiss claimant's request for review. On review, the issues are compensability and penalty and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "FINDINGS OF FACT."

FINDINGS OF ULTIMATE FACT

We adopt the Referee's "FINDINGS OF ULTIMATE FACT."

CONCLUSIONS OF LAW AND OPINION

Compensability

We affirm and adopt the Referee's opinion on this issue.

Penalty and Attorney Fees

Claimant filed a request for review on January 17, 1991. Claimant did not file a brief. Thereupon, the insurer moved to dismiss claimant's request for review, which the Board denied. In response, claimant filed a motion to impose a penalty for unreasonable delay and an attorney fee for unreasonable resistance to the payment of compensation as a result of the insurer's motion to dismiss.

As noted in our interim order denying the motion to dismiss, the insurer's motion was not well founded. On the other hand, claimant's motion was likewise not well founded. Specifically, we have affirmed the Referee's order finding that the claim is not compensable. Hence, claimant could not possibly be entitled to a penalty or fee for an unreasonable delay or resistance to the payment of compensation by virtue of the insurer's motion to dismiss. Thus, claimant's motion, as was the insurer's motion, is denied.

ORDER

The Referee's order dated December 28, 1990 is affirmed.

Board Member Crider Concurring:

I join in the lead opinion. I note, however, that the insurer's motion to dismiss was frivolous. Longstanding Board rules make it absolutely clear that briefs are not jurisdictional. OAR 438-11-020(1). Nevertheless, the Board, unlike the courts, has no general authority to levy a sanction for filing of a frivolous motion. Compare ORS 656.390. The Board will consider the filing of frivolous motions by an insurer or self-insured employer in setting a reasonable fee to which a claimant is otherwise entitled under ORS 656.382(2) or ORS 656.386(1). OAR 438-15-010(4)(h). In this case, however, we have affirmed the Referee's order finding that the claim is not compensable. Hence, claimant is entitled to no fee.

In the Matter of the Compensation of
TAMARA L. GILMORE, Claimant
WCB Case No. 90-12020
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of those portions of Referee Otto's order which: (1) increased her unscheduled permanent disability award for a spinal injury from 17 percent (54.4 degrees), as awarded by Determination Order, to 19 percent (60.8 degrees); and (2) declined to assess an attorney fee pursuant to ORS 656.382(1) for the self-insured employer's untimely payment of temporary total disability benefits. On review, the issues are extent of unscheduled permanent disability and attorney fees. We affirm.

FINDINGS OF FACT

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

Claimant sustained a compensable neck and arm injury on August 5, 1989. On August 28, 1989, Dr. Farris, orthopedic surgeon, indicated on an "827" form that claimant was suffering from "C-7 radiculopathy." (Ex. 7). An MRI performed on September 1, 1989, indicated that claimant had a minimal disc bulging at the C6-7 level. (Ex. 8). Claimant's treating physician, Dr. Franks, neurosurgeon, indicated in a September 20, 1989 chart note that:

> "Because of the equivocal disc bulging at C6-7 I feel should she not improve that water soluble myelograph would be advised in her case." (Ex. 12).

On October 4, 1989, Dr. Burke, M.D., reported that a complete myelogram indicated that "Except for the slightest anterior extradural defect anteriorly at the C5-6 level, I do not appreciate any extradural defects in the cervical region." (Ex. 14). Dr. D'Amelio, radiologist, reported that a CT scan on October 4, 1989, indicated that, "At C6-7 there is n[o] evidence for any disc sapce [sic] abnormality." (Ex. 15).

On March 29, 1990, a "Stipulation and Order of Dismissal" was approved with prejudice. In part, the stipulation provided:

> "The parties agreed to resolve all issues raised or raisable by employer accepting the claim for the herniated C5-6 disc. Claimant has other radiographically demonstrated spinal defects, which are not part of this claim. *** The parties agree that this settlement dispose[s] of all issues raised or which could have been raised, by claimant's request for hearing of November 16, 1989 and March 12, 1990, and that these requests for hearing shall be dismissed with prejudice." (Ex. 31A).

The evaluator's worksheet for the July 17, 1990 Determination Order indicates that the evaluator gave claimant a value of 4 percent for a disc bulge at C6-7 as seen on an MRI. (Ex. 32-2). This is the only mention of claimant's C6-7 region in the record since the October 4, 1989 mylegram and CT scan showed that there was no defect in claimant's C6-7 region.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Disability

Claimant challenges only that portion of the Referee's unscheduled permanent disability calculations under the "standards" in which he concluded that claimant is not entitled to a value for a minimal disc bulge at C6-7. The Referee based his conclusion on the doctrines of res judicata and waiver because claimant entered into a "Stipulation and Order of Dismissal," approved with prejudice on March 29, 1990. We agree and adopt that portion of the Referee's conclusions with the following supplementation.

The term "res judicata" has been utilized to refer to the preclusive effect on a claim ("claim preclusion") and on an issue ("issue preclusion"). North Clackamas School Dist. v. White, 305 Or 48, 50, modified 305 Or 468 (1988). Claim preclusion bars claims, "which were or could have been litigated in the prior proceeding." See Consolidated Freightways v. Poelwijk, 81 Or App 311, 315 (1986). Issue preclusion bars, "relitigation of issues actually litigated and determined, if their determination was essential to the prior order." Id.; see Drews v. EBI Companies, 310 Or 134 (1990); State Farm Fire & Casualty v. Reuter, 299 Or 155, 158 (1985).

Claimant argues that her alleged disc bulge at C6-7 is not a "defect" as described in the "Stipulation and Order of Dismissal," that it was not the intention of the parties to address the C6-7 problems in the stipulation and that because the stipulation provides that the employer withdraws its November 6, 1989 denial, we should assume that the employer was accepting the neck injury which would include the C6-7 bulge.

We cannot go beyond the four corners of the "Stipulation and Order of Dismissal" and infer what the parties' intentions may or may not have been at the time of formation of the stipulation. Because claimant was aware, prior to agreeing to the stipulation, that she may have had a disc bulge at C6-7 that may have stemmed from the August 5, 1989 injury, because the stipulation indicates that "other demonstrated spinal defects" were taken into consideration at the time claimant agreed to the the stipulation, and because claimant specifically agreed in the stipulation that all issues which were raised or could have been raised, were disposed of by the stipulation, we agree with the Referee that the doctrine of res judicata precludes claimant's assertion of the compensability of a C6-7 disc bulge allegedly stemming from her August 5, 1989 compensable injury.

Penalty-Related Attorney Fee

Because there were amounts then due, the Referee relied on amended ORS 656.262(10) and awarded claimant a penalty of 25 percent of the amount due, and held that claimant's attorney was entitled to 50 percent of that amount for services rendered with respect to the employer's unreasonable delay in the payment of temporary disability compensation. We agree.

Claimant requested a hearing in this matter after May 1, 1990. The hearing was convened after July 1, 1990. Neither party contends that former law is controlling. Therefore, the statutory amendments, Or Laws 1990 (Special Session), ch 2, 54, apply. See Ida M. Walker, 43 Van Natta 1402 (1991).

Claimant argues that ORS 656.382(1) provides an additional attorney fee award when the employer has unreasonably delayed the payment of compensation. However, the Board has recently determined that where there are amounts then due stemming from an employer's unreasonable delay in paying compensation, ORS 656.382(1) does not provide a separate and additional attorney fee award for the

same conduct giving rise to payment of an "additional amount" under ORS 656.262(10). See Harry E. Forrester, 43 Van Natta 1480 (1991); Nicolasa Martinez, 43 Van Natta 1638 (1991). Here, therefore, only ORS 656.262(10)(a) applies, which provides that the attorney shall receive one-half the "additional amount" "in lieu of an attorney fee."

ORDER

The Referee's order dated October 18, 1990, as reconsidered November 3, 1990, is affirmed.

September 5, 1991 Cite as 43 Van Natta 1827 (1991)

In the Matter of the Compensation of
ROY E. HUBBARD, Claimant
WCB Case No. 88-10506
ORDER ON REMAND
Ormsbee & Corrigall, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Roseburg Forest Products v. Hubbard, 107 Or App 778 (1991). In our prior order, we found claimant's occupational disease claim for his neck and shoulder strain condition compensable because claimant had established that his work activity was a material contributing cause of his condition. However, the court has recently held that a claimant must prove that his employment was the major contributing cause of his condition or the worsening of his underlying condition. See Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991); Liberty Northwest Insurance Corp. v. Damm, 107 Or App 764 (1991). Consequently, the court has remanded this matter to us for reconsideration in light of Aschbacher and Damm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had proven that his work activities were the major contributing cause of the worsening of his underlying neck and shoulder condition. We affirmed the Referee; however, we concluded that, based upon our interpretation of former ORS 656.802, that only a material contribution to claimant's condition needed to be shown.

The Court of Appeals recently held that to establish compensability of an occupational disease under former ORS 656.802, claimant must prove that his work activities were the major contributing cause of his condition or of the worsening of his underlying condition. See Aetna Casualty Co. v. Aschbacher, supra; Liberty Northwest Insurance Corp. v. Damm, supra. In light of the court's decision, we review the record to determine compensability of claimant's occupational disease claim.

Because claimant's neck and shoulder condition involved repetitive trauma and was gradual in onset, his claim is properly analyzed under former ORS 656.802(1)(c). To establish that his claim is compensable under subsection (1)(c), claimant must prove that his work exposure included a series of traumatic events which were the major cause of the onset or worsening of his neck and shoulder condition and required medical services or resulted in disability. See Aetna Casualty Co. v. Aschbacher, supra. Major cause means an activity or

exposure or combination of activities or exposures which contributes more to the onset or worsening than all other conditions, explanations or exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); Dethlefs v. Hyster Co., 295 Or 309-310 (1983); David K. Boyer, 43 Van Natta 561 (1991).

Here, the Referee found the opinion of Dr. Vancho, claimant's treating chiropractor, to be persuasive. Relying upon Dr. Vancho's opinion and claimant's testimony, the Referee concluded that claimant had met his burden of proof and had shown that his work activities with the employer were the major contributing cause of the worsening of his underlying neck and shoulder condition. We adopt the Referee's "Opinion and Conclusions," with the following supplementation.

We note that although Dr. Vancho did not expressly state that claimant's work activities were the major contributing cause of the worsening of his condition, "magic words" are not required in a case in which the record, as a whole, satisfies claimant's burden of proof. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). Dr. Vancho agreed that claimant's work activities with the employer were an independent, significant, contributing cause of claimant's worsening. Ex. 20-3. Furthermore, Vancho testified by means of deposition that the pathology of claimant's underlying condition worsened as a result of his work activities with the employer. Ex. 23-4.

Under the circumstances, we conclude that the record establishes that claimant's work activities with the employer were the major contributing cause of the worsening of his underlying condition. Accordingly, on reconsideration, the Referee's order dated November 30, 1988 is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation
EVERETT L. LEACH, Claimant
Own Motion No. 91-0407M
OWN MOTION ORDER ON RECONSIDERATION
Nichols & Bogardus, Claimant Attorneys

Claimant requests reconsideration of the Board's August 8, 1991, Own Motion Order which reopened his claim for the payment of temporary disability benefits. Claimant seeks the assessment of a penalty and related attorney fee for the insurer's allegedly unreasonable processing of his claim.

In order to assess a penalty for an insurer's unreasonable claim processing, there must be amounts of compensation "then due" upon which to base the penalty. See ORS 656.262(10)(a). Here, because the insurer was not obligated to pay temporary disability benefits until so ordered by the Board on August 8, 1991, there were no amounts of compensation due at the time of the insurer's allegedly unreasonable delay. See, e.g., Fredrick D. Oxford, 42 Van Natta 476 (1990). Accordingly, we may not assess a penalty under ORS 656.262(10)(a).

On the other hand, we may assess a penalty-related attorney fee for an insurer's unreasonable resistance to the payment of compensation, even in the absence of amounts of compensation "then due." See ORS 656.382(1); Fredrick D. Oxford, supra. Here, the record shows that claimant requested claim reopening by letter dated March 29, 1991. The insurer's date stamp on the letter indicates that it received the request on April 3, 1991. The insurer had 90 days thereafter, or until July 2, 1991, to submit its written recommendation to the

Board regarding the propriety of own motion relief. See OAR 438-12-030. However, the insurer did not submit the written recommendation until July 29, 1991, resulting in a delay of 27 days.

Although a brief delay might have been reasonable in this case, a 27-day delay was unreasonable. Shortly after receiving claimant's own motion request, the insurer sought to verify that claimant was in the work force and therefore qualified for temporary disability benefits. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Cutright v. Weyerhaeuser, 299 Or 290 (1985). Claimant referred the insurer to his accountant for tax and income records. In early June 1991, the insurer's representative contacted the accountant to obtain the records. However, the accountant declined to do so until conferring with claimant's attorney. Claimant's attorney mailed the tax records to the insurer in late June 1991, and they were received by the insurer on July 1. The straightforward documents established that claimant was in the work force. All the carrier had to do was confirm that to the own motion section. Twenty- seven days was an unreasonably long time to take to accomplish that, and we find, therefore, that the insurer unreasonably resisted the payment of compensation. Accordingly, we conclude that a penalty-related attorney fee under ORS 656.382(1) is appropriate. A reasonable fee of $400 is assessed.

Our August 8, 1991 order is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our August 8, 1991 order. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

September 5, 1991 Cite as 43 Van Natta 1829 (1991)

In the Matter of the Compensation of
RUSSELL L. RAGLAND, Claimant
WCB Case No. 90-16841
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Norman Cole (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of those portions of Referee Fink's order that: (1) declined to assess an attorney fee for his counsel's services in obtaining the SAIF Corporation's prehearing rescission of its medical services denial; and (2) declined to assess an attorney fee for allegedly unreasonable claims processing. SAIF cross-requests review of that portion of the Referee's order that assessed a penalty in an amount above 25 percent of the amount then due. In its brief, SAIF also contends that the Referee did not have jurisdiction over this matter. On review, the issues are jurisdiction, penalties and attorney fees. We reverse in part and modify in part.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact, with the exception of the last paragraph in that section.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

SAIF contends that, because the medical services denial was rescinded, the only issue remaining at hearing was penalties and an "out-of-penalty" fee. SAIF

argues that, under the current law, the Referee did not have jurisdiction over this matter. We disagree.

As amended, ORS 656.262(10)(a) now provides that the Director shall have exclusive jurisdiction over proceedings regarding solely the assessment of a penalty under that subsection. However, in the present case, in addition to his request for a penalty and an out-of-penalty fee, claimant also alleged entitlement to an attorney fee under ORS 656.386(1) for his counsel's efforts in obtaining SAIF's rescission of its medical services denial. Accordingly, this proceeding does not involve solely the assessment of a penalty within the meaning of ORS 656.262(10). Therefore, exclusive jurisdiction over this matter rests with the Board, not the Director. See ORS 656.704; ORS 656.283

Attorney fees under ORS 656.386(1)

The Referee, relying on Duane L. Jones, 42 Van Natta 875 (1990), concluded that no attorney fee was available under ORS 656.386(1) for a denial rescinded prior to hearing. However, since the Referee's order, the legislature has effectively overruled Jones by amending ORS 656.386(1) to allow an attorney fee if an attorney is instrumental in obtaining compensation, even though a hearing is not held. See ORS 656.386(1) (amended June 19, 1991). That amendment applies retroactively to cases in which the order was not final on or before the effective date of the act. SB 540, 3. Such is the case here.

In an alternative finding, the Referee concluded that if a request for hearing had not been filed, claimant would not have received the compensation at issue.

We conclude that the Referee's alternative finding supports the conclusion that claimant's counsel was instrumental in obtaining compensation for claimant without a hearing and, accordingly, an attorney fee for services prior to hearing is warranted.

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 prior to the hearing concerning the medical services issue is $150, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case and the minimal value to claimant of the interest involved.

Attorney fees under ORS 656.382(1)

Claimant contends that his counsel is entitled to an attorney fee under ORS 656.382(1) for SAIF's allegedly unreasonable resistance to the payment of compensation. We decline to assess an attorney fee in this case, however, because the factual basis asserted in support of the fee -- SAIF's refusal to timely pay claimant's medical services bill -- is identical to the factual basis for which the Referee assessed a penalty under ORS 656.262(10)(a). Accordingly, the assessment of an attorney fee under ORS 656.382(1)(a) would contravene the legislative intent expressed in ORS 656.262(10)(a) that claimant's attorney receive one-half the penalty, "in lieu of an attorney fee." See Nicolasa Martinez, 43 Van Natta 1638 (1991); Harry E. Forrester, 43 Van Natta 1480 (1991).

Penalties and attorney fees

On review, SAIF does not dispute the Referee's award of a penalty and attorney fee for unreasonable claims processing. However, SAIF contends, and

claimant does not dispute, that the Referee's penalty award exceeds the amount allowed by statute. We agree.

ORS 656.262(10)(a) provides for a penalty of 25 percent of amounts then due. In the present case, SAIF paid $25 of a $117 medical bill and, at hearing, claimant did not challenge SAIF's contention that the $25 payment adequately reimbursed the doctor for the compensable portion of the services. We, therefore, conclude that the Referee's assessed penalty of $100 exceeds the amount allowed by statute. Accordingly, the Referee's penalty award is modified. Claimant is awarded a penalty of 25 percent of $25. Of that amount, one-half shall be be paid to claimant and one-half shall be paid to claimant's counsel, in lieu of an attorney fee. ORS 656.262(10)(a).

We note that claimant is not entitled to a fee for his counsel's efforts at Board level in prevailing on the issue of attorney fees under ORS 656.386(1). See Dotson v. Bohemia, 80 Or App 233 (1986).

ORDER

The Referee's order dated December 10, 1990 is reversed in part and modified in part. That portion of the Referee's order which declined to award an assessed attorney fee for services concerning the SAIF Corporation's rescission of its denial prior to hearing is reversed. For services rendered in conjunction with the rescission of the denial, claimant's counsel is awarded an assessed attorney fee of $150, payable by SAIF. That portion of the Referee's order which assessed a penalty of $100 for unreasonable claims processing is modified. In lieu of the Referee's assessed penalty of $100, claimant is awarded a penalty of 25 percent of $25, payable by SAIF, with half of that amount payable to claimant and half payable to claimant's counsel, in lieu of an attorney fee. The remainder of the Referee's order is affirmed.

September 5, 1991 Cite as 43 Van Natta 1831 (1991)

In the Matter of the Compensation of
DEBBIE L. ROUSE, Claimant
WCB Case No. 90-09080
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Crider and Westerband.

Claimant requests review of Referee Neal's order that upheld the insurer's denial of claimant's injury claim for a fibromyalgia condition. On review, the issue is compensability.

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

The Referee concluded that claimant's fibromyalgia condition, which she characterized as a "consequence of a compensable injury," was not compensable because claimant had failed to prove that her 1986 compensable injury was the major contributing cause of the "consequential condition." See amended ORS 656.005(7)(a)(A). Subsequent to the Referee's order, we issued Julie K. Gasperino, 43 Van Natta 1151 (1991), in which we construed the phrase "consequential condition" to include only problems that arise from conditions previously deemed compensable, as opposed to conditions that arise directly from the injurious event. Accordingly, we held that the 1990 amendments to the

definition of a compensable injury did not affect the standard of compensability for conditions intrinsically related to the underlying compensable event.

In this case, the parties do not address the Referee's characterization of claimant's condition as a "consequential condition." Nonetheless, we conclude that, even if that characterization is incorrect, the condition is not compensable because claimant has failed to prove that her 1986 injury was a material contributing cause of her disability or need for treatment. In doing so, we rely on Dr. Rosenbaum's opinion that, while her condition could be caused by repetitive activity at work, claimant's symptom complex did not result from any injury sustained in 1986.

ORDER

The Referee's order dated December 13, 1990 is affirmed.

September 6, 1991 Cite as 43 Van Natta 1832 (1991)

In the Matter of the Compensation of
HERBERT C. AUSBIE, Claimant
WCB Case No. 88-08507
ORDER ON REMAND
Philip Schuster II, Claimant Attorney
Nelson, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

This matter is before the Board on remand from the Court of Appeals. Liberty Northwest Insurance Corporation v. Ausbie, 107 Or App 762 (1991). The court has reversed our prior order, which found claimant's occupational disease claim for bilateral bone spurs compensable because claimant had established that his work was a material contributing cause of the worsening of his symptoms from his preexisting condition. The court remanded for consideration in light of Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991), which held that a claimant must establish that his employment was the major contributing cause of the worsening of his underlying condition. We proceed with our reconsideration.

FINDINGS OF FACT

We adopt and republish the "Findings of Fact" contained in our February 6, 1990 Order on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

In our prior Order on Reconsideration, relying on Donna E. Aschbacher, 41 Van Natta 1242 (1989), we found that claimant had proven that his work activities were a material contributing cause of a symptomatic worsening of his preexisting foot condition. Consequently, we set aside the insurer's denial of claimant's occupational disease claim. However, the Court of Appeals has recently held that to establish the compensability of an occupational disease under former ORS 656.802, claimant must prove that his work activities were the major contributing cause of his condition or of the worsening of his underlying condition. See Aetna Casualty Co. v. Aschbacher, supra. Relying on its decision in Aschbacher, the court has reversed our order and remanded for reconsideration.

We adhere to and republish that portion of the "Conclusions of Law" in our prior Order on Reconsideration that disagreed with the Referee's analysis of

this claim under an injury theory. Rather, for the reasons discussed below, we conclude that the claim should be analyzed as an occupational disease.

Claimant's work as a door, window and molding installer involved placing doors onto his feet in order to elevate them into position. It also involved kneeling and flexion of his toes. Considering these activities, we conclude that his claim is for a condition resulting from a "series of traumatic events or occurrences" under former ORS 656.802(1)(c).

Claimant suffers from an underlying degenerative condition. Dr. Cook, M.D., examined claimant at the Portland Clinic in 1979 and at that time findings were consistent with degenerative involvement of the MP joint of the big toe. (Ex. 12). Dr. Cook again examined claimant in July 1988 and noted that x-rays showed spurring bilaterally at the MP joint of the big toes and marked degenerative involvement on the right. Thus, in order to establish that his condition is compensable under former ORS 656.802(1)(c), claimant must prove that the series of traumatic events at work were the major contributing cause of a worsening of his underlying condition. Aetna Casualty Co. v. Aschbacher, supra; Weller v. Union Carbide, 288 Or 27, 35 (1979). Worsening in the occupational disease context means pathological exacerbation of the underlying condition. See Wheeler v. Boise Cascade Corp., 298 Or 452, 457 (1985).

The question whether claimant experienced a pathological exacerbation of his preexisting degenerative condition is a complex medical question requiring expert medical analysis. See Uris v. Compensation Department, 247 Or 420, 424-26 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Dr. Wisdom, claimant's treating physician, found that claimant's preexisting foot symptoms had been growing slowly worse and noted that claimant had been diagnosed with degenerative arthritis of the great toe MTP joints in the late 1970's. (Ex. 2-2). Dr. Wisdom felt that claimant's current employment as a carpenter had contributed to a flare-up of the preexisting condition, but it was unlikely that six weeks employment with one firm would be the major etiology of claimant's difficulty. (Ex. 9). Moreover, Dr. Wisdom concluded there was no indication that work as a carpenter had caused a worsening of claimant's underlying condition. He stated that the natural history of this condition is progressive deterioration over a number of years, with increased activity causing increased pain.

We find Dr. Wisdom's opinion, as claimant's treating physician, to be thorough and well-reasoned. Consequently, we find it persuasive. Somers v. SAIF, 77 Or App 259 (1986); Weiland v. SAIF, 64 Or App 810 (1983). At best, Dr. Wisdom's opinion supports a conclusion that claimant's work activities contributed to a worsening of symptoms from claimant's preexisting condition. Such a finding is insufficient to establish that claimant's work activities were the major contributing cause of a worsening of his underlying condition. Therefore, claimant's occupational disease claim is not compensable. Aschbacher, supra.

Accordingly, on reconsideration, the Referee's order dated July 28, 1988 is reversed. The insurer's denials are reinstated and upheld. The Referee's attorney fee award is reversed. The attorney fee award for services on Board review is also reversed.

IT IS SO ORDERED.

In the Matter of the Compensation of
LESLIE G. BROOKS, Claimant
WCB Case No. 89-06207
ORDER ON REVIEW
Barnett, et al., Claimant Attorneys
Douglas Oliver (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Bethlahmy's order that: (1) upheld the SAIF Corporation's denial of his psychological condition; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable failure to timely provide discovery. On review, the issues are compensability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

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

At the outset, we note that the Referee concluded that claimant was required to prove that his employment materially contributed to his mental disorder. Subsequent to the Referee's order, the Court of Appeals held that, under former ORS 656.802(1), to establish a claim for an occupational disease, claimant is required to prove that work exposure was the major cause of his condition. Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991).

The Referee concluded that, although claimant's stress was caused by his belief that his supervisors did not support him, the evidence demonstrated that the situation did not exist as he perceived it. We agree that the only "real" event claimant experienced was that, on one occasion, his supervisor called him in to discuss the "Martin" audit and the supervisor's concerns about a recent appellate case involving the independent contractor issue. Although claimant believed that the money he collected would be returned to the party whom he had audited, the event never occurred.

We agree with the Referee that claimant imagined that his supervisors did not support him. In fact, the record contains letters from two of claimant's supervisors informing the party that claimant's audit was correct, there had been no errors in the audit and, later, that the Division's position on the correctness of the audit remained unchanged. Exs. 11, 14. We conclude that claimant imagined that his employer did not support him and the situation alleged by claimant did not exist in a real and objective sense.

We further note that, in providing opinions on claimant's psychological condition, the doctors (with the exception of Dr. Colbach who concluded that claimant's version of events was not accurate) relied upon his perceptions of his situation at work. Dr. Mayer, M.D., reported that claimant claimed that the money he had collected from the audit had been returned, claimant's judgment was questioned at work and he had no support from his supervisors. Ex. 30. Dr. Conant-Norville, M.D., reported that claimant first had symptoms after a major audit was reversed by a Salem official for no clear reason. Dr. Conant-Norville concluded that claimant's psychological problems arose out of his emotional response to lack of support at work. Ex. 51. Finally, Dr. Johnson reported that claimant had defined his stress as (resulting from) negative feedback and

decisions that were not backed up. Dr. Johnson concluded that the Martin case was a material and major contributing cause of precipitating claimant's stress. Ex. 53.

We conclude that, given the inaccuracy of claimant's reports to the medical experts, the doctors' opinions which conclude that claimant's perceptions were the cause of his disorder are insufficient to support a finding that real, objectively stressful events at work were the major cause of claimant's mental disorder. We conclude that claimant has not proven by clear and convincing evidence that work-related stressors are the major cause of his psychological condition. Accordingly, we affirm the Referee.

ORDER

The Referee's order dated December 27, 1990 is affirmed.

September 6, 1991 Cite as 43 Van Natta 1835 (1991)

In the Matter of the Compensation of
ANTHONY J. COLISTRO, Claimant
WCB Case No. 89-13494
ORDER ON REVIEW
Max Rae, Claimant Attorney
John Motley (Saif), Defense Attorney

Reviewed by Board Members Westerband, Neidig, and Crider.

Claimant requests review of those portions of Referee Michael V. Johnson's order which: (1) upheld the SAIF Corporation's denial of his medical services claim for low back surgery; (2) declined to assess a penalty or related attorney fee for an allegedly untimely denial; and (3) declined to award an assessed attorney fee for services rendered prior to the hearing which resulted in the rescission of the causation aspect of SAIF's denial. On review, the issues are reasonableness and necessity of surgery, penalties and attorney fees, and entitlement to an attorney fee under ORS 656.386(1). We affirm.

FINDINGS OF FACT

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

FINDINGS OF ULTIMATE FACT

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

CONCLUSIONS OF LAW AND OPINION

Medical Services/Surgery

We adopt the conclusions and reasoning concerning the reasonableness and necessity of the proposed surgery as set forth in the Referee's order.

Penalties and Attorney Fees

We adopt the conclusions and reasoning concerning the penalty and attorney fee issue as set forth in the Referee's order.

Attorney Fees

The Referee declined to award claimant's counsel an assessed attorney fee for services relating to SAIF's rescission of the causation aspect of its denial

at hearing. We agree that claimant's counsel is not entitled to an assessed attorney fee. However, we do so on a different basis.

In order to be entitled to an attorney fee under ORS 656.386(1), claimant must finally prevail over a denial of a claim for compensation. To prevail on a denial of medical services, claimant must establish that the medical services are causally related to the compensable injury and are reasonable and necessary. ORS 656.245(1); Wetzel v. Goodwin Brothers, 50 Or App 101 (1981). If a claimant establishes that his need for medical services is causally related to the industrial injury, but does not establish that the services are reasonable and necessary, he has not finally prevailed over a denial of compensation. See Arbra Williams, 43 Van Natta 142, 144 (1991); Lynn M. Elliott, 42 Van Natta 23, 24 (1990).

Here, the only compensation at issue was claimant's medical services claim for low back surgery. SAIF's denial of the low back surgery was based on causation and the need for surgery. At hearing, SAIF rescinded the causation element of its denial, but continued to deny the surgery on reasonable and necessary grounds. We have herein affirmed the Referee's conclusion that the proposed surgery is not reasonable and necessary and consequently, upheld SAIF's denial.

The causal relationship was only one element of SAIF's denial. Therefore, in order to prevail against SAIF's denial, claimant was still required to prove that the surgery was reasonable and necessary. Inasmuch as claimant did not establish that the surgery was reasonable and necessary, he did not finally prevail over SAIF's denial of his claim for surgery. Accordingly, claimant is not entitled to an attorney fee pursuant to ORS 656.386(1). Lynn M. Elliott, supra; See also Jerry E. James, 42 Van Natta 53 (1990).[1]

ORDER

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

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[1] The dissent contends that by abandoning, allegedly prior to hearing, one of its two reasons for denying the claim for compensation, the insurer exposed itself to an award of attorney fees under amended ORS 656.386(1). We disagree.

ORS 656.386(1) provides that a claimant is entitled to attorney fees for either prevailing at hearing against the insurer's denial of a claim for compensation or where the claimant's attorney is instrumental in obtaining the compensation without a hearing. Here, there is no dispute that the "claim for compensation" at issue which the insurer had denied was the February 16, 1989 request of Dr. Rivas to perform an L5-S1 discectomy and fusion. (Ex. 40). By letter of February 21, 1989, claimant's counsel asked SAIF to "[p]lease process this as a claim for pre-authorization of this surgical procedure and advise Dr. Rivas and me of your decision as quickly as practical." (Ex. 41). SAIF denied this claim. Claimant was required to request a hearing, at which the insurer "finally prevailed." Thus, despite the fact that SAIF dropped at the hearing, one of two bases for its denial, claimant's attorney was obviously not instrumental in obtaining the compensation without, or at, the hearing. Second, diagnostic services are compensable, even if the medical services claim is not. Brooks v. D & R Timber 55 Or App 688 (1982). Here, by agreeing at the April 16, 1990 hearing to pay for the diagnostic services, while adhering to its denial, SAIF agreed to do no more than what the law required. In short, there is no indication in this record that diagnostic services were ever really an issue in this case, and that SAIF's agreement to pay for them was anything more than an expression of its willingness to comply voluntarily with the law.

Board Member Crider, dissenting.

The parties presented this case as a dispute concerning whether or not a fee may be assessed under ORS 656.386(1) where an insurer rescinds a denial prior to issuance of a referee's order. Claimant's opening brief at 1-2; Respondent's brief at 5. In view of the Legislature's recent amendment of ORS 656.386(1), claimant's attorney is entitled to an assessed fee. SB 540, sec. 3.

The Board reaches the contrary result by reframing the issues. The Board applies case law dealing with the situation in which an insurer denies medical services; a referee finds that, while the condition for which services are rendered is related to the compensable injury, the services are not reasonable and necessary and thus not compensable; and the referee upholds the denial. In such cases, the claimant is entitled to no fee for proving that the condition is related to the injury. The reason: The denial has been set aside neither in whole nor in part. Moreover, the referee's finding that the condition was causally related to the injury will have no res judicata effect in a subsequent proceeding because the finding was not essential to the referee's decision.

This is not such a case. In this case, we do not deal with a referee's finding; rather, we deal with the insurer's explicit decision to accept part of the claim. Claimant had an accepted claim for an injury to the stomach and right thumb. The denial which precipitated the litigation denied the compensability of claimant's back condition:

> "We have recently received information that you are seeking treatment for back and arm problems which is [sic] allegedly related to your injury. After reviewing the information in your file, we are unable to pay for that treatment/surgery, as the treatment/surgery is not related, reasonable or necessary for the accepted condition."

At hearing, SAIF agreed that the back condition was compensably related to the compensable injury and, furthermore, agreed to pay for certain medical services for the back condition which had been recommended by examining physicians, Dr. Gritzka and Dr. Brooks. The partial rescission of the denial was memorialized in Referee Johnson's interim order. Thus, claimant's attorney clearly procured acceptance of the previously-denied back condition and some treatment therefor. The only remaining issue was surgery. In such a case, claimant's attorney was clearly instrumental in obtaining compensation without hearing. He is entitled, therefore, to an assessed fee.

September 6, 1991 Cite as 43 Van Natta 1837 (1991)

In the Matter of the Compensation of
STEPHANIE A. FARRELL, Claimant
WCB Case No. 90-08146
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Brown's order which upheld the self-insured employer's denial of her claim for a back injury. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant worked for the employer as a child care aide. On March 5, 1990, while at work, she reached into a storage shed to retrieve a tricycle for one of the children she was attending. She felt a popping sensation in her back, but did not immediately experience pain. Claimant continued to work that day; however, she began experiencing back soreness and some leg pain.

Although she continued to experience some soreness and pain, claimant continued to work until March 13, 1990. On that date, claimant was standing in her living room and noticed her husband coming home. She straightened up and her left leg went numb and buckled causing her to collapse. The following day, claimant notified her employer of the March 5, 1990 incident and sought medical treatment. Physical examination at that time revealed decreased ranges of motion and muscle spasm.

On March 27, 1990, claimant was examined by Dr. Gilsdorf. Dr Gilsdorf took claimant's history of the March 5, 1990 incident and noted decreased ranges of motion, absent left ankle jerk, nonsymmetrical straight leg raise and hypesthesia of the left foot. Dr. Gilsdorf diagnosed lumbar sprain syndrome and an acute herniated nucleus pulposus at left L5-S1.

On March 29, 1991, the employer denied claimant's claim on the basis that it did not occur in the course and scope of her employment.

Claimant had not experienced low back symptoms prior to the March 5, 1990 incident. Following that incident there were no off-work activities which contributed to claimant's back and leg symptoms.

ULTIMATE FINDINGS OF FACT

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

The March 5, 1990 incident was a material contributing cause of claimant's disability and need for medical treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee found that although claimant had established that the March 5, 1990 incident occurred, she did not prove that her disability and need for medical treatment was related to that incident. We disagree.

The sole issue in this case is whether claimant has established a compensable injury. Because a hearing was convened after July 1, 1990, her claim is properly analyzed under the 1990 revisions to the Workers' Compensation Act. See Ida M. Walker, 43 Van Natta 1402 (1991).

Therefore, in order to establish a compensable injury, claimant must show an accidental injury arising out of and in the course of employment. ORS 656.005(7)(a). The injury must be established by medical evidence, supported by objective findings. Id; Suzanne Robertson, 43 Van Natta 1505 (1991).

Claimant credibly testified that she felt her back "pop" following the March 5, 1990 tricycle incident. She further testified that she had not experienced back symptoms prior the March 5, 1990 incident. Following the incident, claimant experienced ongoing low back and leg symptoms which led her to seek treatment after her leg buckled on March 13, 1990. There is no evidence of an

intervening cause between March 5, 1990 and March 13, 1990, when she sought medical treatment, which would account for claimant's back and leg symptoms.

Dr. Gilsdorf took claimant's history of the March 5, 1990 incident and diagnosed lumbar sprain syndrome and an acute herniated nucleus pulposus at left L5-S1. His diagnosis was supported by objective findings which included decreased range of motion, absent left ankle jerk, nonsymmetrical straight leg raise and hypesthesia of the left foot. There is no contrary medical evidence.

Under these circumstances, we find that claimant has sustained a compensable injury. Dr. Gilsdorf's report provides objective findings of an injury. Claimant's credible testimony, in conjunction with the history given to Dr. Gilsdorf, establishes a material causal link between the objective findings and the March 5, 1990 incident. Accordingly, claimant has established a compensable injury. See Mark Weidle, 43 Van Natta 855 (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 at hearing and on review concerning the compensability 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 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 November 1, 1990 is reversed. The self-insured employer's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review concerning the compensability issue, claimant's counsel is awarded an assessed attorney fee of $1,500, payable by the self-insured employer.

September 6, 1991 Cite as 43 Van Natta 1839 (1991)

In the Matter of the Compensation of
MISAEL R. GARCIA, Claimant
WCB Case No. 90-11683
ORDER ON REVIEW (REMANDING)
Hollis Ransom, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Garaventa's order which upheld the insurer's denial of his claim for a low back injury. Claimant has requested that this matter be remanded for the taking of additional evidence. On review, the issues are remand and compensability. The motion for remand is granted.

FINDINGS OF FACT

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

In June 1990, claimant filed a request for hearing, challenging the insurer's denial. Simultaneously, claimant requested that the insurer provide copies of all existing and future medical documents and other information relating to his claim. In July 1990, claimant's former counsel wrote Dr. Cohen concerning medical billings, but did not ask for any medical documents from Dr. Cohen.

Following the hearing, claimant's counsel obtained records from Holladay Park Medical Center. Among the documents received were Dr. Cohen's chartnotes of June 15, 1990, July 24, 1990 and August 21, 1990 relating to claimant's treatment for low back symptoms. The insurer was not in possession of these records. However, on August 7, 1990, the insurer had written Dr. Cohen informing him of its denial.

The documents obtained by claimant after the hearing are relevant to the question of compensability. They are the type routinely provided by providers to insurers.

FINDINGS OF ULTIMATE FACT

The record is incompletely developed without the documents obtained by claimant after the hearing.

The documents were not obtainable with the exercise of due diligence at the time of the hearing.

CONCLUSIONS OF LAW AND OPINION

Should we determine that a case has been improperly, incompletely or otherwise insufficiently developed, we may remand to the Referee for further evidence taking, correction or other necessary action. ORS 656.295(5). To merit remand, it must be established that the evidence relevant to the issues raised in the remand request was unobtainable with due diligence before the hearing. See Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986). Due diligence does not always require that claimant request records directly from medical providers who are required by rule to submit reports to the insurer. Penni L. Mumm, 42 Van Natta 1615, 1617 (1990). Rather, it is sufficient that claimant seek disclosure of records from the insurer. Id.

Here, claimant made a standard request of the insurer to provide all medical documents and other information relating to his claim. His former counsel contacted Dr. Cohen concerning the payment of medical billings, but did not request any records from Dr. Cohen. The insurer did not provide claimant with Dr. Cohen's chartnotes relating to his low back injury. The record does not establish that the insurer was in possession of Dr. Cohen's chartnotes at the time of hearing. However, prior to the hearing, the insurer had contacted Dr. Cohen by letter, informing him of its denial.

We conclude that claimant exercised due diligence by initially requesting medical documentation and other claim information from the insurer. While it is true that claimant's former attorney had contacted Dr. Cohen prior to the hearing, it is not incumbent upon claimant to request medical documentation from a provider, particularly in this instance where the insurer had contacted Dr. Cohen prior to the hearing. Moreover, the documents submitted were of the type that Dr. Cohen should have submitted to the insurer pursuant to OAR 436-10-030. Under these circumstances, we conclude that without the admission of the aforementioned medical evidence, the record has been insufficiently developed. Mumm, supra at 1617.

Accordingly, the Referee's order is vacated. This case is remanded to Referee Garaventa with instructions to reopen the record and to reconsider this matter in light of this additional evidence.

ORDER

The Referee's order dated October 19, 1990, as republished December 5, 1990, as corrected January 2, 1991, is vacated. This matter is remanded to Referee Garaventa for further action consistent with this order.

In the Matter of the Compensation of
SHARON D. JULIEN, Claimant
WCB Case No. 90-11932
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Susan D. Ebner (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of Referee Tenenbaum's order that: (1) set aside its denial of cervical strain and associated muscle contraction headaches; and (2) assessed a penalty and attorney fee for an allegedly unreasonable denial. On review, the issues are compensability, penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the third full paragraph on page 2 of the Referee's "FINDINGS," and supplement as follows.

Claimant has had a history of migraine headaches since she was in her teens. She also has diabetes, hypertension and renal infarction, for which she takes a number of different medications.

Claimant's job required her to respond to telephone inquiries regarding collections. In 1985, after computers were installed, claimant held her telephone between her head and shoulder while at the same time working at her computer terminal. Headsets became available in 1987, although claimant did not regularly use one.

Claimant was off work during the summer of 1989 for non-work-related surgery. She returned to work half-time in mid-September 1989 and began full-time work on October 11, 1989.

Claimant was diagnosed with muscle tension headaches in October 1984 and July 1986. (Exs. 1, 2). She was diagnosed with sinusitis and associated headaches in May 1986 and twice in December 1989. (Ex. 1a-1). She was diagnosed with migraine headaches in November 1989, on January 10 and 22, 1990, and on March 5, 1990. (Ex. 4).

On January 23, 1990, claimant filed a claim complaining of ongoing muscle tension, neck, shoulder and arm strain from using the computer and answering telephones. She specified that the most recent occurrence was on January 19, 1990. (Ex. 6A-1).

Claimant was without a headset on the days she worked from April 6 through April 24, 1990.

Claimant was terminated on May 2, 1990, for excessive absences.

On May 3, 1990, claimant filed a second claim for headache and neck pain she allegedly experienced from April 20 through April 25, 1990. (Ex. 8A).

SAIF denied claimant's claim on May 14, 1990.

FINDINGS OF ULTIMATE FACT

The existence of claimant's muscle tension headaches and neck pain is not established by medical evidence supported by objective findings.

Claimant's work activity was not the major contributing cause of her neck and head conditions.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's work-related cervical and headache complaints were a material cause of her need for medical treatment. She accordingly concluded that the condition was compensable and set aside SAIF's denial. We disagree.

In deciding this matter, the Referee applied the law as amended by Or Laws 1990 (Special Session), Ch 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990."

An occupational disease is, inter alia, a disease arising out of and in the course of employment caused by any series of traumatic events or occurrences to which an employee is not ordinarily subjected other than during a period of regular employment, and which requires medical services or results in disability or death. ORS 656.802(1)(c). Claimant complained of neck strain and headaches that she related to the continuous use of a telephone and computer and the absence of a headset. Accordingly, in order to establish a compensable occupational disease, claimant must prove, by medical evidence supported by objective findings, that her employment conditions were the major contributing cause of her neck strain and headaches. ORS 656.802(2). "Objective findings" include, but are not limited to, "range of motion, atrophy, muscle strength, muscle spasm and diagnostic evidence substantiated by clinical findings." ORS 656.005(19); Suzanne Robertson, 43 Van Natta 1505 (1991). Furthermore, considering claimant's history of migraine headaches, we conclude that the cause of her condition is a complex medical question which turns on an analysis of medical evidence. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 259.

The only medical evidence of muscle tension headaches made prior to claimant's termination from employment were two diagnoses of that condition, one in October 1984 and the second in July 1986. In January 1990, when claimant filed the first claim, she specified that the most recent occurrence was on January 19, 1990. On January 22, 1990, the urgent care physician diagnosed a migraine headache, noting that claimant had had three migraines in the past month and quoting claimant's statement that "this is the same HA--no difference from usual." (Ex. 6) In her second claim, claimant stated that she was off work from April 23 through April 27 and again on May 1, 1990 because of a work-related sore neck and headache. She also alleged that the treatment she received at an emergency room on or about April 20, 1990 resulted in severe tremors in her body and caused her eyes to swell. (Ex. 8A, tr. 30). There is no evidence in the file that claimant consulted a physician during this time period, although she had received an injection for a migraine headache on March 5, 1990, about six weeks earlier. (Ex. 8).

On May 5, 1990, claimant consulted Dr. Denker at the Kaiser Industrial Medicine Clinic. (See Ex. 10). Denker found full range of motion in the neck and no tenderness in the trapezius or mastoid process. He did not report any symptoms of a strain or of a muscle tension headache. Nevertheless, he diag

nosed cervical strain and muscular headaches and opined that they were primarily related to her work, based on claimant's history. A physician's opinion based on a patient's history is only as reliable as the history is accurate. James D. Shirk, 41 Van Natta 90, 93 (1989). In addition to a number of inaccuracies regarding her current employment status, the number and reason for her absences from work, and her alleged visit to the emergency room on April 20, claimant reported that she had no family history of migraines. Instead, she reported that her headaches were due to the change to computers and a bad headset at work. At the same time, the headache symptoms she reported to Dr. Denker were congruent with her migraine symptoms. We accordingly do not find Dr. Denker's diagnosis and opinion regarding causation persuasive, based on the history claimant related to him, nor are we persuaded by the diagnoses and opinions of Drs. Breen, Fuller and Peterson, for the same reason. (See Exs.13 and 15).

We therefore conclude that claimant has failed to establish by medical evidence supported by objective findings that she experienced a neck strain and associated muscle tension headaches related to her work, as contrasted with her noncompensable migraine headaches. See ORS 656.802(1)(c) and (2). We accordingly reinstate SAIF's denial.

The Referee proceeded to award a 15 percent penalty and associated attorney fee for an unreasonable denial. Because we find claimant's claim noncompensable, we reverse the penalty and attorney fee.

ORDER

The Referee's order dated October 25, 1990 is reversed. The SAIF Corporation's denial is reinstated and upheld. The penalty and related $300 attorney fee is reversed. The assessed attorney fee of $1,700 is reversed.

September 6, 1991 Cite as 43 Van Natta 1843 (1991)

In the Matter of the Compensation of
BILL G. KELLEY, Claimant
WCB Case No. 90-06695
ORDER ON REVIEW
Garlock, et al., Claimant Attorneys
Nelson, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of those portions of Referee Tenenbaum's order which: (1) declined to dismiss claimant's request for hearing on the basis of his failure to appear; (2) set aside its partial denial of claimant's claim for an L5-S1 disc herniation; and (3) set aside its partial denial of claimant's claim for an L4-5 disc herniation. On review, the issues are dismissal and compensability.

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

Although claimant's disc protrusions at L4-5 and L5-S1 were diagnosed in January 1990, the insurer only denied the L5-S1 disc protrusion in its March 1990 denial. Claimant requested a hearing on March 26, 1990, which was convened and continued in late June 1990. Therefore, the law prior to the 1990 amendments governed the resolution of the issue of compensability of claimant's L5-S1 disc condition. See Oregon Laws 1990, Chapter 2, 54(2). The Referee applied

the correct law and found that claimant had established that her industrial injury was a material contributing cause of her L5-S1 disc condition.

As noted above, claimant's L4-5 disc condition was diagnosed in January 1990; however, the insurer did not deny this condition until August 1990. Claimant first contested this denial at the August 14, 1990 hearing. Therefore, it is arguable that the issue of compensability of claimant's L4-5 disc condition should be analyzed under the 1990 revisions to the Workers' Compensation Act. See Ida M. Walker, 43 Van Natta 1402 (1991). Under the 1990 amendments, in order to establish the compensability of a consequential condition, claimant must show that the industrial injury is the major contributing cause of his disability or need for treatment. ORS 656.005(7)(a)(B); Mark N. Wiedle, 43 Van Natta 855 (1991).

Assuming, without deciding, that claimant's L4-5 disc condition is properly analyzed under the 1990 revisions, we would still find it compensable. Both Dr. Amsden and Dr. Wayson directly attribute claimant's L4-5 disc condition to his compensable knee condition. We agree with the Referee that Dr. Amsden's and Dr. Wayson's opinions are persuasive. Therefore, claimant has established that his L4-5 disc condition is compensable regardless of whether a material contributing cause standard or the major contributing cause standard is applied.

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 $1,260, 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.

ORDER

The Referee's order dated September 21, 1990, as reconsidered October 17, 1990 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,260, payable by the insurer.

In the Matter of the Compensation of
DOUG D. LAGRAVE, Claimant
WCB Case No. 90-08793
ORDER ON REVIEW
Claudette L. Yost, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Mongrain's order which declined to direct the self-insured employer to pay the amount of unscheduled permanent disability awarded by the February 1, 1990 Determination Order. On review, the issue is whether claimant is entitled to payment of unscheduled permanent disability benefits awarded by the Determination Order. We reverse.

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

The Referee assessed a penalty under ORS 656.262(10) for the employer's failure to pay unscheduled permanent disability awarded by the February 1, 1990 Determination Order. However, the Referee did not order the employer to pay the permanent disability benefits that the employer unlawfully withheld. Claimant contends that by failing to order payment of the benefits, the Referee erred. We agree.

The February 1, 1990 Determination Order required the employer to pay claimant 14 percent (44.8 degrees) unscheduled permanent disability. That order remained in effect until it was "corrected" by the April 13, 1990 Determination Order. See Former ORS 656.268(4); Georgia-Pacific v. Piwowar, 305 Or 494, 504 (1988).

The employer was required to pay claimant the full amount of permanent disability awarded no later than the 30th day following the February 1, 1990 Determination Order. ORS 656.230(2); Former OAR 436-60-150(5)(a). If the employer did not agree with the award of permanent disability made by the Determination Order, the appropriate remedy was to request that the Determination Order be abated and reconsidered before its obligation to pay the award matured. Former ORS 656.268(4); OAR 436-60-150(5)(a). Inasmuch as the employer did not avail itself of this process, it was obligated to pay claimant the permanent disability awarded by the February 1, 1990 Determination Order. Because the employer did not pay the permanent disability awarded by the February 1, 1990 Determination Order, it must do so now. Piwowar, supra; Hutchinson v. Louisiana-Pacific, 67 Or App 577, 581, rev den 297 Or 340 (1984).

Accordingly, the employer is directed to pay claimant the amount equal to 14 percent unscheduled permanent disability as awarded by the February 1, 1990 Determination Order. Inasmuch as the Referee awarded claimant five percent unscheduled permanent disability and that award was not appealed, the employer is allowed to offset the amount of permanent disability paid pursuant to the Referee's order against the amount awarded by this order.

ORDER

The Referee's order dated November 21, 1990 is reversed in part and affirmed in part. That portion which declined to order payment of the unscheduled permanent disability awarded by the February 1, 1990 Determination Order is reversed. The self-insured employer is directed to pay claimant 14 percent (44.8) degrees unscheduled permanent disability. The self-insured employer is allowed an offset of the amount of permanent disability paid pursuant to the Referee's order against the amount herein awarded. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. This attorney fee shall not be subject to any offset based upon prior overpayment to claimant. OAR 438-15-085(2). The remainder of the order is affirmed.

In the Matter of the Compensation of
CAROL J. PAXTON, Claimant
WCB Case No. 90-01572
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Westerband, Neidig and Crider.

The self-insured employer requests review of that portion of Referee Hoguet's order that instructed the employer to pay an approved attorney fee awarded by a prior referee. The issue on review is attorney fees. We reverse.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the Referee's findings of fact.

CONCLUSIONS AND OPINION

The employer contends that the Referee erred in ordering it to pay claimant's attorney an approved fee authorized by a prior referee, payable out of increased permanent disability compensation. The employer paid the entire amount of the increased permanent disability compensation to claimant.

This case is controlled by former OAR 438-15-010 et seq., the rules in effect at the time of the June 12, 1989 Opinion and Order authorizing the approved fee. See WCB Admin. Order 2-1989 (effective April 1, 1989). Pursuant to former OAR 438-15-040(1), if a referee awards additional compensation for permanent partial disability, the referee shall approve a fee of 25 percent of the increased compensation, but not more than $2,800, to be paid out of the increased compensation. If the claimant consents in the attorney retainer agreement, the referee 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 of permanent disability. Former OAR 438-15-085(1).

We previously addressed the issue raised in this case in our decision in Mohammad Zarifi, 42 Van Natta 670 (1990). In that case, the Board issued an order stating that "[c]laimant's attorney is allowed a fee in the amount of 25 percent of the increased compensation awarded under this order." The insurer paid the entire amount of the increased compensation to claimant. We concluded that the insurer was not responsible for the approved fee because the Board did not order direct payment to claimant's attorney, and the claimant did not consent to direct payment in a retainer agreement.

The Zarifi case was analyzed under the attorney fee rules set forth at former OAR 438-47-010 et seq., whereas the rules applicable in the present case are found at former OAR 438-15-010 et seq. However, the operative language of the rules remains the same. Compare former OAR 438-47-010(3) and (5), 438-47-025 and 438-47-080 to former OAR 438-15-010(1) and (3), 438-15-040(1) and 438-15-085(1).

We, therefore, analyze the present case in light of our decision in Zarifi. Here, the retainer agreement signed by claimant contained language providing for direct payment of approved fees to claimant's attorney. However, that alone does not obligate the employer to pay the fee directly to claimant's attorney. In addition to such agreement, the referee must order payment of the fee directly to claimant's attorney, as provided in former OAR 438-15-085(1).

Here, the order awarding the fee "FINALLY ORDERED that claimant's attorney be paid 25 percent of the additional compensation granted by this Order . . . ." The Referee concluded that this language was a directive to the employer to pay the fee directly to claimant's attorney. We disagree. This language merely authorizes payment of a 25 percent attorney fee. It does not address whether the fee is to be paid to claimant's attorney by the claimant, or by the employer directly to claimant's attorney. Thus, the employer was under no obligation to pay the fee directly to claimant's attorney, and we reverse the Referee's contrary ruling.

ORDER

The Referee's order dated December 27, 1990 is reversed. The attorney fee ordered reimbursed by the Referee's order is reversed.

Lynn-Marie Crider, Chair, dissenting.

I would read the prior order as did the Referee. When a referee simply "allows" or "approves" an out-of-compensation fee, he permits collection of the fee. When, as here, a referee orders claimant's attorney to be paid 25 percent of the additional compensation, the order requires payment by the employer, just as the order that "claimant be paid a total unscheduled disability award" of 50 percent requires payment by the employer. Because the order required payment by the employer, the employer's failure to pay the fee directly was error. Therefore, I would affirm.

I note, however, that this kind of error may be avoided if referees use the following magic words: "Claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased compensation awarded by this order, not exceeding $2,800, payable by the self-insured employer directly to claimant's attorney."

In the Matter of the Compensation of
DONALD A. RASBERRY, Claimant
WCB Case No. 90-15978
ORDER ON REVIEW
Robert M. Lusk, Claimant Attorney
Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of Referee Crumme's order which set aside its partial denial of claimant's left rotator cuff condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

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 reasoning concerning the compensability issue as set forth in the Referee's order with the following supplementation.

In its denial, SAIF indicated that it was unable to provide benefits for claimant's current condition stating that, "The injury of April 3, 1989 is not the major contributing cause of the current rotator cuff tear and need for surgery." At hearing, SAIF's counsel reiterated that the only issue was whether claimant's compensable injury was the major cause of his current left shoulder condition. (Tr. 1, 2). On review, SAIF for the first time, contends that the proposed surgery is not reasonable or necessary.

Inasmuch as the issue of whether the proposed surgery is reasonable and necessary was not raised by SAIF's denial, nor by its counsel at hearing, we decline to reach that issue on review. See Richard R. Hendrickson, 42 Van Natta 473 (1990); Edward A. Rankin, 41 Van Natta 1926, 2133 (1989); Patricia N. Hall, 40 Van Natta 1873 (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 on review concerning the compensability issue is $1,000, 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 issue, and the value of the interest involved.

ORDER

The Referee's order dated January 28, 1991 is affirmed. For services on review concerning the compensability issue, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the SAIF Corporation.

September 6, 1991 Cite as 43 Van Natta 1848 (1991)

In the Matter of the Compensation of
WILLIAM W. SWINT, Claimant
WCB Case No. 90-15842
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Neidig and Moller.

The insurer requests review of Referee Spangler's order which: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) awarded an allegedly excessive assessed fee of $2,000 for claimant's counsel's services at hearing. On review, the issues are aggravation and attorney fees. We reverse.

FINDINGS OF FACT

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

In March 1986, prior to claim closure by the August 1986 Determination Order, claimant's treating physician, Dr. Van Veen, M.D., thought claimant's condition was medically stationary but anticipated that claimant would continue to have some problems with low back pain. (Ex. 13). In May 1986, Dr. Becker,

orthopedic surgeon, considered claimant's condition medically stationary and anticipated recurrence of claimant's symptoms. (Ex. 14-3). Dr. Van Veen noted in August 1986, just prior to claim closure, that claimant had right hip pain, numbness down the lateral aspect of both thighs and radiation of pain down both legs. (Ex. 2-3, 2-4, 2-5). Prior to claim closure, Dr. Van Veen prescribed that claimant wear a back brace/support while working. (Exs. 2; 9).

Claimant's treating chiropractor, Smith, noted that since his compensable 1985 injury, claimant has continued to have occasional pain and problems with his low back including leg pain. (Ex. 23-1). Since the compensable 1985 injury, claimant has periodically had to restrict his physical activities, change the way he performed his work, and sometimes has had to wear a back brace in order to work. (Tr. 11-12). Since the compensable injury, claimant has suffered from 4-5 similar flare-ups, with "the same kind of pain" in the same place. (Tr. 13-15, 23). Every year, since the compensable injury, claimant has had to take at least a half day off from work to recover from the symptomatic flare-ups. (Tr. 13-15, 23). The flare-up in 1990 was the same kind of flare-up claimant has experienced for four years. (Tr. 15, 20, 22). Claimant sought treatment for his low back in 1990 because he hoped that something other than more medication could help relieve his discomfort. (Tr. 15, 23). Claimant, who is now in his own drywall business with his son, took a couple of days off from work after the April 1990, flare-up. (Tr. 16).

Claimant's exacerbation was anticipated by the August 1986 Determination Order, which awarded him 20 percent unscheduled permanent disability.

CONCLUSIONS OF LAW AND OPINION

Aggravation

The Referee concluded claimant has sustained a compensable aggravation because claimant had proven by medical evidence, supported by objective findings, that his condition had worsened since the last arrangement of compensation. We agree that claimant has established a worsened condition, in the form of a symptomatic exacerbation. However, we do not agree that claimant has thereby established a compensable aggravation.

To establish a compensable aggravation, claimant must prove a worsened condition resulting from the industrial injury. ORS 656.273(1); Perry v. SAIF, 307 Or 654 (1989). A worsened condition occurs when claimant's physical condition or symptoms become exacerbated and cause increased disability or diminished earning capacity. Id. However, claimant has the further burden to prove that he has sustained a worsening of his compensable low back condition that is more than a waxing and waning of symptoms as contemplated by the last award or arrangement of compensation. ORS 656.273(8). If there was medical evidence prior to the last award or arrangement of compensation of the possibility of future flare-ups, the assumption is that the parties considered that evidence at the time of closure, unless there are indications to the contrary. Lucas v. Clark, 106 Or App 687 (1991); see also International Paper Co. v. Turner, 91 Or App 91, rev den 307 Or 101 (1988).

Here, the record establishes that prior to claim closure, claimant's treating physician, Dr. Van Veen, predicted that claimant would have periodic flare-ups of pain in his low back with heavy lifting. While opining that claimant's condition was medically stationary, and predicting that claimant would suffer from periodic flare-ups, Dr. Van Veen noted that claimant's condition included radiating pain into his legs along with numbness of his legs. Because there is no indication to the contrary, we assume that this evidence was considered at the time of the last award of compensation in August 1986.

The evidence does not indicate that the April 1990 flare-up is more than what was anticipated at the time of claim closure. Claimant testified that he has suffered from four to five similar flare-ups, with "the same kind of pain" in the same place since the compensable injury. He testified that the flare-up in April 1990, was the same kind of flare-up he has experienced for four years. He also testified that every year, since the compensable injury, he has had to take at least a half day off from work to recover from the symptomatic flare-ups and that he took a couple of days off from work after the April 1990 flare-up.

Since the compensable 1985 injury, claimant has periodically had to restrict his physical activities, change the way he performed his work, and sometimes has had to wear a back brace in order to work. Prior to claim closure, Dr. Van Veen recommended to claimant that he take precautions while working such as wearing a back brace and limiting his work activities to accommodate his low back condition. Similarly, Dr. Becker suggested that claimant obtain help with heavy lifting. Although there is indication that claimant had muscle spasms in his leg along with or after the April 1990 flare-up, the record also indicates that claimant had leg pain and numbness prior to the August 1986 Determination Order. We cannot discern from the evidence in the record, that the alleged 1990 leg muscle spasm is more disabling than was noted or anticipated in August 1986.

Accordingly, we conclude that claimant has not carried his burden to prove that he has sustained a compensable aggravation of his compensable low back condition.

Assessed Attorney Fees

Because we have determined that claimant has not sustained a compensable aggravation and are reversing the order of the Referee with regard to that issue, we decline to address the issue of whether the assessed attorney fee was excessive.

ORDER

The Referee's order dated December 10, 1990, as reconsidered on December 18, 1990, is reversed. The insurer's aggravation denial is reinstated and upheld. The Referee's attorney fee award is reversed.

In the Matter of the Compensation of
MALCOM R. TAYLOR, Claimant
WCB Case No. 90-07445
ORDER ON REVIEW (REMANDING)
Saif Legal Department, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant, pro se, requests review of Referee Mills' order that: (1) approved a stipulation, on the record, that awarded claimant additional temporary disability compensation and authorized the SAIF Corporation to offset an overpayment against that additional compensation; and (2) declined to assess a penalty and associated attorney fee for SAIF's allegedly unreasonable failure to pay the additional compensation. The issues on review are scope of review, temporary disability compensation, and penalties and attorney fees. We remand.

FINDINGS OF FACT

On April 6, 1990, claimant filed a request for hearing raising the issues of temporary disability compensation and penalties and attorney fees.

Claimant was present at hearing and represented through legal counsel. After prehearing discussion between the parties, the Referee stated that the parties had resolved the issue concerning claimant's entitlement to temporary disability benefits. The Referee found that, pursuant to the parties' agreement, SAIF was obligated to pay claimant an additional $772.28 in temporary disability benefits. At the same time, the Referee stated that the parties had agreed that SAIF was entitled to recover an overpayment of $396. Therefore, the Referee stated, the parties had agreed that SAIF would pay claimant the balance of $376.78. No party voiced any objection to the Referee's statement of their agreement. The Referee's resulting opinion and order reflected this conclusion.

With regard to the penalty and associated attorney fee issue, the Referee heard legal argument from the parties' counsel. In his opinion and order, the Referee concluded that SAIF's failure to timely pay temporary disability benefits was not unreasonable. He, therefore, declined to award either a penalty or an associated attorney fee.

No witnesses testified at the hearing and no exhibits were offered or admitted into evidence.

Within 30 days of the Referee's order, on September 28, 1990, claimant filed a letter with the Board wherein he requested "reconsideration of the hearing." The letter was treated as a request for Board review. In his brief on review, claimant raises both the temporary disability issue and the penalty and attorney fee issue.

The record on review is incompletely developed.

CONCLUSIONS OF LAW AND OPINION

At hearing, the Referee recited the parties' oral agreement concerning claimant's entitlement to temporary disability compensation and SAIF's entitlement to an offset. On review, claimant contends that the agreement recited by the Referee at hearing and appearing in his order does not fully resolve the parties' dispute concerning the temporary disability issue. In addition, claimant contests the Referee's refusal to award a penalty for unreasonble claims processing concerning the temporary disability issue.

Our review is limited to the record developed at hearing. Should we determine that a case has been improperly, incompletely or otherwise insufficiently developed, we may remand to the Referee for further evidence taking, correction or other necessary action. ORS 656.295(5).

Here, no witnesses testified at hearing and no exhibits were offered or admitted into evidence. Further, the record is silent on whether claimant understood the terms of the stipulation and assented to those terms. As a result, we conclude that the record is not sufficiently developed to address claimant's contentions concerning the temporary disability and penalty and attorney fee issues.

Accordingly, we shall remand this matter to the Referee for further development of the record on these issues. See Edwin L. Carson, 43 Van Natta 107, 835 (1991) (remand appropriate where record insufficient to determine whether claimant understood and freely entered into stipulation). The Referee shall

create a record from which to evaluate the circumstances surrounding the formulation of the stipulation agreement. In addition, the Referee shall address the question of whether a simultaneous offset of an overpayment against a temporary disability award is appropriate. See Sullivan v. Banister Apelines, 91 Or App 493; Milton D. Forell, 41 Van Natta 2194 (1989); Buddy Tillman, 41 Van Natta 239 (1989). The Referee shall further develop the record on the penalty and attorney fee issue. The Referee shall have the discretion to proceed in any manner that will achieve substantial justice to all parties.

ORDER

The Referee's order dated August 30, 1990 is vacated. This matter is remanded to the Referee for further proceedings consistent with this order.

September 6, 1991 Cite as 43 Van Natta 1852 (1991)

In the Matter of the Compensation of
JAMES O. TUMLINSON, Claimant
WCB Case No. 89-21083
ORDER ON REVIEW
Depaolis, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Spangler's order which: (1) declined to grant permanent total disability; and (2) affirmed a Determination Order award of 44 percent (140.8 degrees) unscheduled permanent disability for low back and psychological conditions. In his brief, claimant contends that the case must be remanded for another hearing to determine the extent of his psychological condition. On review, the issues are remand, res judicata, and extent of permanent disability, including permanent total disability. We decline to remand and affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Conclusions of Law" with the following comment.

Claimant argues that this Referee's Opinion and Order impermissibly reverses the findings and conclusions found in a prior Opinion and Order. Specifically, claimant contends that the instant Opinion and Order contains findings that are contrary to findings in a previous Opinion and Order and that the Referee's findings are barred by issue preclusion. Therefore, claimant argues, the matter must be remanded to correct this legal error.

To begin, we note that the issue before the Referee at the previous hearing was compensability of a psychological aggravation of claimant's industrial injury. At the present time, the issue before the Referee is extent of unscheduled permanent disability.

The rule of issue preclusion is that if an issue is actually litigated and determined by a valid and final judgment and the determination is essential to

the judgment, the determination is conclusive in a subsequent action between the parties, whether on the same or a different claim. North Clackamas School District v. White, 305 Or 48, 53; Restatement (Second) of Judgments 27 (1982). Here, the issue of extent of disability was not litigated at the previous hearing. Instead, the issue involved the question of the causal relationship between claimant's compensable injury and his psychological condition. A determination concerning the permanency of that condition was not essential to the judgment. Thus, the Referee's conclusion here that claimant exaggerates his disabilities independent of his compensable psychological condition was not barred by issue preclusion. See Hanes v. Washington County Community Action, 107 Or App 304 (1991).

Moreover, the extent of claimant's permanent disability is determined as of the date of hearing herein. Gettman v. SAIF, 289 Or 609 (1980). Even if we were to give preclusive effect to the earlier Referee's finding, that would solely result in the conclusion that claimant did not consciously exaggerate his symptoms as of the date of the prior November 1987 hearing. Such a conclusion could not preclude a finding, almost three years later, that claimant was then malingering for purposes of secondary gain. (See Ex. 94-1).

ORDER

The Referee's order dated August 22, 1990 is affirmed.

September 6, 1991 Cite as 43 Van Natta 1853 (1991)

In the Matter of the Compensation of
SUSAN E. VANDUSEN, Claimant
WCB Case No. 90-13331
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Miller, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Michael Johnson's order that increased her unscheduled permanent disability from 5 percent (16 degrees), as awarded by Determination Order, to 17 percent (54.4 degrees) unscheduled permanent disability for her low back condition. 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 has eight years of formal education and does not have a GED degree. Her highest SVP during the ten years prior to the date of hearing was 2 as a cannery worker (DOT 529.686-014). Claimant has not attained competence to perform other than an entry-level position.

As a result of her compensable injury, claimant has loss of range of motion in the thoracolumbar area and in both hips.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was entitled to 17 percent unscheduled permanent disability under the "standards." We apply the standards in effect on May 8, 1990, the date of the Determination Order, and modify.

Age

The appropriate value for claimant's age of 40 years is 1. Former OAR 436-35-300(4).

Formal education

The appropriate value for claimant's eighth grade education (without a GED) is 1. Former OAR 436-35-300((3)(b).

Skills

Former OAR 436-35-300(4) adopts by reference the "SVP" values assigned to various occupations by the Dictionary of Occupational Titles (DOT). Claimant's highest SVP value during the ten years prior to the date of hearing was 2 as a cannery worker (DOT# 529.686-014). Therefore, the appropriate value for skills is 4. Former OAR 436-35-300(4).

Training

We have concluded that 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 worked as a laborer for the employer and the record does not show training sufficient to qualify her for other than entry-level work. Therefore, the appropriate training value is 1. Former OAR 436-35-300(5)(a).

Adaptability

The Referee concluded that claimant had returned to regular work. On review, claimant contends that she returned to modified work. Claimant argues that, before her injury, her work included stacking and tearing down totes, which weighed between 20 to 30 pounds each. Claimant also stacked pallets, which she estimated weighed approximately 50 pounds per pallet. Claimant testified that she stacked approximately 200 to 300 pallets per day. Claimant argues that she no longer tears down totes and her job involves the lighter work of dumping totes. Claimant also contends that her treating doctor and several other doctors have stated that she cannot continue tearing down totes.

The employer argues that, in the Fall of 1989, claimant had attained enough seniority to become a "bracket 8" employee, who is less likely to be assigned the task of performing heavy general labor jobs, such as tearing down totes. The employer acknowledges that when claimant was a "bracket 9" employee (i.e., her at-injury job), 70 to 80 percent of her work involved tearing down totes and the rest of her time was spent performing general labor work. The employer contends that, after claimant became a bracket 8 employee, she occasionally would be required to tear down totes, but generally was assigned to lighter work.

We conclude that, regardless of the fact that claimant's work as a bracket 8 employee involved some of the same tasks that her previous job entailed, she nonetheless returned to modified work. "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).

Here, claimant's work before her injury involved primarily heavy work tearing down totes and stacking pallets. Following her injury, although claimant was not entirely taken off the task of breaking down totes, she avoided the job because of her back condition. See C. Bernice Chandler, 43 Van Natta 899 (1991) (Although claimant's usual and customary work was heavy and she had been released to regular work, claimant herself found it necessary to modify her duties and was actually performing work in the medium category).

Although the employer essentially argues that it was claimant's seniority, rather than any physical restrictions, that resulted in her changed job duties, we conclude that the seniority issue is not dispositive. Claimant testified that, following her injury in June 1988, she was assigned to repack (dumping totes) rather than tearing down totes. Although the employer requested that claimant tear down totes on several occasions, claimant testified that she was unable to perform the task. Finally, claimant's promotion to a bracket 8 position did not occur until 1989 or 1990, which was over a year after her injury.

We conclude that claimant's testimony is consistent with the record, which indicates that, although she continued to work a 40 hour week, she had been on a light duty position for approximately the last six months of 1988. Ex. 9-1. Claimant, therefore, was performing modified work after her injury, and the fact that she later received a promotion to a position requiring lighter work is not relevant. See former OAR 436-35-270(3)(b).

Claimant's usual and customary work required the physical capacity to do heavy work. Claimant's modified work required her to frequently lift from 20 to 25 pounds, which falls within the medium category. Accordingly, the appropriate adaptability value is 1. Former OAR 436-35-310(3)(a).

Impairment

For reduced thoracolumbar flexion (from 90 degrees to 55 degrees), claimant is entitled to an impairment value of 3.5 percent. Former OAR 436-35-360(6). For reduced thoracolumbar extension (from 30 degrees to 12 degrees), claimant is entitled to an impairment value of 2 percent. Former OAR 436-35-360(7). For loss of right flexion (from 30 degrees to 20 degrees), claimant is entitled to an impairment value of 2 percent. Former OAR 436-35-360(8). For loss of left flexion (from 30 degrees to 22 degrees), claimant is entitled to an impairment value of 1.5 percent. Former OAR 436-35-360(8). For loss of right rotation (from 30 degrees to 20 degrees), claimant is entitled to an impairment value of 2 percent. Former OAR 436-35-360(9). For loss of left rotation (from 30 degrees to 15 degrees), claimant is entitled to an impairment value of 3 percent. Former OAR 436-35-360(9). For a total rating of the thoracolumbar area, the values for loss of motion are added. Former OAR 436-35-360(10). They total 14 percent.

The Referee did not award claimant a value for lost range of motion in the hips. We find, however, that the Orthopaedic Consultants and the other physicians who examined claimant noted that her back pain radiated into her hips. Accordingly, we assign claimant the following values for lost range of motion in the hips. The Consultants reported that hip rotation could not be performed. For loss of internal rotation of both hips (from 40 degrees to 0 degrees), claimant is assigned a value of 5 percent for each hip. Former OAR 436-35-340(9). For loss of external rotation of both hips (from 50 degrees to 0

degrees), claimant is assigned a value of 7 percent for each hip. Former OAR 436-35-340(11). To arrive at a value for bilateral loss of motion in the hips, the values are added for a total value of 24 percent.

To arrive at a total impairment value, the values of different residuals are combined (not added). Therefore, we combine the value for lost range of motion in the thoracolumbar spine (14) with the value for lost range of motion in the hips (24) for a total impairment value of 35 percent.

Finally, claimant agrees with the Referee's conclusion that she is entitled to 83 percent of the total impairment value, as the Consultants have opined that the remainder of her impairment is attributable to her noncompensable degenerative condition. Accordingly, we conclude that claimant is entitled to an impairment value of 29 percent, which is 83 percent of 35.

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. When that value is multiplied by claimant's adaptability value, 1, the product is 7. When that value is added to claimant's impairment value of 29, the result is 36 percent unscheduled permanent disability. Claimant's permanent disability under the "standards" is, therefore, 36 percent.

ORDER

The Referee's order dated January 10, 1991 is modified. In addition to the Determination Order and Referee's awards of unscheduled permanent disability, claimant is awarded 19 percent (60.8 degrees) unscheduled permanent disability, for a total award to date of 36 percent (115.2 degrees). Claimant's counsel is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's counsel by the self-insured employer. However, the total attorney fee awarded by the Referee and Board orders shall not exceed $3,800.

In the Matter of the Compensation of
TIMOTHY S. WAGGONER, Claimant
WCB Case No. 90-00014
ORDER ON REVIEW
Ainsworth, et al., Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Brown's order which: (1) upheld the SAIF Corporation's partial denial of claimant's claim for an L4-5 disc condition; and (2) awarded claimant's prior counsel, rather than his current counsel, an assessed attorney fee of $1,000 for services concerning the rescission of SAIF's partial denial of L5-S1 disc space narrowing. In its brief, SAIF contends that claimant is not entitled to the aforementioned $1,000 assessed attorney fee. On review, the issues are compensability and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

Claimant sustained a compensable injury to his low back in August 1989. He was treated for this injury by Dr. Crisp, chiropractor. X-rays revealed a disc space narrowing at L5-S1. SAIF accepted the claim as a lower thoracic-lumbar muscular strain. In its acceptance letter, SAIF denied L5 disc narrowing. However, SAIF later conceded that its partial denial was not valid as it had not been sent by certified mail. Thereafter, on March 21, 1990, SAIF issued a formal partial denial of L5 disc narrowing.

Following the compensable injury, claimant was able to return to his regular work as a plumber; however, he continued to experience low back and some intermittent lower extremity symptoms. In June 1990, he experienced an acute increase in low back and lower extremity symptoms and was hospitalized. He was referred to Dr. Dunn, neurosurgeon, who diagnosed a herniated nucleus pulposus at L4-5. A lumbar CT scan revealed a prominent protrusion at L4-5.

The hearing was convened on May 10, 1990. At the beginning of the hearing, SAIF rescinded its denial of the L5-S1 disc space narrowing. However, at that time, SAIF orally denied claimant's L4-5 disc condition. Both claimant's prior counsel and current counsel were instrumental in SAIF's decision to rescind its denial.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant's industrial injury was not causally related to his L4-5 disc condition. We agree.

Claimant bears the burden of proving by a preponderance of the evidence that an industrial injury materially contributed to his disability or need for medical treatment. Milburn v. Weyerhaeuser Co., 88 Or App 375, 378 (1987).

Inasmuch as claimant's L4-5 disc condition was not diagnosed until 10 months following the compensable injury and claimant's diagnoses include a lumbar-thoracic strain, a disc space narrowing at L5-S1 and a disc herniation at L4-5, the issue of whether claimant's L4-5 disc condition is causally related to the compensable injury is a complex medical question. Thus, although claimant's testimony is probative, the resolution of this issue largely turns on an analysis of the medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Dr. Crisp, who treated claimant following the compensable injury, reported that claimant had sustained a disc space narrowing at L5-S1. She explained that when a disc space narrowed, a herniation was implied as the disc necessarily had less space to occupy. Although Dr. Crisp explains how a herniated disc occurs where the disc space has narrowed at the same level, she does not explain how a disc space narrowing at one level can cause a disc herniation at another level.

Dr. Dunn diagnosed a herniated disc at L4-5. He reported that claimant's industrial injury caused disc damage which progressed to herniation. Dr. Dunn reviewed x-rays taken prior to and after claimant's industrial injury and noted a "5mm" decrease in the size of the disc at the lumbosacral level. He therefore opined that the industrial injury caused injury to the disc at the lumbosacral level.

Dr. Dunn's opinion that claimant's lumbosacral disc has decreased in size is consistent with Dr. Crisp's report that claimant's L5-S1 disc space has

narrowed. However, neither physician explains how the findings at the L5-S1 level are causally related to claimant's L4-5 disc herniation. Moreover, Dr. Crisp reported claimant's disc space narrowing at L5-S1 in August 1989, whereas the L4-5 disc herniation was not diagnosed until June 1990. Under these circumstances, we conclude that claimant has failed to establish that his compensable injury is a material contributing cause of his L4-5 disc condition.

Attorney Fees

The Referee awarded claimant's prior counsel an assessed attorney fee for services rendered in conjunction with SAIF rescinding its partial denial of claimant's L5-S1 disc space narrowing. We agree that claimant is entitled to an assessed attorney fee; however, we modify the Referee's order.

At the time of the instant hearing, an assessed attorney fee was not available if a compensability denial was rescinded prior to hearing. Duane L. Jones, 42 Van Natta 875 (1990), aff'd, Jones v. Oregon State Correctional Institution, 107 Or App 78 (1991). However, since the Referee's order, the legislature has effectively overruled Jones by amending ORS 656.386(1) to allow an attorney fee if an attorney is instrumental in obtaining compensation, even though a hearing is not held. See ORS 656.386(1) (June 19, 1991). Based on this legislative revision, the Jones court has withdrawn its decision and remanded for reconsideration. 108 Or App 230 (1991). Here, since we find both of claimant's counsels to have been instrumental in obtaining compensation, we agree with the Referee that an attorney fee for services prior to the hearing concerning SAIF's rescission of its partial denial of claimant's L5-S1 disc space narrowing is warranted.

Although we agree with the Referee that claimant is entitled to an assessed attorney fee, we modify that portion of his order that awarded it specifically to claimant's prior counsel. We have herein found that both claimant's prior and current counsel were instrumental in SAIF's decision to rescind its denial. However, the way in which a fee is distributed to claimant's current and former counsel is a matter to be decided between the two of them, not this forum. Fred L. Snider, 43 Van Natta 577 (1991).

ORDER

The Referee's order dated November 14, 1990 is affirmed in part and modified in part. That portion which awarded an $1,000 assessed attorney fee to claimant prior counsel is modified. For services concerning the rescinded denial of L5-S1 disc space narrowing, claimant's prior and current counsel are awarded an assessed attorney fee of $1,000, payable by the SAIF Corporation. The remainder of the order is affirmed.

In the Matter of the Compensation of
ELSIE B. GREENOUGH, Claimant
WCB Case No. 90-01919
ORDER ON REVIEW
Carney, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Myzak's order which declined to grant permanent total disability. On review, the issue is permanent total disability. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" except as follows: the last sentence of the last paragraph on page 2; the last two sentences of the first paragraph on page 3; and the second full paragraph on page 3 of the Referee's Amended Opinion and Order. Furthermore, we supplement the adopted "Findings of Fact" as follows.

Claimant was in her mid-teens in the Philippines when World War II began. She was a part of the Philippine "resistance" and killed invading Japanese. As a result of that experience she has preexisting symptoms that are suggestive of Post Traumatic Stress Syndrome. Those symptoms include continuing nightmares, fear of killing someone, and problems dealing with stress. (Ex. 41A-4).

Claimant was diagnosed as a borderline personality, meaning that she lives in a condition of chronic emotional instability. She was able to function for many years, but after her 1982 interaction at work with a supervisor, she collapsed psychologically. She has never recovered from that collapse. (Ex. 45-1). Whenever her employer-at-injury provided some employment opportunity, claimant was mentally unable to avail herself of it. She could not bring herself to call the employer, and suffered acute anxiety attacks when she tried to do so. (Ex. 45-1, 45A).

Although work would have been therapeutic for claimant, she was not able to return to her work-at-injury, nor to any job created by her employer-at-injury, because of her ongoing psychological problems. (Tr. 42-43).

Claimant's preexisting psychological condition, combined with her compensable condition and subsequent aggravation of that condition resulted in her being unable to deal with life, people and work, and in an inability to summon emotional reserves to deal with the jobs offered by the employer-at-injury. (Tr. 31-32).

Claimant's anxiety, depression and anger toward her employment resulted in her opting to retire, rather than return to work angry and depressed to only once again quit her employment in a state of crisis as she had done in the past. (Ex. 35-2).

Claimant's compensable psychological disease worsened her preexisting psychological condition.

ULTIMATE FINDINGS OF 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 occupational disease, claimant would be willing to seek regular gainful employment.

CONCLUSIONS OF LAW AND OPINION

Claimant can establish permanent total disability, by proving that she is completely mentally disabled and therefore unable to regularly perform work in a gainful and suitable occupation. ORS 656.206(1)(a); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Although we consider preexisting disabilities and their impact on performing work at a gainful and suitable occupation, preexisting disabilities are considered only as the condition exists at the time of the claimant's compensable occupational disease, or to the extent that the claimant's compensable occupational disease worsened the preexisting condition. Searles v. Johnston Cement, 101 Or App 589 (1990); Fowler v. SAIF, 82 Or App 604 (1986).

Unless claimant's mental incapacity renders a work search futile, SAIF v. Scholl, 92 Or App 594, 597 (1988), she must also establish that she has made reasonable efforts to obtain regular gainful employment. ORS 656.206(3). Moreover, even if a work search would be futile, she must further establish that, but for the compensable occupational disease, she would have been willing to return to work. SAIF v. Stephen, 308 Or 41, 47-48 (1989).

In September 1982, claimant suffered a compensable stress-related occupational disease. She treated with Dr. Moss, psychiatrist, several times a month through October 1983 but little improvement in her condition was noted. Several medications were tried to relieve her persistent depression, but they only relieved acute symptoms and did nothing for her chronic depressive condition. (See e.g. Exs. 6 through 9). Claimant, realizing that it was important for her to return to work, returned to half-time work in June 1983, although she continued to experience anxiety and depression about work. (Ex. 6-4, 6-5).

After her return to work, her depression increased. She had flashes of homicidal thoughts. In November 1983, Dr. Moss left his practice in Oregon and Dr. Colbach began treating claimant. By June 1984, claimant had greatly improved and was back to work on a full-time basis. She remained under the weekly care of Dr. Colbach.

In September 1984, Dr. Colbach stated that claimant had reached a stationary state. However, he also stated that she was not as stable emotionally as she was prior to her difficulties. (Ex. 22). Claimant's claim was closed in October 1984, with a 10 percent unscheduled permanent disability award. A subsequent stipulation increased her unscheduled permanent disability award to 22.5 percent. Dr. Colbach continued to follow claimant.

In July 1988, claimant suffered a compensable aggravation of her occupational disease and was referred to psychologist Peter Barbur, M.S. She began treatment and returned to work after two weeks, but was not able to remain at work. She has not worked since that time.

Her employer offered claimant two jobs that it felt would accommodate claimant's anxiety and depression. When Dr. Colbach discussed the job possibilities with claimant, she became very upset. Dr. Colbach changed her medication from antidepressant medication to an antipsychotic drug. He noted that claimant and the employer would have to struggle quite a bit if claimant returned to work and even then, he did not know if it would be successful. (Ex. 32).

Dr. Colbach eventually informed the employer, in February 1989, that claimant was not going to accept the jobs it had offered. He stated that every time she attempted to follow up on a job possibility, she became overwhelmed with anxiety. He did not think she was consciously manipulating the situation; rather, he thought she had reached a point in her life where she was "burned out" or depressed and the circumstances were beyond her control. (Ex. 36).

Dr. Turco examined claimant in an independent medical examination in June 1989. He also testified at hearing. He felt that, no matter what job claimant was offered, she would not take it. He explained that he did not mean that in a pejorative sense, and felt that claimant should retire. However, claimant expressed to him that she did not want to retire, and felt that she had to "hang on" so that she was not forgotten by the employer after what she felt were twenty-five years of dedicated service. (Ex. 37-1, 2). Claimant also testified that she had no intentions of retiring, even at age 65, and that, but for the psychological breakdown in 1982 and aggravation in 1988, she would still be working. (Tr. 61, 64).

Dr. Turco agreed with Dr. Colbach that claimant's depression was beyond her control. He believed it had to do with her lifelong experiences. (Ex. 37-5). Dr. Turco stated that claimant was representative of the "Humpty-Dumpty Syndrome." Although she worked hard all her life, she came to a point "where there is a culmination of the stress associated with a buildup of the same stress throughout life producing a depressive episode." (Ex. 37-6). In claimant's case, her stress-related occupational disease was the factor that produced the episode.

In retrospect, at hearing, Dr. Turco believed that claimant was permanently totally disabled when he examined her in June 1989. Additionally, even though Dr. Turco agreed with Dr. Colbach that work would be therapeutic for claimant, (ex. 37-5), he testified that claimant had turned down the jobs offered by the employer because her mental disability would not allow her to deal with the jobs/employer. Moreover, Dr. Turco believed that it would be futile for claimant to try to find other jobs at this point in her life because she lacked the emotional reserves to look for a job outside of the job-at-injury.

Just prior to hearing, in April 1990, Dr. Colbach reiterated that claimant was unable to work because of her mental condition. He stated that the 1982 interaction at work with a supervisor caused her to feel rejected and hurt and to collapse psychologically. She has never recovered from that collapse. (Ex. 45-1). Dr. Colbach further stated that he believed that claimant was permanently and totally disabled and was incapable of returning to work because of her underlying mental illness. There is no volitional or motivational component preventing her from returning to work; she cannot return because she "just doesn't have the emotional resources." (Ex. 45-2).

Although the Referee found that claimant had not mitigated her damages by returning to work, something that Dr. Turco and Dr. Colbach felt would be therapeutic, we conclude, after a de novo review of the record, that claimant's psychological condition precludes returning to any employment. Claimant has a preexisting psychological disorder. She was able to work successfully for almost twenty-five years before her compensable injury caused a worsening of her psychological condition. The uncontroverted evidence from two psychiatrists and one psychologist indicates that claimant is permanently totally disabled due to her compensable psychological condition and that it would be futile for her to seek work. Moreover, we are persuaded that, but for the compensable

psychological condition, claimant would have been willing to seek regular gainful employment.[1]

Accordingly, claimant has established that she is permanently and totally disabled. The effective date of a permanent total disability award is the earliest date when a claimant proves that all elements necessary to her claim existed. Adams v. Edwards Heavy Equipment, Inc., 90 Or App 365 (1988); Arva M. Perkins, 42 Van Natta 2384 (1990). In this case, both Dr. Colbach and the psychologist, Mr. Barbur, stated that they did not think claimant could ever return to work as early as January 1989. Consequently, we conclude that the award of compensation for permanent total disability shall commence as of January 1, 1989. The insurer is authorized to offset any permanent partial disability compensation paid after January 1, 1989 as a prepayment of claimant's permanent total disability compensation. See Pacific Motor Trucking Co. v. Yaeger, 64 Or App 28 (1983).

ORDER

The Referee's order dated September 19, 1990, as amended September 21, 1990, is reversed. Claimant is granted permanent total disability benefits, effective January 1, 1989. The insurer is entitled 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 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.

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[1] In reaching this conclusion, we note and reject the employer's contention that under Sarantis v. Sheridan Corp., 69 Or App 575 (1984), claimant failed to mitigate the extent of her disability by "unreasonably refusing" to follow doctor's advice to accept one or the other job the employer had created for her. In Sarantis, the court said that in judging the reasonableness of a refusal to undergo offered medical treatment (in this case, the return to work) the relevant factors include "the worker's present physical and psychological conditions, the degree of pain accompanying and following his treatment . . . and the likelihood that it would significantly reduce the worker's disability." Id. at 577. "Furthermore, these factors are relevant to the extent that they affect the claimant's ability to undergo the treatment and achieve a successful result." Id. at 578. Here, Drs. Colbach and Turco opined and we have found that claimant was unable to undergo the "treatment," because of her psychological condition. Since she could not undergo the treatment, it was obviously, not unreasonable for her to refuse it. Stated in another way, although in ideal circumstances returning to work would be therapeutic, the doctors clearly indicated that because of claimant's psychological condition, returning to work was contraindicated and not prescribed as treatment from which claimant could benefit.

In the Matter of the Compensation of
ROGER B. LINDSAY, Claimant
WCB Case No. C1-01454
ORDER DENYING RECONSIDERATION
Welch, et al., Claimant Attorneys
Nelson, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

By order dated July 23, 1991, the Board disapproved the parties' Claim Disposition Agreement (CDA) because the agreement did not provide the present discounted value of the structured settlement. The Board reasoned that, without the present discounted value, it could not determine whether the proposed attorney fee is within the strictures of OAR 438-15-052. By letter dated August 27, 1991, claimant takes exception to our refusal to approve the CDA. Specifically, claimant contends that the present value of the CDA is the same as the payout value of the settlement; therefore, the attorney fee is proper and not excessive. We view claimant's letter as a request for reconsideration.

Entitlement to an attorney fee in connection with a CDA is expressly subject to OAR 438-15-052. Claimant's attorney fee agreement clearly states that attorney fees are to be paid in accordance with Workers' Compensation Board rule. In those circumstances where the proceeds are to be paid to claimant over an extended period of time while the attorney fee is to be paid when the claim disposition agreement is approved, we have required the present discounted value of the settlement as of the date the parties execute the agreement. We do so because, while the attorney fee would be paid when the agreement is approved, claimant's monies are to be paid over several years, thereby resulting in a reduced present value. Without this information, we are unable to determine whether a proposed attorney fee is within the strictures of OAR 438-15-052. See, e.g., Thomas M. Green, 43 Van Natta 1517 (1991).

Although claimant contends that the present value of the CDA is the same as the payout value of the settlement, no information has been received from the insurer to confirm the present value of the settlement. Without that value, we are unable to reconsider our prior order disapproving the CDA, as it is not possible to determine whether the proposed attorney fee is within the strictures of OAR 438-15-052.

Moreover, we recently amended OAR 438-15-052 to reflect this requirement. The amended rule does not apply to the CDA currently submitted by the parties because that agreement was filed before September 2, 1991. Nevertheless we note, for the future benefit of the parties, that subsection (2) of amended OAR 438-15-052 provides that:

> "(2) When the settlement proceeds are to be paid in more than one payment payable within a period of more than one year from the date of approval, for purposes of approving an attorney fee under section (1), settlement proceeds shall be calculated based on the 'present value' of the total settlement proceeds. 'Present value' may be represented by the actual present value of the total settlement proceeds or the purchase price of any annuity designed to fund payment of the total settlement proceeds. The parties shall provide the Board with a written statement of the 'present value' of the total settlement proceeds." (Emphasis supplied).

It is not necessary that the insurer or self-insured employer purchase an annuity to fund payment of the settlement proceeds for the rule to apply. Rather, the rule applies to any CDA where the payment proceeds are to be paid over more than a one-year period. Under the rule, without a written statement of present value, we shall decline to approve any CDA that provides for settlement proceeds that would be paid out over more than one year from the date of approval.

Accordingly, claimant's request for reconsideration is denied.

IS SO ORDERED.

September 9, 1991 Cite as 43 Van Natta 1864 (1991)

In the Matter of the Compensation
MARK D. LOBB, Claimant
WCB Case Nos. 90-13085 & 90-13084
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Foss, Whitty, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of those portions of Referee Michael Johnson's order which: (1) increased claimant's award of scheduled permanent disability for loss of use or function of the left hand from 25 percent (37.5 degrees), as awarded by Determination Order, to 41 percent (61.5 degrees); and (2) directed it to pay claimant's award of scheduled permanent disability at a rate of $305 per degree. On review, the issues are extent of scheduled permanent disablity and rate of scheduled permanent disability. We modify in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Disability

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). Specifically, we apply the standards in effect on February 23, 1990, the date of claimant's Determination Order.

The Referee awarded claimant an additional 16 percent scheduled disability for his left hand injury. We modify.

The parties do not dispute the Referee's assigned impairment values other than the impairment value assigned for loss of grip strength. Therefore, we only address claimant's entitlement to an impairment value for loss of grip strength.

The insurer contends that the Referee erred by awarding a value for loss of grip strength as the evidence does not establish claimant's normal grip strength or, alternatively, does not show how much of claimant's lost grip strength is due to atrophy. We agree that under the circumstances, claimant is not entitled to an award for decreased grip strength.

Loss of grip strength is ratable under the standards provided that the loss is attributable to nerve damage, atrophy, or other anatomical changes due to the compensable condition. Former OAR 436-35-110(3); Martha L. Brunner, 42 Van Natta 2587, 2589 (1990). The measurement of such loss is required to be provided by a physician. Former OAR 436-35-005(1); Robert C. Killion, 42 Van Natta 2109, 2110 (1990).

Here, Dr. Whitney found that claimant's grip strength on the left was 62-59 lbs. as compared with 130-123 lbs. on the right. However, Dr. Whitney does not indicate what is normal for claimant's left hand grip strength, therefore we are unable to rate grip strength on this basis. See Jay D. Marrington, 42 Van Natta 2871 (1990); Gary L. Waldrupe, 42 Van Natta 2623 (1990). Further, assuming arguendo that Dr. Whitney's measurements do indicate a loss of grip strength, there is no indication that he attributed such loss to nerve damage, atrophy or other anatomical change due to claimant's compensable injury. Consequently, we conclude that claimant is not entitled to an award under former OAR 436-35-110. Accordingly, we modify claimant's award to reflect no value for loss of grip strength. Therefore, the amount of scheduled permanent disability under the standards is 32 percent.

Finally, claimant contends that his scheduled disability exceeds that available under the standards. After reviewing the record, we conclude that claimant is adequately compensated under the standards and has not shown clear and convincing evidence of permanent disability greater than 32 percent.

Rate of Scheduled Permanent Disability

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

In Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), we held that the 1990 Oregon Laws, Chapter 2, section 7 amendment to ORS 656.214(2), which increased the value per degree of scheduled permanent disability from $145 to $305, applied to all awards of scheduled disability made on or after May 7, 1990, regardless of the date of injury.

Accordingly, because the Referee's award of increased scheduled permanent disability was made after May 7, 1990, the Referee correctly concluded that the award should be paid at the rate of $305 per degree.

Attorney Fee/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 rate of scheduled disability issue is $500, to be paid by the insurer. 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 December 28, 1990 is modified in part and affirmed in part. That portion which awarded claimant an additional 16 percent (24 degrees) scheduled permanent disability is modified. In lieu of the Referee award and in addition to the Determination Order, claimant is awarded 7 percent (10.5 degrees) scheduled permanent disability for a total of 32 percent (48 degrees). The remainder of the order is affirmed. For services on review concerning the rate of scheduled permanent disability issue, claimant's counsel is awarded an assessed attorney fee of $500, payable by the insurer.

In the Matter of the Compensation of
LOU D. BALES, Claimant
WCB Case No. 88-05665
ORDER ON REMAND
Burt, et al., Claimant Attorneys
Gale Gage (Saif), Defense Attorney

Reviewed by Board Members Crider and Tenenbaum.

This matter is before the Board on remand from the Court of Appeals. SAIF Corporation v. Bales, 107 Or App 198 (1991). The court reversed the Board's prior order, Lou D. Bales, 42 Van Natta 932 (1990), which held that claimant's physical examinations prior to his diagnosis of chronic obstructive pulmonary disease (hereinafter COPD) satisfied the statutory requirement of former ORS 656.802(3). On that basis, the Board found that the presumption of work-relatedness in favor of fire fighters applied and set aside the SAIF Corporation's denial of claimant's occupational disease claim for COPD. The court has remanded for reconsideration of the adequacy of the physical examinations consistent with its interpretation of former ORS 656.802(3). We proceed to do so.

FINDINGS OF FACT

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

Claimant had not seen a doctor for 30 years prior to his first examination by Dr. Foster in April 1983. At that time, Dr. Foster performed a limited examination for a viral upper respiratory infection which included a stethoscopic check of claimant's heart and lungs. The examination did not include any lung testing or other respiratory analysis. (Tr. 41-42, 56). Claimant returned to Dr. Foster twice in 1986 for a health problem unrelated to his lungs. In March 1987, claimant returned to Dr. Foster complaining of shortness of breath and dizziness. (Ex. 7b-7). Dr. Foster noted that claimant's lungs were clear but performed no further lung examination and began treating claimant for hypertension. Dr. Foster first performed a pulmonary function test on claimant in October 1987. The test revealed severe COPD. (Ex. 4-1). Thereafter, claimant filed his occupational disease claim. (Ex. 6).

A pulmonary function test is a relatively common procedure. It is performed by spirometry. It costs between $50 to $100. (Ex. 17-14, Tr. 65). The test is ordinarily utilized only if a patient exhibits significant symptomatology and if the results will influence the physician's advice to the patient or the physician's choice of treatment. (Tr. 65). The test will reveal obstructive lung disease before it becomes symptomatic. A mild or moderate lung impairment may not be identified by a stethoscopic examination such as was performed by Dr. Foster in 1983. (Tr. 50).

On-the-job smoke exposure has materially contributed to claimant's current impairment of health and need for treatment.

FINDINGS OF ULTIMATE FACT

Claimant's work exposure to smoke is not the major contributing cause of the onset or worsening of his COPD condition.

CONCLUSIONS OF LAW AND OPINION

Former ORS 656.802(3), the "fire fighter's presumption," provides that any death, disability or impairment of health of a fire fighter caused by any

lung or respiratory tract disease shall be presumed to result from the fire fighter's employment, provided that "any such fire fighter must have taken a physical examination upon becoming a fire fighter, or subsequently thereto, which failed to reveal any evidence of such condition or impairment of health which preexisted employment." Furthermore, any denial for a condition arising under the "fire fighter's presumption" must be on the basis of clear and convincing evidence that the condition was not caused by the fire fighter's employment. Former ORS 656.802(3).

In its previous order, the Board found that: (1) claimant was examined by his treating physician, Dr. Foster, in 1983 and several times subsequently; (2) claimant's lungs were clear; and (3) there was no evidence of COPD. Concluding that these examinations satisfied the statutory requirement of a "physical examination" under former ORS 656.802(3), the Board found that the fire fighter's presumption applied. The Board also found claimant's COPD condition compensable because SAIF had not proved by clear and convincing medical evidence that the COPD condition was unrelated to claimant's employment as a fire fighter.

The court reversed, reasoning that "the legislature intended as a predicate to the presumption that a physical examination under ORS 656.802(3) must be of the type that would reveal any evidence of 'any disease of the lungs or respiratory tract, hypertension or cardiovascular-renal disease' for which claimant later seeks compensation." Bales, supra, 107 Or App at 201. The court concluded that the legislature intended by the term "physical examination" an examination "at least as 'rigid' and 'competent' as that required by certain exhibits" submitted to the legislature. Id. at 202 n. 3. These exhibits included the Oregon City Civil Service Commission's medical standards for fire fighters and police officers which required specific tests for chest mobility and respiration, including a lung x-ray. Id. Further, the court found that the fact that the previous examination found "'no evidence' of COPD does not relate to the adequacy of the examination to reveal evidence of the disease." Id. at 202. Consequently, the court remanded for reconsideration in light of the court's interpretation of former ORS 656.802(3).

After conducting our reconsideration, we find that claimant's physical examinations prior to the diagnosis of COPD were not adequate to reveal evidence of the disease.

We have found that the physical examinations performed by Dr. Foster prior to October 1987, which revealed no evidence of COPD, were limited to a stethoscopic check of the heart and lungs. On the basis of the opinions of Drs. Foster and Montanaro, we conclude that claimant could have suffered from underlying COPD prior to October 1987 which could not have been detected by the stethoscopic check. Dr. Foster testified that a pulmonary function test is sensitive and will disclose problems before the patient experiences any symptoms. Dr. Montanaro, a specialist in allergies and immunology, stated that a pulmonary function test, which is performed with a spirometer, is a simple, common test which would determine whether there was any underlying obstruction in the lungs.

Although the extent of the testing conducted by Dr. Foster over the years was not inappropriate from the standpoint of treatment, we find that the prior physical examinations were not rigid and competent examinations adequate to reveal evidence of COPD. Thus, we conclude that claimant has not met the statutory requirement that would make the fire fighter's presumption applicable to his case. Therefore, claimant must prove that his COPD is compensable under the occupational disease law without the benefit of the fire fighter's presumption.

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). Because claimant continued to work as Fire Chief at the time of hearing, his last exposure to the work which he alleges caused his COPD was in June 1988. Accordingly, the occupational disease law which became effective January 1, 1988 is applicable. See Johnson, supra, at 146-48.

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). Inasmuch as claimant's work activities included inhalation of smoke, dust, fumes, vapors and gasses, we analyze his claim under former ORS 656.802(1)(a).

In an occupational disease setting, where multiple causes combine to produce one indivisible disease, 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. Former ORS 656.802(1)(a); Runft v. SAIF, 303 Or 493, 498 (1987); Dethlefs v. Hyster Co., 295 Or 298, 309-10 (1983).

Claimant smoked up to two packs of cigarettes per day for almost 30 years. He stopped smoking in 1978 when he was 44. His work exposures include 22 years as a fire fighter during which time he did not use protection devices. Considering such circumstances, we conclude that the compensability issue 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). When, as here, there is a dispute between medical experts, we rely on those medical opinions which are both well reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986).

Dr. Parosa, a consulting pulmonary specialist, had an accurate history as to claimant's lack of use of protective devices at work. (Ex. 14-3). Even with this accurate history, Dr. Parosa opined that the predominate cause of claimant's COPD was his cigarette smoking history and that there was only a possibility of a worsening of his underlying condition based on his unprotected work exposure to smoke. (Ex. 13). This possibility does not rise to the level of the major contributing cause; claimant must prove more than just the possibility of a causal connection. Gormley v. SAIF, 52 Or App 1055, 1060 (1981). Furthermore, in a later report, Dr. Parosa's opinion was also not specific in that he opined that he could not attribute specific percentages to claimant's cigarette smoking and his work exposures but that both had "an etiologic part to play." (Ex. 14). Neither of these opinions support claimant's contention that his work exposure was the major contributing cause of his COPD.

Dr. Montanaro, a specialist in allergy, immunology and rheumatology, examined claimant on March 10, 1988. Respiratory diseases are a large part of an allergist's practice and Montanaro has treated 6 to 8 fire fighters for respiratory disease, about half of whom suffered from COPD. (Ex. 17-4, 17-24, 17-25). Initially, Dr. Montanaro had an inaccurate history in that he understood that claimant always wore protection during his exposures to smoke at work. However, even after Montanaro was informed that claimant did not wear such protection, he maintained his opinion that claimant's work exposure neither caused the COPD nor worsened the underlying condition. (Ex. 17-9, 17-10). Montanaro reasoned that if claimant's work exposure caused or worsened claimant's COPD, then claimant would have suffered from chronic bronchitis symptomatology when he was exposed to smoke at work. Since claimant did not suffer from that condition, Montanaro opined that claimant's history of 30 years of cigarette smoking was the major contributing cause of his COPD condition. (Ex. 17-10, Tr. 97).

Montanaro also opined that COPD was a slow developing disease and, therefore, that it was not inconsistent with the course of the disease that claimant would not begin to have symptoms until years after he had stopped smoking cigarettes. (Ex. 12-1, 17-11, 17-12).

Dr. Foster, treating physician, is the only physician to opine that claimant's work was the major contributing cause of his COPD. (Tr. 72). He based this opinion on the fact that claimant remained asymptomatic after he quit smoking until 1987 when he suddenly developed shortness of breath and his condition rapidly declined. (Tr. 73-74).

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. Foster.

Dr. Foster is a general practitioner and not an expert in lung diseases. When questioned by the Referee as to the basis of his opinion, he stated that he could not quote any scientific articles and relied on Montanaro's inaccurate history about claimant's use of protection devices to discredit Montanaro's opinion rather than explain his own opinion. (Tr. 74) However, as noted above, when Montanaro was informed that claimant did not wear protection devices, he provided a well reasoned explanation as to why that fact did not change his opinion that the cause of claimant's COPD was his history of cigarette smoking. (Ex. 17-9, 17-10).

Furthermore, Dr. Foster's opinion is inconsistent in that he bases it on the fact that claimant did not have symptoms until 1987; however, like Dr. Montanaro, Dr. Foster opined that an obstructive-type lung disease could have been ongoing before it ever caused any symptoms and that a person would not notice any symptoms of COPD until the disease became moderate to severe. (Tr. 78-79). Because of this inconsistency in Dr. Foster's opinion, we do not find it persuasive and, accordingly, give it less weight. See David H. Olson, Jr., 42 Van Natta 1336 (1990).

We conclude that Dr. Montanaro has provided the most persuasive and well reasoned opinion regarding the cause of claimant's COPD. Furthermore, we give greater weight to the opinion of Dr. Montanaro, than we do to that of Dr. Foster, based on Montanaro's expertise as an allergist in treating respiratory diseases, which is relevant to evaluating claimant's condition. See Abbott v. SAIF, 45 Or App 657, 661 (1980).

Therefore, we conclude that claimant has failed to prove that his work exposure was the major contributing cause of his COPD.

Accordingly, on reconsideration, we reverse the Referee's order dated August 12, 1988. The SAIF Corporation's denial is reinstated and upheld. The Referee's attorney fee award, and our prior attorney fee award are reversed.

IT IS SO ORDERED.

In the Matter of the Compensation of
DIANE G. FRIEDMAN, Claimant
WCB Case No. 90-14733
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Mitchell, et al, Defense Attorneys

Reviewed by Board Members Crider and Tenenbaum.

The self-insured employer requests review of Referee Fink's order which set aside its denial as amended at hearing, of claimant's occupational disease claim for bilateral carpal tunnel syndrome and bilateral upper extremity myalgias affecting the neck, shoulders, elbows and arms. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact as our own, and supplement with the following findings.

Claimant's job as a grocery checker involved intensive, repetitive hand, wrist and arm movements.

Claimant filed an occupational disease claim for pain affecting her neck, arms and wrists on May 16, 1990. On May 29, 1990, Dr. Hoggard, claimant's treating physician, forwarded a form 827 to the employer, diagnosing claimant's conditions as multiple myalgias including cervical myalgia, bilateral shoulder tendinitis, bilateral epicondylitis and bilateral carpal tunnel syndrome (CTS). On June 28, 1990, the employer denied claimant's CTS condition. Claimant filed a request for hearing on July 17, 1990, and the hearing was held on December 12, 1990. At the hearing, the employer amended its denial to include claimant's other upper extremity conditions.

FINDING OF ULTIMATE FACT

Claimant's work activities as a grocery checker constituted a series of traumatic events or occurrences which were the major contributing cause of her current disability and need for treatment for CTS, cervical myalgia, bilateral shoulder tendinitis and bilateral epicondylitis.

CONCLUSIONS OF LAW AND OPINION

Claimant requested a hearing in this case after May 1, 1990, and the hearing was convened after July 1, 1990. Neither party contends that the former law is controlling. Therefore, we apply the 1990 amendments to ORS 656.802. Or Laws 1990 (Special Session), ch. 2, 54; see Ida M. Walker, 43 Van Natta 1402 (1991).

Claimant's work activities of lifting and passing grocery items over an electronic scanner, operating a cash register and bagging groceries involved repetitive hand, wrist and arm movements; she has been diagnosed as suffering from activity-related bilateral CTS, cervical myalgia, bilateral shoulder tendinitis and bilateral epicondylitis. Considering these activities, we conclude that her claim is properly analyzed as an occupational disease, under ORS 656.802(1)(c). See Sibley v. City of Phoenix, 107 Or App 606 (1991). To establish the compensability of her upper extremity conditions, therefore, claimant must prove that employment conditions were the major contributing cause of her bilateral CTS, cervical myalgia, bilateral shoulder tendinitis and bilateral epicondylitis. ORS 656.802(2).

Carpal Tunnel Syndrome

The Referee relied on the opinion of Dr. Long, consulting physical medicine and rehabilitation specialist, to find claimant's CTS condition compensable. We find that the opinions of Dr. Long and Dr. Hoggard, claimant's treating physician, are based on a complete and accurate history, and cogently explained, well-reasoned and, therefore, are persuasive regarding the relationship between claimant's work activities and her CTS condition. Consequently, we rely on both their opinions in finding that claimant's work activities as a grocery checker were the major contributing cause of her bilateral CTS.

The employer argues that Dr. Nathan is the only physician with the relevant expertise to evaluate causation, and that only Dr. Nathan describes in detail claimant's work activities. Therefore, the employer contends, his opinion is more persuasive. We disagree.

Dr. Nathan, independent examining orthopedic surgeon and hand specialist, examined claimant on June 6, 1990. He would not allow claimant to describe her work-related hand movements but rather would only permit "yes" or "no" answers to specific questions. Furthermore, although the doctor notes that claimant's off-work activities were not the major contributing cause of her CTS condition, without further explanation he states that none of her work activities exert the necessary counterforces which would result in the focal slowing seen on the nerve studies. Dr. Nathan does not explain the basis of his opinion that claimant's CTS is not work-related or how he concludes that her condition is the result of an underlying, intrinsic disease process which has not been affected by her work activities. Under these circumstances, we do not find Dr. Nathan's opinion on causation to be based on a complete and accurate description of claimant's work activities or to be well-reasoned; accordingly, we do not find it persuasive.

On the other hand, Dr. Hoggard has treated claimant for her CTS for many years. He has examined her on numerous occasions, sent her for electrodiagnostic studies, and is thoroughly familiar with both her work activities as a grocery checker and her off-work activities. Based on this knowledge, Dr. Hoggard explains that claimant's work as a grocery checker for the past 15 years has required repeated and constant flexing and extending of her wrists. Therefore, he concludes, this chronic work situation was the major contributing cause of claimant's bilateral CTS.

In addition, at her request, claimant was also examined by Dr. Long on November 16, 1990. Dr. Long took complete vocational and avocational histories, and performed a thorough examination, including electrodiagnostic studies. Although in his report Dr. Long does not describe claimant's work activities in the same detail as Dr. Nathan, claimant credibly testified that over a four hour period, Dr. Long not only examined her but allowed her to explain in detail how she performs her job. Based on this complete information, Dr. Long concludes that claimant's work required intensive and repetitive use of the hands, wrists and arms, causing her to develop significant lesions on the median nerves which manifest as symptoms of bilateral CTS. Therefore, Dr. Long opines, claimant's work activities as a grocery checker were the major contributing cause of her bilateral CTS.

We find Drs. Long and Hoggard's opinions to be well reasoned and persuasive. Consequently, we conclude that claimant has established the compensability of her CTS, her disability and her need for treatment.

Other Bilateral Upper Extremity Conditions

The Referee found that claimant's work activities as a grocery checker were the major contributing cause of the development of her cumulative trauma disorder. Thus, he impliedly found that claimant's work activities were also the major contributing cause of the development of her other non-carpal tunnel upper extremity conditions. We agree that these conditions are also compensable. In reaching this decision, we rely on the opinion of consulting physician Dr. Long, as Dr. Hoggard has offered no separate opinion regarding the causation of these conditions.

As already noted, Dr. Long obtained complete histories, performed a thorough examination, and obtained a detailed explanation from claimant regarding her job duties. Moreover, he performed repeat electrodiagnostic testing in November 1990, which now reveals the presence of ulnar irritation at the elbows and radial irritation affecting the forearms, in addition to the previously documented median nerve compression. Based on all these data, Dr. Long concludes that claimant's intensive and repetitive use of her hands and arms as a grocery checker caused her to develop a cumulative upper extremity trauma disorder which includes CTS, cervical myalgia, bilateral tendinitis and bilateral epicondylitis. Therefore, Dr. Long opines, claimant's work activities as a grocery checker were also the major contributing cause of her other bilateral upper extremity conditions.

Dr. Nathan concedes that claimant has a history of work related neck, shoulder, upper arm and wrist pain. However, based on electrodiagnostic testing performed as a part of his May 1990 independent examination, which revealed only median nerve compression at claimant's wrists, Dr. Nathan diagnosed only the presence of bilateral CTS. However, his examination was performed five months prior to that of Dr. Long and prior to the November 1990 electrodiagnostic studies, which now reveal evidence of ulnar and radial nerve compression. Therefore, Dr. Nathan's opinion that claimant's shoulder and upper arm discomfort is probably referred pain from her wrists is not based on complete and accurate information. Thus, we find his report to be of little value in determining the cause of claimant's cervical, shoulder and arm conditions.

We find Dr. Long's opinion on this issue to be well reasoned and based on complete information. Accordingly, we defer to his opinion and find that claimant's work activities were the major contributing cause of her current disability and need for treatment for her non-carpal tunnel bilateral upper extremity conditions. Consequently, we conclude that claimant has established the compensability of her cervical myalgia, bilateral shoulder tendinitis and bilateral epicondylitis.

Claimant's attorney is entitled to a reasonable assessed fee for her services on review concerning the compensability 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 fee for claimant's counsel's services on review 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 January 7, 1991 is affirmed. For services on review concerning the compensability issue, claimant's attorney is awarded a reasonable assessed fee of $800, to be paid by the employer.

In the Matter of the Compensation of
LAWRENCE W. HORNER, Claimant
WCB Case Nos. 90-03927 & 89-20059
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Roberts, et al., Defense Attorney

Reviewed by Board Members Neidig and Moller.

The self-insured employer requests review of that portion of Referee Michael Johnson's order that set aside its denial of claimant's bilateral carpal tunnel syndrome condition. Claimant cross-requests review of that portion of the Referee's order that affirmed a Determination Order award of 8 percent (25.6 degrees) unscheduled permanent disability for his neck injury. On review, the issues are compensability and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact, with the exception of the Referee's finding that claimant experiences neck pain while driving the lift truck because he is frequently required to look up. In addition, we do not adopt the final sentence of the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

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

Because claimant continued to be exposed to working conditions after January 1, 1988, which could have caused his bilateral carpal tunnel syndrome, the occupational disease law which became effective January 1, 1988, is applicable. Former ORS 656.802. Furthermore, because claimant's symptoms of numbness and tingling began during his work as a lift truck operator, which required repetitive use of his hands, wrists and arms, we conclude that his claim is for a condition resulting from a "series of traumatic events or occurrences," pursuant to former ORS 656.802(1)(c).

Therefore, to establish that his bilateral carpal tunnel syndrome arose out of and in the course of his employment, claimant must prove not only that his condition resulted from a series of traumatic events, but that his work exposure was the major cause of his need for medical services or of his physical disability. Former ORS 656.802(1)(c); Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991).

The Referee found that claimant first sought treatment for his carpal tunnel condition in the summer of 1989 and he underwent surgery for his condition in early 1990. The Referee concluded that claimant had proven that his employment was the major contributing cause of his carpal tunnel condition. We agree.

In reaching his conclusion that claimant had established that his bilateral carpal tunnel condition was compensable, the Referee relied upon the opinion of Dr. Buza, M.D., claimant's treating physician. The employer argues that it was error for the Referee to defer to the opinion of a treating doctor on the basis that he had the opportunity to observe claimant's condition on more than one occasion, as resolution of the case requires expert analysis rather than external observation.

We disagree with the employer's argument. The question we must resolve here is whether claimant's employment activities were the major cause of his carpal tunnel condition. Unlike Dr. Barton who examined claimant a single time only after his carpal tunnel surgery, Dr. Buza examined claimant both while he was still performing his work activities and after his release from work. Under the circumstances, Dr. Buza's opinion concerning the degree of work contribution to claimant's condition is more persuasive than the opinion of Dr. Button. See, e.g., Givens v. SAIF, 61 Or App 490 (1983).

Finally, the employer argues that Dr. Buza's opinion is not persuasive because he was initially unaware of claimant's job duties and because he relied upon incorrect information regarding the amount of time claimant spent at each duty. We disagree. Dr. Buza was subsequently informed of claimant's job duties and he reiterated that claimant's work activities were the major contributing cause of his carpal tunnel condition. We also conclude that Dr. Buza had an accurate account of claimant's history and any inconsistencies between his report and claimant's testimony are minor ones that do not detract from the persuasiveness of Dr. Buza's opinion.

Extent of unscheduled permanent disability

Claimant argues that the Referee erred by failing to award 5 percent (each) for his chronic conditions limiting repetitive use of his neck and shoulder. In the alternative, claimant contends that there is clear and convincing evidence that his unscheduled disability award under the standards is inadequate. We disagree.

Claimant testified that his neck ached and he was unable to turn it as far as he previously could. He further testified that it bothered his neck to look upward while climbing a ladder and it bothered his upper body to turn and twist while driving the Hyster. We conclude that the evidence is not sufficient to establish that claimant's chronic neck condition limits repetitive use of his neck. Similarly, although claimant testified that he had pain in his shoulder and had difficulty rotating both shoulders, there is no evidence that his condition limits the repetitive use of his shoulder. Accordingly, we conclude that an award under former OAR 436-35-320(4) is not merited.

Finally, we conclude that claimant has not shown by clear and convincing evidence that his award of unscheduled permanent disability under the "standards" is inadequate.

For prevailing on the issue of compensability, claimant's counsel is entitled to an assessed 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 assessed fee for claimant's counsel's services on Board review concerning the issue of compensability is $500, to be paid by the employer. 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 October 4, 1990, as amended October 10, 1990, is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed fee of $500, payable by the self-insured employer.

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

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Brazeau's order which found claimant's low back injury claim was not compensable. On review, claimant contends that her claim is compensable.

We affirm and adopt the Referee's order, subject to the following supplementation and modification.

On July 9, 1990, we remanded this case to the Referee for a hearing to determine whether SAIF Corporation's acceptance of the claim on behalf of the noncomplying employer was based on fraud, misrepresentation or other illegal activity. Connie M. Krone, 42 Van Natta 1543 (1990). Our decision was based upon the rationale articulated in Kristi L. Chase, 42 Van Natta 1247 (1990).

Following the hearing, the Referee issued his Opinion and Order on Remand. Finding that claimant misrepresented that her injury was work-related, the Referee concluded that SAIF had relied upon that misrepresentation in accepting the claim. Consequently, the Referee set aside SAIF's acceptance.

Since the issuance of the Referee's order, the Court of Appeals has effectively overruled the rationale expressed in the Chase decision. In Blain v. Owen, 106 Or App 285, 290 (1991), the court held that a noncomplying employer may challenge the compensability of a claim at any time pursuant to ORS 656.283. See Cindy L. Brooks-Lusk, 43 Van Natta 1235 (1991). In accordance with the Blain holding, we have reasoned that, unless a noncomplying employer waives the right to contest compensability by failing to raise it during an earlier proceeding, the employer is entitled to a hearing on the issue of compensability. Alice M. Sketo, 43 Van Natta 866 (1991).

Here, the noncomplying employer requested a hearing objecting to SAIF's acceptance, (on the noncomplying employer's behalf), of claimant's injury claim. Since there has not been an earlier proceeding during which the employer could contest compensability of the claim, we hold that the employer has not waived its entitlement to a hearing concerning the compensability issue. Furthermore, in light of the Blain holding, we conclude that, in order to prevail concerning the compensability issue, the employer need not establish that SAIF's acceptance of the claim was based on fraud, misrepresentation, or other illegal activity. Brooks-Lusk, supra. Therefore, we turn to the merits of the compensability issue.

After concluding our review, we agree with the Referee's conclusion that claimant did not injure her back at work. However, in reaching this decision, we do not base our conclusion upon the fourth and fifth reasons given by the Referee for discounting claimant's testimony. (Delay in filing claim and prior back pain.) Rather, as did the Referee, we rely upon the testimony of Mrs. Ficek, Carriger, and Rusty Summers that collectively supported the following conclusions, each of which is contrary to claimant's testimony: (1) claimant did not perform vacuum duties while working at G-Tech; (2) for a significant period following the alleged November 2, 1988 work injury, claimant did not exhibit behavior which would suggest that she was experiencing back pain; and

(3) claimant worked a full shift on Sunday November 6, 1988 without exhibiting back impairment. Based on the foregoing reasoning, we find that claimant's back injury claim is not compensable.

ORDER

The Referee's order dated November 8, 1990 is affirmed.

September 10, 1991 Cite as 43 Van Natta 1876 (1991)

In the Matter of the Compensation of
LARRY D. MAYDEN, Claimant
WCB Case Nos. 91-05419 & 91-02607
ORDER DENYING MOTION TO DISMISS
Welch, et al., Claimant Attorneys
Thomas Castle (Saif), Defense Attorney
Beers, et al., Defense Attorneys

The SAIF Corporation has requested Board review of a Referee's July 19, 1991 Order on Reconsideration that: (1) republished the Referee's June 6, 1991 Opinion and Order which, among other actions, dismissed claimant's hearing request concerning EBI Companies' denial of claimant's "new injury" claim; and (2) awarded claimant's attorney a fee pursuant to ORS 656.386(1) when SAIF rescinded its denial of claimant's aggravation claim prior to hearing. Contending that the "sole issue" in the appealed Referee's reconsideration order involves the Referee's attorney fee award payable by SAIF, EBI has moved that we dismiss it as a party to these proceedings. The motion is denied.

FINDINGS OF FACT

Claimant filed hearing requests concerning denials issued by SAIF and EBI. Claimant also protested a Reconsideration Order from the Evaluation Section and sought penalties and attorney fees against SAIF for allegedly unreasonable claims processing.

Prior to hearing, SAIF rescinded its denial and accepted claimant's aggravation claim. At the hearing, claimant withdrew his hearing request concerning EBI's denial of his "new injury" claim. Thereafter, the hearing proceeded regarding claimant's entitlement to an attorney fee payable by SAIF pursuant to ORS 656.386(1) and SAIF's payment of claimant's scheduled permanent disability award at $145 per degree.

On June 6, 1991, the Referee issued an Opinion and Order declining to award claimant a carrier-paid attorney fee pursuant to ORS 656.386(1) against SAIF. In addition, the Referee directed that claimant's scheduled permanent disability award be paid at $305 per degree. Finally, the Referee dismissed claimant's hearing request concerning EBI's denial.

Claimant moved for reconsideration, contending that he was entitled to a carrier-paid fee under SB 540, which had been recently signed by the Governor. On July 2, 1991, the Referee abated his order for reconsideration.

On July 19, 1991, the Referee issued an Order on Reconsideration. The Referee granted claimant a carrier-paid attorney fee under amended ORS 656.386(1) to be paid by SAIF. As modified by this attorney fee award, the Referee "republished and incorporated by reference as if fully set forth herein" the June 6, 1991 Opinion and Order. SAIF timely requested review of the Referee's July 19, 1991 order.

CONCLUSIONS OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). The time within which to appeal an order continues to run, unless the order has been stayed, withdrawn, or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986). In order to abate and allow reconsideration of an order issued under ORS 656.289(1), at the very least, the language of the second order must be specific. Farmers Insurance Group v. SAIF, 301 Or 612, 619 (1986).

Here, on July 2, 1991, the Referee expressly abated his June 6, 1991 Opinion and Order to consider claimant's motion for reconsideration. Thereafter, on July 19, 1991, the Referee issued an Order on Reconsideration specifically republishing his June 6, 1991 Opinion and Order, as modified by his reconsideration order. Since SAIF requested Board review within 30 days of the Referee's Order on Reconsideration and because that order republished and modified the Referee's June 6, 1991 Opinion and Order, we conclude that we have jurisdiction over all issues considered by the Referee and addressed in his orders.

EBI contends that it is not a "necessary party to this appeal" because SAIF has apparently only contested the Referee's attorney fee award. For the reasons previously discussed, we disagree with EBI's assertion that the sole issue on review is the issue expressly discussed in the Referee's reconsideration order. Furthermore, although a Referee's conclusions and opinions in consolidated cases may be separately stated, if the Referee's decisions are contained in one final order, we retain jurisdiction to consider all matters contained therein. Riley E. Lott, Jr., 42 Van Natta 239 (1990); William E. Wood, 40 Van Natta 999 (1988).

Thus, inasmuch as the dismissal of claimant's hearing request concerning EBI was contained in one final order and since that order has been republished in the Referee's reconsideration order and appealed to the Board, we retain jurisdiction over that hearing request and EBI remains a party to this proceeding. See Zurich Ins. Co. v. Diversified Risk Management, 300 Or 47 (1985); Riley E. Lott, supra; Rual E. Tigner, 40 Van Natta 1789 (1988). However, considering the circumstances concerning the dismissal of claimant's hearing request regarding EBI's denial, as a practical matter, EBI's participation in this case will likely be nominal. Lott, supra.

Accordingly, EBI's motion to dismiss is denied. A hearing transcript has been ordered. Upon its receipt, copies will be distributed to the parties and a briefing schedule implemented. Thereafter, this matter will be docketed for review.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARTIN V. McBETH, Claimant and DAVID G. JOHNSON, Claimant
WCB Case Nos. 90-18243 & 90-18346
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Darrell Bewley, Defense Attorney

Reviewed by Board Members Tenenbaum and Crider.

In these two consolidated cases, the insurer requests review of Referee Quillinan's order that set aside the insurer's denials of claimants' injury claims. The insurer also objects to the Referee's exclusion of testimonial evidence from claimants' supervisor and seeks remand to the Referee for the introduction of additional evidence. On review, the issues are remand and compensability. We deny the insurer's request for remand and affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact and make the following additional findings. The employer acquiesced in its operations manager's decision to furnish transportation to claimants in a company pickup.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Issue

The insurer contends that the Referee erred in refusing to allow Mr. Whitlow, claimants' supervisor, to testify at hearing. The Referee excluded Mr. Whitlow's testimony because he had failed to leave the hearing room following a ruling granting an earlier motion to exclude witnesses.

In workers' compensation hearings, a Referee is not bound by statutory rules of evidence and may conduct a hearing in any way necessary to achieve substantial justice. See ORS 656.283(7). After our de novo review of the record, we conclude that the Referee did not abuse her discretion under this standard in excluding testimony from claimants' supervisor.

Remand

In its brief, the insurer also requests remand to the Referee for the taking of additional information. Contending that Mr. Whitlow's testimony was improperly excluded, it argues that the record was not sufficiently developed.

To merit remand for the consideration of additional evidence, it must be clearly shown that the material evidence was not obtainable with due diligence at the time of the hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). In this case, the insurer attempted to introduce evidence that was excluded by the Referee. On review, we have determined that the Referee did not abuse her discretion in excluding that testimony. There is no other evidence that the insurer seeks to introduce. Under these circumstances, we conclude that the evidence which the insurer seeks to introduce on remand is not "material evidence" as to the compensability of claimants' injury claims. Accordingly, we conclude that remand is not appropriate under the circumstances and deny the insurer's request. See David F. Grant, 42 Van Natta 865 (1990).

Compensability

The question presented is whether claimants were in the course and scope of their employment when they were injured while receiving a ride home from work

with their supervisor. The Referee concluded that they were and set aside the insurer's denials. We agree.

To establish a compensable injury, a worker must prove that his injury arose out of and in the course of 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, injuries sustained while traveling to and from work are not compensable. Gwin v. Liberty Northwest Insurance Co., 105 Or App 171 (1991) There are, however, exceptions to this so-called "coming and going rule." In I-L Logging Co. v. Mfgrs. & Whlse. Ind. Exc., 202 Or 277 (1954), the Court stated that an employment relationship may exist during travel to and from work if the employer provides transportation to the job and pays for the travel costs. It explained:

> "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 cases 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 part of a contract for hire, pays the workman an extra sum of money to cover the cost of transportation, or where the employer compensates the employe for the 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.

On this subject, Professor Larson adds that providing transportation to an employee need not be accomplished by express contract, but may "come about as a result of custom and usage * * * as when employees, working at some distance from their homes, engage in the known and habitual practice of riding on the employer's trucks." 1 Larson, Workmen's Compensation Law, 17.30 at 4-225 (1985). (Footnotes omitted.)

In this case, we find that the evidence supports the finding that the employer acquiesced in its operations manager's decision to furnish company-paid transportation to claimants. At the time of hiring, both the employer and claimants' supervisor, Mr. Whitlow, were aware of the fact that claimants would not be able to provide their own transportation to the work site. Although not expressly required to do so, Whitlow, in light of his supervisory responsibilities, agreed to provide transportation and regularly picked claimants up at their respective homes and took them to and from work. The employer was aware that claimants were relying on Whitlow for transportation, did not discourage or forbid the arrangement, and paid for all transportation expenses either through Whitlow or directly by providing Whitlow a company truck.

The insurer contends that, regardless of the employer conveyance exception to the "coming and going rule," claimants' injuries are not compensable by virtue of ORS 656.025, which provides:

> "(1) For the purpose of this chapter, an individual is not a subject worker while commuting in a voluntary commuter ride sharing arrangement unless:

(a) The worker is reimbursed for travel expenses incurred therein;

(b) The worker receives payment for commuting time from the employer; or

(c) The employer makes an election to provide coverage.

(2) As used in this section, "voluntary commuter ridesharing arrangement" means a car pool or van pool arrangement in which participation is not required as a condition of employment and in which not more than 15 persons are transported to and from their places of employment, in a single daily round trip where the driver also is on the way to or from the driver's place of employment.

We agree that claimants were neither reimbursed for travel expenses nor paid for commuting time, nor did the employer elect to provide coverage for the commuting time. We do not agree, however, that claimants were engaged in a "voluntary commuter rideshare program." Implicit in the term commuter ridesharing is the notion that the commuters have pooled their resources in some way to provide shared transportation. Where transportation was provided by the employer and the employee made no contribution whatever, claimants were not ridesharing within the meaning of ORS 656.025. Whitlow's conduct, as acquiesced in by the employer, effectively made the transportation arrangement an integral part of the employment conditions. Under those circumstances, we conclude that claimants were subject workers at the time of injury and were not statutorily excluded under ORS 656.025.

After our de novo review, we hold that the injuries suffered by claimants were sustained in the course and scope of their employment and that their respective claims were not barred by either the "going and coming rule" or ORS 656.025.

Attorney Fees on Review

After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that $1,500 is a reasonable assessed fee for claimants' counsel's efforts on Board review. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimants' respondent's briefs), the complexity of the issues presented, and the value of the interest involved.

ORDER

The Referee's order dated December 28, 1990 is affirmed. For services rendered on Board review, claimants' attorney is awarded an assessed fee of $1,500, to be paid by the insurer.

In the Matter of the Compensation of
THOMAS D. OLIVE, Claimant
WCB Case No. 90-13631
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of that portion of Referee Quillinan's order that declined to award an attorney fee for claimant's counsel's efforts in connection with the insurer's pre-hearing rescission of its denial of claimant's bilateral carpal tunnel syndrome claim. The insurer cross-requests review of those portions of the Referee's order that: (1) assessed a penalty of 25 percent of the time loss which would have been due under claimant's carpal tunnel claim, had claimant not already been receiving time loss under his neck claim; and (2) awarded claimant's attorney an assessed attorney fee for an unreasonable denial. On review, the issues are penalties and attorney fees. We reverse.

FINDINGS OF FACT

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

On February 20, 1990, Dr. Hubbard reported that claimant's nerve conduction studies demonstrated a mild carpal tunnel on the left and a moderate carpal tunnel on the right. Recommending release surgery, Hubbard concluded that "it is hard to relate" claimant's neck complaints with his carpal tunnel symptoms.

On March 8, 1990, claimant filed his claim for bilateral carpal tunnel syndrome. Claimant alleged that his four months lifting heavy files, desks, and other miscellaneous items as a warehouse worker had caused his condition.

On May 9, 1990, a vocational evaluation concerning claimant's accepted neck injury claim was conducted. During the evaluation, claimant stated that he had experienced numbness in his fingers and hands since "he drove truck." Noting that claimant had been driving truck "off and on" for a variety of employers since that time, the specialist reported that claimant had advised his doctors of these complaints on "numerous occasions but 'they don't seem to listen.'" The vocational specialist also reported that claimant enjoyed "tinkering with cars," drawing, and building model cars.

On May 24, 1990, the insurer issued its denial. After "investigating the facts and medicals" regarding his claim, the insurer stated that there was insufficient evidence to support a conclusion that claimant's work was the major contributing factor in the development of his bilateral carpal tunnel syndrome condition.

CONCLUSIONS OF LAW AND OPINION

Claimant requested a hearing in this case after May 1, 1990. The hearing convened after July 1, 1990. Therefore, the "litigation savings clause" contained in SB 1197, Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. SB 1197, Section 54(3). Finally, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

The Referee found the insurer's denial of claimant's claim for a bilateral carpal tunnel syndrome condition to be unreasonable. She assessed a penalty of 25 percent of the time loss which would already have been payable under that claim, had claimant not been receiving time loss under an open claim with the same insurer for his neck condition. We reverse.

A penalty is assessable under amended ORS 656.262(10) when a carrier "unreasonably delays or unreasonably refuses to pay compensation." The reasonableness of a carrier's denial must be gauged based upon the information available to the carrier at the time of its denial. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n.3 (1985). The standard for determining whether a denial is unreasonable is whether the carrier had a legitimate doubt as to its liability for the claim. Brown v. Argonaut Insurance Co., supra.

Here, when the insurer issued its denial, it had received Dr. Hubbard's chart note which did not contain a statement relating claimant's bilateral carpal tunnel syndrome to his work activities. The only arguable reference to claimant's work offered by Dr. Hubbard was the statement that "it is hard to relate" claimant's neck complaints to his carpal tunnel complaints. Also in the insurer's possession at the time of its denial was a recent report from a vocational specialist. In discussing claimant's carpal tunnel complaints, the specialist reported that claimant had experienced such symptoms since 1980 when he began truck driving for a succession of prior employers. The specialist also noted that claimant enjoyed "tinkering with cars", drawing, and building model cars.

When the physician's failure to expressly relate claimant's carpal tunnel complaints to his work activities is considered in conjunction with the vocational specialist's references to claimant's continuing history of similar complaints dating back to 1980 with a number of prior employers, we conclude that the insurer had a legitimate doubt regarding its liability for claimant's bilateral carpal tunnel syndrome claim. Consequently, we do not find the insurer's denial to have been unreasonable. Accordingly, we reverse the Referee's assessment of a penalty and attorney fee for an unreasonable denial.

Finally, the Referee declined to award an attorney fee for claimant's counsel's efforts associated with the insurer's rescission of its denial prior to the November 9, 1990 hearing. Relying upon Duane L. Jones, 42 Van Natta 875 (1990), the Referee held that claimant was not entitled to an attorney fee when the insurer's denial was rescinded prior to the hearing. The Jones decision was initially affirmed by the Court of Appeals. Jones v. Oregon State Correctional Institution, 107 Or App 78 (1991).

However, on June 19, 1991, the Governor signed Senate Bill 540 A-Engrossed, which amends ORS 656.386(1) to provide that "[i]f an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held, a reasonable attorney fee shall be allowed." Section 1. Section 3 further states that the amendments "apply to all claims for which an order relating to the issue on which attorney fees are sought has not become final on or before the effective date of this 1991 Act, regardless of the date of injury." The Act took effect on its passage. Section 4. Relying on the enactment of Senate Bill 540, the Jones court reconsidered its earlier opinion, reversed the Board's order, and remanded for the award of an attorney fee. Jones v. Oregon State Correctional Institution, 108 Or App 230 (1991).

Here, since this matter has not become final, the amendments to ORS 656.386(1) are applicable. Considering claimant's counsel's efforts in submitting a hearing request concerning the insurer's denial and in light of his

counsel's efforts in eliciting a medical report concerning claimant's wrist condition and its relationship to his work activities, we conclude that claimant's attorney was instrumental in obtaining compensation for claimant through the rescission of the insurer's denial prior to the scheduled hearing. Therefore, we hold that claimant is entitled to an insurer-paid attorney fee under revised ORS 656.386(1).

After considering the factors set forth in OAR 438-15-010(4), we conclude that a reasonable attorney fee concerning the rescission of the insurer's denial 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 the record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated October 30, 1990, as clarified December 13, 1990, is reversed. Claimant's attorney is awarded a reasonable insurer-paid attorney fee of $750, for his services in connection with the insurer's pre-hearing rescission of its denial. This award is in lieu of the Referee's $350 attorney fee award concerning the insurer's allegedly unreasonable denial. The Referee's assessment of a penalty is also reversed.

September 10, 1991 Cite as 43 Van Natta 1883 (1991)

In the Matter of the Compensation of
RICHARD J. STEVENSON, Claimant
WCB Case No. 90-07562
CORRECTED ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Neidig and Westerband.

The insurer requests review of Referee Thye's order that: (1) set aside its denial of claimant's aggravation claim for a left leg deep venous thrombosis (DVT) condition; and (2) assessed a penalty for failure to accept or deny the claim within 60 days, one-half of which was to be paid to claimant's attorney in lieu of a fee. In its brief, the insurer requests remand for admission of additional medical evidence. On review, the issues are remand, aggravation and penalties and fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

In the last sentence of the next to last paragraph of the "Findings," the Referee stated that there is no evidence that the insurer received Dr. Bietz' May 16, 1990 letter or Dr. Neufeld's May 31, 1990 concurrence before August 24, 1990. Instead, we find that the insurer received Dr. Bietz' May 16, 1990 letter on May 24, 1990.

The insurer commenced payment of interim compensation on June 6, 1990.

Claimant's February 20, 1990 aggravation claim was denied on August 20, 1990.

The insurer unreasonably resisted the payment of compensation by delaying acceptance or denial of the claim.

CONCLUSIONS OF LAW AND OPINION

Remand

The insurer moves for remand to allow it to depose Dr. Porter. In support of its motion, the insurer contends that the Referee erred in denying a continuance for that purpose. The insurer asserts that the record is incomplete without the deposition and that the deposition was unavailable at the time of hearing with the exercise of due diligence.

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).

First, we are unpersuaded that Dr. Porter's disposition is necessary for a complete record. The record includes a report from Dr. Porter, which was solicited by the insurer. Hence, this is not a case in which the Referee's denial of a continuance precluded cross-examination of a physician. Rather, it precluded post-hearing amplification of Porter's previously stated opinion.

Second, we are unpersuaded that the insurer exercised due diligence. Although claimant did not request a hearing on the compensability issue until 30 days before hearing, the insurer denied the claim. The August 20, 1990 denial stated: "Medical information is insufficient to substantiate that your thrombosis is causally related to your industrial injury of December 31, 1985." (Ex. 95). Because compensability became an issue by virtue of the denial, the insurer cannot now argue that it lacked timely notice of that issue. Moreover, we conclude that the insurer has not established that it could not have obtained Dr. Porter's deposition in the exercise of due diligence prior to hearing. Consequently, we deny the motion to remand.

Applicable law

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session). Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Oregon Laws 1990, Chapter 2, Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. Oregon Laws 1990, Chapter 2, Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. See Brian L. Dunn, 43 Van Natta 1673 (1991); Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Compensability

We adopt the Referee's "Conclusion and Opinion" on this issue.

Penalty and Fee

The Referee determined that claimant's attorney's February 15, 1990 letter inquiring about commencement of time loss constituted an aggravation claim. (See Ex. 86A). We agree. See ORS 656.273(2); Stevens v. Champion International, 44 Or App 587, 590 (1980); Herman M. Carlson, 43 Van Natta 963, 964 n.1 (1991). The claims examiner stated that she received that letter on February

20, 1990. (Tr. 44). Therefore, we also agree with the Referee's determination that claimant perfected an aggravation claim on February 20, 1990.

Under ORS 656.273(6) and ORS 656.262, the insurer must accept or deny a claim within 90 days, or risk imposition of penalties. See Brian L. Dunn, supra. In this case, the February 20, 1990 claim was not denied until August 20, 1990. Because the insurer did not accept or deny the claim within 90 days, a penalty may be assessed if there were amounts then due between the date when an acceptance or denial should have issued and the date of the denial. Jeffrey D. Dennis 43 Van Natta 857, 858 (1991).

Temporary disability compensation must be paid within 14 days of the insurer's receipt of medical verification of the claimant's inability to work due to a compensable worsening. ORS 656.273(6). The Referee found that the insurer received Dr. Bietz's February 6, 1990 letter and "initial workup," explaining claimant's five to seven day hospitalization for DVT treatment prior to receiving the attorney's letter inquiring about time loss benefits. Inasmuch as Dr. Bietz' reports are date stamped February 9, 1990, we agree that the insurer received them before it received the attorney's February 15, 1990 letter. (See Exs. 82, 85). However, neither the February 6 report nor any other medical evidence related claimant's hospitalization to his compensable condition until Dr. Bietz authored his May 16, 1990 report, which the insurer received on May 23, 1990. (See Tr. 40). Thus, although the insurer became aware that claimant had been hospitalized in January 1990, it did not have the notice or knowledge statutorily required to trigger its duty to pay interim compensation, until it received Bietz' May 16, 1990 letter.

It is undisputed that the insurer commenced payment of interim compensation on June 6, 1990, 14 days after it received Bietz' May 16, 1990 letter which related claimant's DVT to his 1985 compensable injury. (See Tr. 40-41). Inasmuch as the insurer commenced payment of interim compensation within 14 days of medically verified notice that claimant had been hospitalized due to a compensable worsening of his accepted condition, claimant has not proven that he is entitled to any compensation which was not timely paid. Inasmuch as there were no amounts due during the delay period in this case, there is no basis for a penalty. See Wacker Siltronic v. Satcher, 91 Or App 654 (1988).

However, ORS 656.382(1) warrants an attorney fee when a carrier engages in conduct which constitutes unreasonable resistance to the payment of compensation, even though there are no amounts then due upon which to base a penalty. See Nicolasa Martinez, 43 Van Natta 1638 (1991).

In the present case, the insurer did not accept or deny the February 20, 1990 claim within 90 days, as required by ORS 656.273(6). By failing to timely respond to the claim, the insurer delayed the ultimate resolution of the dispute. We find that its failure to respond to claimant's claim was unreasonable and that its nonaction had the effect of delaying benefits which were compensable. Therefore, the insurer unreasonably resisted the payment of compensation to claimant and an attorney fee pursuant to ORS 656.382(1) is assessed on this basis. See Steve Chambers, 42 Van Natta 524 (1990); Jack O. Pichette, 41 Van Natta 2136 (1989). Having considered 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 untimely denial is $300.

Claimant's attorney is also entitled to a reasonable assessed fee for his services on review successfully defending against the insurer's appeal regarding claimant's aggravation claim for a current DVT condition. 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 fee for claimant's counsel's services on

review concerning the aggravation 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, and the value to claimant of the interest involved.

ORDER

The Referee's order dated November 9, 1990 is affirmed in part and reversed in part. That portion of the order that assessed a penalty of 25 percent of the time loss payable to claimant to August 20, 1990 is reversed. The remainder of the order is affirmed. Claimant's attorney is awarded a reasonable assessed fee of $300, for his services regarding the untimely denial. Claimant's attorney is awarded a reasonable assessed fee of $700, for his services on review regarding the aggravation issue

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September 10, 1991 Cite as 43 Van Natta 1886 (1991)

In the Matter of the Compensation of
WONDER WINDOM-HALL, Claimant
WCB Case No. 90-06799
ORDER ON RECONSIDERATION
Schwabe, et al., Defense Attorneys

The self-insured employer requests reconsideration of our August 14, 1991 order which vacated a referee's dismissal order and remanded this matter to the Hearings Division for further proceedings to determine whether claimant had established justification for postponement of her hearing. The employer contends that the issue before the Board is dismissal, not postponement.

We conclude that this case is controlled by our decision in Mark R. Luthy, 41 Van Natta 2132 (1989). In Luthy, neither claimant nor his attorney appeared at the time set for hearing. The Referee dismissed the request for hearing pursuant to former OAR 438-06-071. After the Referee's order issued, claimant's attorney wrote the Referee to request that he reschedule the matter. There was no response to this request in the record. Interpreting former OAR 438-06-071, we held that a Referee must consider a motion for postponement of a hearing even after an order of dismissal has been issued. We remanded for further proceedings to determine whether postponement was justified.

Similarly, here, claimant neither personally appeared at hearing nor did she appear through counsel. The Referee properly entered a dismissal order pursuant to OAR 438-06-071. Subsequent to issuance of the order, claimant wrote to the Referee, requesting that the dismissal order be "overruled." As required by our rule as interpreted in Luthy, the Referee considered the request. However, the Referee applied a "good cause" standard justifying failure to appear. Instead, in accordance with Luthy, the appropriate standard is whether claimant has established extraordinary circumstances justifying postponement or continuance under OAR 438-06-081. Therefore, we have remanded for further proceedings under the appropriate standard. We adhere to that determination.

Accordingly, the motion for reconsideration is granted and our prior order withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our August 14, 1991 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD J. FLEISCHER SR., Claimant
WCB Case No. 89-06085
ORDER ON REMAND
Burt, et al., Claimant Attorneys
Darryl Nelson, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Liberty Northwest Insurance Corp. v. Fleischer, 108 Or App 189 (1991). The court reversed our order that had set aside an occupational disease denial because a series of repetitive, traumatic work activities were a material contributing cause of claimant's back condition. The court remanded for reconsideration in light of Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991), which held that a claimant must establish that work activities or exposure was the major contributing cause of the claimant's condition or the worsening of an underlying condition. We proceed with our reconsideration.

FINDINGS OF FACT

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

Claimant's work activities included repetitive pushing and pulling of a rug shampooer and buffer, as well as repetitive bending and occasional lifting.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had not established that his work activities were the major contributing cause of his low back condition. We reversed the Referee's order, reasoning that claimant must only establish that his work activities were a material contributing cause of low back symptoms.

The court has held that to establish compensability of an occupational disease under former ORS 656.802, claimant must prove that his work activities were the major contributing cause of his condition or of the worsening of his underlying condition. See Aetna Casualty Co. v. Aschbacher, supra. In light of the court's decision, we review the record to determine compensability of claimant's occupational disease claim. Following our reconsideration, we adopt the Referee's "Conclusions of Law and Opinion" with the following supplementation.

Because claimant's low back condition involved repetitive trauma and was gradual in onset, his claim is properly analyzed under former ORS 656.802(1)(c). To establish that his condition is compensable under subsection (1)(c), claimant must prove that his work exposure included a series of traumatic events which were the major cause of the onset or worsening of the low back condition and required medical services or resulted in disability. See Aetna Casualty Co. v. Aschbacher, supra. Major cause means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening than all other conditions, explanations, or exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); Dethlefs v. Hyster Co., 295 Or 309-310 (1983); David K. Boyer, 43 Van Natta 561 (1991).

Here, Dr. Fohrman, claimant's treating rheumatologist, concluded that claimant's work activities were "a major contributing cause to [claimant's] back symptoms." "Magic words" are not required to establish the compensability of a claim. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). However, Dr. Fohrman does not address the potential contribution to claimant's current back condition from a variety off-work activities occurring some several months before his claim until the week immediately preceding the filing of his claim.

Under such circumstances and considering the conclusory nature of Dr. Fohrman's opinion, we do not find it persuasive. See Blakely v. SAIF, 89 Or App 653, 656, rev den 305 Or 672 (1988); Moe v. Ceiling Systems, 44 Or App 429 (1980).

Consequently, we are not persuaded that claimant has established that his work activity was the major contributing cause of his back condition. Therefore, claimant has failed to carry his burden of proof. See Aetna Casualty Co. v. Aschbacher, supra.

Accordingly, on reconsideration, the Referee's order dated July 6, 1989 is affirmed.

IT IS SO ORDERED.

September 12, 1991 Cite as 43 Van Natta 1888 (1991)

In the Matter of the Compensation of
GERALD D. SPENCER, Claimant
Own Motion No. 66-0226M
OWN MOTION ORDER
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted to the Board claimant's claim for temporary disability and medical benefits relating to his September 10, 1963, industrial injury. SAIF opposes reopening of his claim for payment of temporary disability and medical benefits, contending that claimant's current right leg condition, which required hospitalization, is unrelated to the compensable injury. Alternatively, SAIF requests that we authorize reimbursement from the Reopened Claims Reserve for an independent medical report and written response from the treating physician to questions concerning the causal relationship of the hospitalization to the 1963 compensable injury. Claimant recognizes that the record is inadequately developed and seeks additional time to obtain and submit evidence.

The evidence in the record indicates that claimant's current right leg condition could be the result of a 1988 or 1990 claim when a different insurer was on the risk, an off-the-job burn incident, diabetes, obesity, or the 1963 injury. We thus conclude that an independent medical report and a medical report from claimant's attending physician regarding the cause of claimant's current right leg condition would best assist us in determining the compensability of claimant's current condition. Specifically, we require opinions as to the relative contributions of each of the aforementioned incidents or medical conditions to claimant's need for hospitalization in December 1990. Accordingly, we find that special circumstances justify the provision of further medical services for claimant, consisting of an independent medical report and a medical report from claimant's attending physician, and reopen claimant's claim to provide these specific medical services. See OAR 438-12-037(1)(f). The Board will defer further action on claimant's request for payment of temporary disability and medical benefits until we receive those medical reports as well as anything further claimant wishes to present. Upon receipt of the reports, claimant shall have 14 days to respond. Thereafter, the Board will take the request for benefits under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD A. STOCK, Claimant
WCB Case No. 90-13183
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Darryl Nelson, Defense Attorney

Reviewed by Board Members Neidig, Westerband, and Crider.

Claimant requests review of Referee Otto's order that dismissed his request for hearing on the basis that the Referee lacked jurisdiction over the matter. Claimant contends that, if the Referee had jurisdiction, he is entitled to penalties and attorney fees for an alleged unreasonable denial. Claimant also asserts that his attorney is entitled to an assessed attorney fee for his services in obtaining the insurer's rescission of its denial. On review, the issues are jurisdiction and penalties and attorney fees. We affirm.

FINDINGS OF FACT

On June 18, 1990, claimant requested a hearing. The request was made using the Board's form for hearing requests. Claimant checked the blocks for "compensability-industrial injury," "compensability-occupational disease," "penalties & attorney fees," and "other." In the "other" block, claimant indicated, "Liberty Northwest's denial of 6-18-90; late denial; unreasonable denial." Before hearing, the insurer rescinded its denial of the claim. At hearing, claimant agreed with the Referee's statement of the issues as solely "penalties and attorney fees for some unreasonable conduct by the insurer." Tr. 1.

Counsel for the insurer moved to dismiss the request for hearing, contending that exclusive authority to address penalty and attorney fee issues is with the Director of the Department of Insurance and Finance. The Referee received no exhibits and took no testimony. He granted the motion from the bench.

CONCLUSIONS OF LAW AND OPINION

The Referee dismissed claimant's request for hearing on the basis that, pursuant to ORS 656.262(10), the Hearings Division no longer has jurisdiction over proceedings in which penalties and penalty-related attorney fees are the only issue.

On review, claimant contends that the issues are whether claimant is entitled to an attorney fee under ORS 656.386(1); whether claimant is entitled to a penalty under ORS 656.262(10); and whether claimant is entitled to an attorney fee under ORS 656.382(1). He argues that, because the sole issue was not entitlement to a penalty under ORS 656.262(10), the Hearings Division had jurisdiction of the matter. He seeks an attorney fee award.

The insurer argues that the only issue in this case was assessment of a penalty, pursuant to ORS 656.262(10), and a penalty-related attorney fee, pursuant to ORS 656.382(1), for an unreasonable denial. The insurer contends that claimant did not raise the issue of an attorney fee under ORS 656.386(1) until Board level, and that claimant should therefore be precluded from raising that issue on Board review and from asserting the issue as the basis for the Board's exercise of jurisdiction over the penalty and attorney fee issue. The insurer argues that the Hearings Division lacked jurisdiction over the sole issues actually raised at hearing. On the merits, the insurer contends that claimant is entitled to neither a penalty nor a penalty-related attorney fee because claimant cannot establish that there were amounts then due against which to assess a penalty.

We agree with the insurer's contention that claimant did not seek a fee under ORS 656.386(1) at hearing. Hence, the question is whether the Referee had jurisdiction to hear claimant's request for penalties and penalty-related fees.

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), SB 1197. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in SB 1197, Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. SB 1197, Section 54(3). Moreover, neither party contends that application of the 1990 amendments will produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we also analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Prior to the 1990 amendments, ORS 656.262(10) read as follows:

> "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."

ORS 656.382(1) provided assessment of an attorney fee if an insurer or self-insured employer refused to pay compensation due under an order or otherwise unreasonably resisted the payment of compensation. The case law clearly established that a worker need not prove that there were amounts of compensation then due in order to establish an unreasonable resistance to the payment of compensation entitling the worker to award of a fee under ORS 656.382(1). See Ellis v. McCall Insulation, 308 Or 74 (1989); Cindi A. Cadieux, 41 Van Natta 2259 (1989).

Under these circumstances, when a worker contended that an insurer had processed a claim unreasonably and that he or she was entitled to either a penalty or a fee for such conduct, the worker checked the block on the Board's standard hearing request form for "penalties and attorney fees." No further specification was required; the Referee awarded whatever remedy to which claimant was entitled under the evidence adduced at hearing.

In 1990, the Legislature left ORS 656.382(1) intact, but amended ORS 656.262(10) to delete the cross reference to the attorney fee provision and to provide that when a penalty was awarded, the attorney fee should be awarded out of, rather than in addition to, the penalty amount:

> "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.... The entire additional amount shall be paid to the worker if the worker is not represented by an attorney. If the worker is represented by an attorney, the worker shall be paid one-half the additional amount and the worker's attorney shall receive one-half the additional amount, in lieu of an attorney fee."

Finally, the 1990 amendments eliminated Hearings Division jurisdiction over proceedings in which only a penalty under ORS 656.262(10) is at issue. The Hearings Division retains jurisdiction, however, over proceedings in which a penalty issue is joined with another issue.

The problem before us is whether the Hearings Division has jurisdiction of the traditional request for hearing on "penalties and attorney fees." The answer is, "It depends." It depends on whether the claimant is truly seeking a penalty (and an attorney fee out of the penalty amount) or whether the claimant is truly seeking an insurer-paid attorney fee under ORS 656.382(1); for a claimant is never entitled to both a penalty and a ".382(1)" fee for the same processing infraction. Nicolasa Martinez, 43 Van Natta 1638 (1991); Harry E. Forrester, 43 Van Natta 1480 (1991).

If claimant has a viable request for a penalty, then claimant's attorney is only entitled to a fee out of the penalty amount. That out-of-penalty fee, to which claimant's attorney is entitled under ORS 656.262(10), is in lieu of the fee otherwise awardable for the same conduct under ORS 656.382(1). Therefore, if the unreasonable conduct which supports the penalty is the sole issue, then we hold that the Director has exclusive jurisdiction of the matter. If, on the other hand, claimant cannot establish all of the elements necessary to prove entitlement to a penalty but can nevertheless prove unreasonable resistance to the payment of compensation, then claimant is entitled to a fee under ORS 656.382(1). The Hearings Division has exclusive jurisdiction over such requests.

In so holding, we reject the view that a party may vest jurisdiction in the Hearings Division over a penalty issue simply by also alleging entitlement to a fee under ORS 656.382(1). To take that approach would permit a party to avoid the Director's jurisdiction by making groundless allegations. Instead, we believe that, if the sole issue remaining at the time set for hearing is penalties and attorney fees for the same conduct, then the request must be dismissed for lack of jurisdiction.

Nevertheless, given that the Board's own forms for requesting hearings continue to treat penalties and attorney fees as a single issue, no request for hearing should be dismissed on the ground that the Director has sole jurisdiction until the claimant has been given an opportunity to clarify the request. If a claimant, who has specified the sole issue as penalties and attorney fees, continues to claim both a penalty and an attorney fee for the same conduct at hearing, then the request shall be dismissed for lack of jurisdiction. If, on the other hand, the claimant raises a separate fee as the sole issue or alleges different unreasonable conduct in support of the fee than in support of the penalty (such that a penalty and a separate fee could be awarded), then the hearing should proceed.

In this case, at hearing, claimant continued to claim both a penalty and a fee for the same unreasonable conduct. Therefore, we affirm the Referee's dismissal of the request for hearing.

ORDER

The Referee's order dated November 13, 1990 is affirmed.

Board Member Crider, dissenting.

I agree with the Board's approach to the reconciliation of ORS 656.262(10) and ORS 656.382(1); but I disagree with its conclusion that remand for clarification of the issues is not necessary in this case. Here, the Referee's attempt to

clarify the issues at hearing was characterized by the same flaw as is the Board's form for request for hearing. That is, the Referee stated that the only issue was entitlement to penalties and attorney fees. Claimant's attorney did acquiesce in that formulation of the issues. However, when Hearings Division jurisdiction attaches or does not attach depending on whether or not a claimant truly seeks a penalty, acquiescence in the traditional formulation of claims processing issues as "penalties and attorney fees" is insufficient. Because the Board declines to remand for clarification in this case, I dissent.

September 12, 1991 Cite as 43 Van Natta 1892 (1991)

In the Matter of the Compensation of
DONALD A. WILLIAMS, Claimant
WCB Case No. 89-17142
SECOND ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Claimant requests reconsideration of our July 30, 1991 Order on Reconsideration, which denied remand, reversed the Referee's July 3, 1990 order, and reinstated and upheld the insurer's August 28, 1989 denial of an occupational disease claim. Claimant contends the Board inappropriately considered the insurer's "de facto" denial for claimant's low back condition in its Order of Reconsideration. Further, claimant requests an assessed attorney fee for having prevailed on the "de facto" denial. In the alternative, claimant requests remand for further evidence taking. On August 29, 1991, we withdrew our Order to consider claimant's argument, as well as the insurer's response.

We have previously discussed the remand issue in our prior Order on Reconsideration and adopt that reasoning, but add the following with regard to claimant's contention regarding the low back condition.

The scope of our de novo review encompasses all issues considered by the Referee. Our review is not limited to those issues specifically raised by the parties on review. Destael v. Nicolai Co., 80 Or App 596 (1986); Russell v. A & D Terminals, 50 Or App 27, 31 (1981). A party has a right to request review of the Referee's "order." ORS 656.295(1). Pursuant to ORS 656.295(6), "The Board may affirm, reverse, modify or supplement the order of the referee and make such disposition of the case as it determines to be appropriate." (Emphasis added).

The issue before the Referee was the compensability of claimant's occupational disease claim for a degenerative hip and low back condition. The Referee held that the occupational disease claim was compensable. In the "order" section, the Referee specifically set aside the August 28, 1989 denial and a "de facto" denial of the low back condition.

The insurer requested review of the Referee's order. Our Order on Review affirmed and adopted without comment the Referee's order. The insurer requested reconsideration of the order in light of the court's recent decision in Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991). By Order on Reconsideration, we denied remand and reversed the Referee's order, thereby reinstating the insurer's denial.

Claimant has requested we abate and rescind our Order on Reconsideration, arguing that it was improper for us to address claimant's low back condition. It is claimant's contention that the "de facto" denial that was set aside and remanded to the insurer for claims processing by the Referee was never appealed, and hence, remained compensable. In essence it is claimant's contention that

his low back condition was a separate claim from claimant's degenerative hip condition. We disagree.

We note that there was only one claim filed by claimant on June 19, 1989. That claim reflected an occupational disease with an onset date of June 1, 1986. Body parts were not specified, although the medical record reflects that the hip, by and large, was the primary problem, and that secondary was claimant's low back and left leg pain.

At hearing only one legal theory was argued by the parties, that of an occupational disease claim. The factual basis for the claim was the same for both the hip and the back. The parties addressed the hip and low back as if they were addressing one condition. The parties did not attempt to establish that the hip and back conditions were separate unrelated conditions originating from different causative factors. Rather they were treated as if they were one claim arising from the same work-related activities. Consequently, we properly considered the left hip and low back conditions as one occupational disease claim.

Accordingly, on reconsideration, as supplemented and clarified herein, we adhere to and republish our July 30, 1991 Order on Reconsideration effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

September 13, 1991 Cite as 43 Van Natta 1893 (1991)

In the Matter of the Compensation of
ROBERT S. ROBINSON, Claimant
WCB Case No. C1-01674
RECONSIDERATION ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Pozzi, Wilson, et al., Claimant Attorneys
Roderick Peters (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

By order dated August 20, 1991, the Board disapproved the parties' Claim Disposition Agreement (CDA) upon a finding that the amount of consideration was in doubt. Specifically, the Board found that the summary sheet listed the consideration to claimant as $20,500 ($2,500 attorney fee and $18,000 proceeds to claimant). However, on pages three and four of the agreement the consideration to claimant was listed as $33,000 ($2,500 attorney fee and $30,500 proceeds to claimant). Inasmuch as the proposed agreement contained two different amounts of consideration, we were unable to determine the specific amount of consideration. The parties have submitted a revised page one of the CDA that has been changed to conform with pages three and four of the body of the CDA. The parties request reconsideration of that order contending that the error was due to inadvertence.

The Rules of Practice and Procedure relating to requests for reconsideration of orders disapproving claim disposition agreements were amended effective September 2, 1991. WCB Admin. Order 5-1991 (August 21, 1991). OAR 438-09-035 provides that:

> "(1) A motion for reconsideration of final orders issued by the Board under ORS 656.236 and these rules shall be filed within 10 days of the date of mailing of the order.

(2) The Board may reconsider final orders under ORS 656.236, provided that the motion for reconsideration:

(a) Is filed in accordance with section (1); and

(b) States specifically the reasons(s) reconsideration is requested.

(3) 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, unless the Board finds good cause for allowing the additional submission."

Here, the disapproval order was mailed on August 20, 1991, and the parties request for reconsideration was received on August 28, 1991. The parties state their reason for requesting reconsideration is inadvertent error. Therefore, the request was timely filed and specific in accordance with OAR 438-09-035(1), (2)(a) and (2)(b). Consequently, we may consider the motion for reconsideration. OAR 438-09-035(2).

In support of their motion for reconsideration, the parties have submitted a revised page one of the agreement to clarify that the correct amount of consideration is indeed -- $33,000 ($2,500 attorney fee and $30,500 proceeds to claimant) -- as noted on pages three and four of the agreement. Therefore, the parties move that we attach and integrate this new document into the original CDA for reconsideration and approval by the Board.

Our review on reconsideration is generally limited to information in the record before the Board at the time our final disapproval order was mailed. However, we may consider additional information in our review if we find good cause for allowing the additional submission. OAR 438-09-035(3).

Here, the parties contend that the typographical error on page one was inadvertent, and have submitted a revised page one evidencing that the correct amount of consideration is $33,000 as noted in the body of the CDA, rather than $20,500 as noted on the summary sheet. We find, as the parties assert, that this error was inadvertent. Therefore, the parties have established good cause and the Board will consider this additional information on reconsideration. See OAR 438-09-035(3).

Accordingly, we grant the motion for reconsideration. On reconsideration, we find that this agreement is now in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. We do not find any statutory basis for disapproving the agreement. See ORS 656.236(1). Accordingly, this claim disposition agreement is approved. An attorney fee payable to claimant's attorney according to the terms of this agreement is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
RANDY G. FISHER, Claimant
WCB Case No. 91-04114
ORDER OF DISMISSAL (REMANDING)
Merrill Schneider, Claimant Attorney
Kenneth Russell (Saif), Defense Attorney

The SAIF Corporation has requested Board review of Referee Crumme's order dated August 16, 1991. Contending that the Referee abated his order before SAIF requested review, claimant moves for dismissal of the request for review as premature. We remand.

FINDINGS OF FACT

The Referee's Opinion and Order issued August 16, 1991. On August 21, 1991, claimant moved for reconsideration of the Referee's order. On August 26, 1991, SAIF mailed, by certified mail, its request for the Board review of the Referee's order to the Board. See OAR 438-05-046(1)(b).

By order dated "August 29, 1991," the Referee abated his August 16, 1991 order and granted SAIF an opportunity to respond to the motion for reconsideration. Claimant's counsel received the Referee's abatement order on August 27, 1991.

Contending that the Referee's abatement order actually issued on August 26, 1991, claimant moved the Board for an order dismissing SAIF's request for review as premature. In addition, claimant has requested that the Referee issue a corrected order evidencing the proper date of his abatement order.

CONCLUSIONS OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). Timely request for Board review is a jurisdictional prerequisite for our review. ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983). Upon the filing of a request for Board review of a Referee's order, jurisdiction over the case vests with the Board. Ramey S. Johnson, 40 Van Natta 370, 371 (1988).

Here, SAIF filed its request for review of the Referee's August 16, 1991 order when, on August 26, 1991, it mailed by certified mail its request to the Board. OAR 438-05-046(1)(b). The Referee's abatement order is dated August 29, 1991, three days after SAIF's request for review was filed with the Board. Therefore, it would appear that the Referee's abatement order was issued without authority. See Ramey S. Johnson, supra.

Notwithstanding these observations, claimant contends that the Referee's abatement order is misdated. To support this contention, claimant notes that the Referee's "August 29, 1991" order was received by claimant's attorney on "August 27, 1991." A date stamp from the attorney's office confirms this contention. In addition, claimant's attorney's letters to the Referee and the Board providing notification of this apparent error are dated "August 28, 1991."

Based on these circumstances, claimant asserts that the Referee's abatement order was actually mailed on August 26, 1991. Should that assertion be accurate, the Referee would retain jurisdiction over this case because the abatement order and SAIF's request for Board review would have occurred on the same date. See James D. Whitney, 37 Van Natta 1463 (1985) (where simultaneous

acts affect the vesting of jurisdiction in this forum, in the interest of administrative economy and substantial justice, we will give effect to the act that results in the resolution of the controversy at the lowest possible level).

We may remand if we consider the record to be improperly, incompletely, or otherwise insufficiently developed. ORS 656.295(5). Considering the circumstances detailed above, we find the record insufficient for us to determine when the Referee's abatement order was mailed. Since such a determination is vital to resolving the issue of jurisdiction, we conclude that remand is appropriate.

Accordingly, the request for Board review is dismissed and this matter is remanded to Referee Crumme'. The Referee is directed to conduct further proceedings to determine when his abatement order was mailed. Such a proceeding may be conducted in any manner that will achieve substantial justice. Should the Referee determine that his abatement order was mailed on or before August 26, 1991, the Referee shall proceed with the reconsideration of his August 16, 1991 order. Thereafter, the Referee shall issue a final, appealable order on reconsideration. In the event the Referee determines that his abatement order was mailed on or after August 27, 1991, the Referee shall issue a final, appealable order withdrawing his abatement order and republishing his August 16, 1991 order without reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
STEVEN D. PEFFER, Claimant
WCB Case No. C1-01676
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT
Goldberg & Mechanic, Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Neidig and Moller.

By order dated August 20, 1991, the Board disapproved the parties' Claim Disposition Agreement (CDA) on the basis that the agreement provided for an attorney fee in excess of the limit set by OAR 438-15-052. Specifically, the Board found that the extraordinary circumstances raised by the parties to justify a larger attorney fee are not directly related to the obtaining or formulation of the proposed claim disposition agreement. Claimant has requested reconsideration of that order contending that under the circumstances of this case, an extraordinary attorney fee is justified. Claimant submits an additional affidavit from his counsel supporting a finding of extraordinary circumstances.

Claimant also requests telephonic oral argument on his motion for reconsideration. A claimant who is not represented by an attorney has the statutory right to appear before the Board. ORS 656.236(1). Here, claimant is represented by counsel. Therefore, we deny claimant's request for oral argument and proceed with our review.

Entitlement to an attorney fee in connection with a CDA is expressly subject to OAR 438-15-052. 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 proceeds in excess of $12,500. See OAR 438-15-052. Under extraordinary circumstances, a fee may be

approved in excess of the strictures of OAR 438-15-052. Rollie Clark, 43 Van Natta 194 (1991).

Here, the attorney fee exceeds the amount allowed under OAR 438-15-052. The agreement provides that the insurer will pay claimant a total of $20,000 with $5,000 of that amount as an attorney fee. On reconsideration, claimant contends that the attorney fee is justified due to the extraordinary circumstances of this claim. In reliance on claimant's additional affidavit regarding those circumstances, the Board finds extraordinary circumstances surrounding this claim which justify an attorney fee which exceeds the strictures of OAR 438-15-052. Accordingly, claimant's request for reconsideration is granted.

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 claim disposition agreement is approved. An attorney fee payable to claimant's attorney according to the terms of the agreement is also approved.

The parties may move for reconsideration of this final Board order by filling a motion for reconsideration within 10 days of the date of mailing of this order. OAR 438-09-035(1).

IT IS SO ORDERED.

September 16, 1991 Cite as 43 Van Natta 1897 (1991)

In the Matter of the Compensation of
GLENN ABBE, Claimant
WCB Case No. C1-01831
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Coughlin, et al., Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller .

On September 3, 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 438-15-052(1) provides that, when a claim disposition agreement is approved, the Board may approve an attorney fee in an amount up to 25 percent of the first $12,500 of the agreement proceeds plus 10 percent of the remaining proceeds. Under extraordinary circumstances, an attorney fee exceeding those strictures may be approved. Id.

Here, the agreement provides for consideration of $17,500, out of which the SAIF Corporation will recover an overpayment of $1,970.00, as per a March 18, 1990 Determination Order. Inasmuch as the overpayment was made pursuant to prior claims processing obligations, that overpayment cannot qualify as "proceeds" of the parties' CDA. Raymond E. Clonkey, 43 Van Natta 1778, 1779 (1991). Where the parties include an overpayment of compensation within the stated sum of the claim disposition agreement, the approved attorney fee is calculated on the actual consideration claimant receives under the agreement rather than the stated sum. Id. Thus, after SAIF recovers its $1,970.00 overpayment, claimant shall actually receive agreement proceeds totalling $15,530.00.

The agreement recites that claimant's attorney shall receive an attorney fee of $3,625. Based on our calculations, the proposed attorney fee exceeds the strictures of OAR 438-15-052(1) by $197.00. Moreover, the agreement does not indicate any extraordinary circumstances which would justify the excessive fee. Because the proposed disposition exceeds the bounds of our rules, we find it is unreasonable as a matter of law. See OAR 438-09-020(2); Raymond E. Clonkey, supra. 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 procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
MELVIN D. MANIRE JR., Claimant
WCB Case Nos. 90-09620, 90-09619 & 90-09618
ORDER DENYING MOTION TO DISMISS
Welch, et al., Claimant Attorneys
Julene Quinn (Saif), Defense Attorney
Roberts, et al., Defense Attorneys
Beers, et al., Defense Attorneys

The SAIF Corporation, on behalf of RSG Forest Products, has requested Board review of a Referee's order finding it responsible for claimant's cervical condition and proposed surgery. Catch the Wind, Inc. and its insurer, Connecticut Indemnity (Connecticut), has moved that we dismiss them as a party to these proceedings. The motion is denied.

FINDINGS OF FACT

Claimant filed hearing requests against several employers / insurers contesting their denials. The hearing requests were consolidated. Prior to a May 10, 1991 reconvened hearing, claimant withdrew his hearing request in WCB Case No. 91-00081, which pertained to Dees Landscaping / Liberty Northwest Insurance Corp.'s denial. Thereafter, the Referee issued an order dismissing claimant's hearing request insofar as it pertained to the Dees / Liberty Northwest denial.

Also before the May 10, 1991 reconvened hearing, claimant expressly withdrew his hearing request concerning Conncecticut's February 27, 1991 denial. However, claimant's hearing request regarding Connecticut was not dismissed in a separate Referee's order. Instead, the Referee documented claimant's withdrawal and the dismissal of claimant's hearing request concerning Connecticut's denial in his eventual June 14, 1991 Opinion and Order.

At the May 10, 1991 reconvened hearing, claimant, RSG/SAIF and Garron Ground Management/SAIF litigated responsibility for claimant's current cervical condition and proposed surgery. Thereafter, the Referee issued an order finding RSG/SAIF responsible for the claim. In the same order, the Referee also dismissed claimant's hearing request concerning Connecticut. RSG/SAIF timely requested review of the Referee's order. Thereafter, Garron Ground/SAIF also requested review.

CONCLUSIONS OF LAW

Although a Referee's conclusions and opinions in consolidated cases may be separately stated, if the Referee's decisions are contained in one final order, we retain jurisdiction to consider all matters contained therein. Riley E. Lott, Jr., 42 Van Natta 239 (1990); William E. Wood, 40 Van Natta 999 (1988).

Here, Connecticut acknowledges that claimant's hearing request concerning its denial was dismissed within the body of the Referee's June 14, 1991 Opinion and Order. Yet, contending that the WCB case number which pertains to claimant's claim with Connecticut (WCB Case No. 91-00081) was not referred to in the Referee's order or in RSG/SAIF's request for Board review, Connecticut argues that it is not a party to these proceedings. We disagree.

To begin, WCB Case No. 91-00081 pertained to claimant's hearing request concerning Dees Landscaping / Liberty Northwest, which was dismissed pursuant to a separate, final, appealable order. Thus, neither that case number nor the Referee's dismissal order has any effect on claimant's hearing request regarding Connecticut. In any event, neither the statutes nor our rules assign any significance to case numbers; our review is of appealed Referees' orders. See William E. Wood, supra, at page 1001. Moreover, as Connecticut concedes, the dismissal of claimant's hearing request regarding the Connecticut denial was actually contained in the Referee's June 14, 1991 Opinion and Order.

Inasmuch as the dismissal of claimant's hearing request concerning Connecticut was contained in one final order and since that order has been appealed, we retain jurisdiction over that hearing request and Connecticut remains a party to this proceeding. See Zurich Ins. Co. v. Diversified Risk Management, 300 Or 47 (1985); Riley E. Lott, supra; Rual E. Tigner, 40 Van Natta 1789 (1988). However, considering the circumstances concerning the dismissal of claimant's hearing request regarding Connecticut's denial and the remaining parties' lack of opposition to Connecticut's dismissal motion, as a practical matter, Connecticut's participation in this case will likely be nominal. Lott, supra.

Accordingly, Connecticut's motion to dismiss is denied. The briefing schedule shall be revised as follows. RSG/SAIF's appellant's brief shall be due 21 days from the date of this order. Claimant's, Connecticut (if any), and Garron Ground/SAIF's respondent's briefs shall be due 21 days from the date of mailing of RSG/SAIF's brief. Garron Ground/SAIF's brief shall also include its cross-appellant's brief. RSG/SAIF's reply/cross-respondent's brief, claimant's cross-respondent's brief, and Connecticut's cross-respondent's brief (if any) shall be due 14 days from the date of mailing of Garron Ground/SAIF's brief. Garron Ground/SAIF's cross-reply shall be due 14 days from the date of mailing of the latest timely cross-respondent's brief. Thereafter, this matter will be docketed for review.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID A. MARTINA, Claimant
WCB Case No. 90-17457
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Nelson, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of Referee Livesley's order that increased claimant's unscheduled permanent disability award for a back injury from 32 percent (102.4 degrees), as awarded by Determination Order, to 49 percent (156.8 degrees). On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation. Claimant has worked as a truck driver for 23 years. Claimant's at-injury job required heavy work, which involved lifting up to 100 pounds. After claimant's surgery, Dr. Filarski, claimant's treating physician, restricted him from bending, lifting, and carrying. (Ex. 1-22). Claimant returned to sedentary modified work, which required no lifting or carrying. (Ex. 11, Tr. 7). He worked at this modified job for approximately nine months and then was laid off when the employer sold part of his trucking business. (Ex. 22-2, Tr. 9).

FINDINGS OF ULTIMATE FACT

Claimant has competence in a specific vocational pursuit, namely truck driving.

As a result of his work activities for the insured, claimant suffers from a chronic condition limiting repetitive use of his back.

CONCLUSIONS OF LAW AND OPINION

Claimant's condition became medically stationary on March 22, 1990. His claim was closed by Determination Order on August 30, 1990. In rating claimant's permanent disability, we apply the January 1, 1989 standards, which are the standards effective at the time of the Determination Order. (WCD Admin. Order 7-1988); former OAR 436-35-001 et seq.

The parties do not dispute the values assigned to age (1), formal education (1) and skills (3). Therefore, we do not address those issues.

Training

The Referee assigned a value of +1 based on his conclusion that claimant's training as a shoe repairperson was of no value because claimant had never actually performed that work and there was no market for it. We agree with the insurer's contention that claimant has demonstrated competence in some specific vocational pursuit.

Former OAR 436-35-300(5) provides that no training value is allowed for workers who have competence in some specific vocational pursuit. "Specific vocational pursuit" means employment other than an entry level position. Jimmie L. Wilson, 42 Van Natta 2526 (1990); Larry L. McDougal, 42 Van Natta 1544 (1990). Claimant has worked as a truck driver for 23 years. We find that his employment record establishes that he has demonstrated competence in that specific vocational pursuit. See Raymond S. Voller, 43 Van Natta 72 (1991).

Because of that finding, we do not address the issue of whether his shoe repairperson training qualifies as competence in a specific vocational pursuit. Therefore, the appropriate training value is 0. Former OAR 436-35-300(5).

Adaptability

The Referee assigned a value of +6 based on Dr. Filarski's limitation of sedentary to light work. The insurer argues that claimant's at injury job was medium work and he returned to light modified work. Although we agree that claimant returned to modified work, we do not agree with the insurer's rating of claimant's jobs.

Claimant was released to modified work by his attending physician in May 1989 and did in fact return to the modified work. He worked until the employer sold most of his trucking business and laid off most of his employees, including claimant. (Ex. 22-2, Tr. 9). He was not working at the time of the hearing because the job ended, not because of his compensable injury. Therefore, we conclude that claimant's adaptability is properly determined under former OAR 436-35-310(3). See Cleophas C. Chambliss, 43 Van Natta 904 (1991).

The matrix at former OAR 436-35-310(3) compares the physical capacity of claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. See Cleophas C. Chambliss, supra.

The employer reported that his company usually loaded and unloaded the trucks by forklift, and when unloading by hand was required, the drivers were instructed to hire "lumpers." (Ex. 22-3). However, the employer did not indicate whether the drivers actually hired "lumpers" or did not help them unload.

The insurer argues that claimant only testified to "handling" up to 100 pounds, and that it is not clear that this "handling" included actual lifting. (Tr. 5). However, claimant testified that, after his surgery, he was not able to return to his regular truck driving job which involved "lifting up to 100 pounds." (Tr. 7). The Referee found claimant credible and we agree with this finding based on the record. On this basis, we find that claimant's at injury job required the physical capacity to perform heavy work.

The insurer argues that Dr. Filarski's limitation of "no heavy lifting" and claimant's testimony that he can occasionally lift 20 pounds establishes that the modified job required light work. (Ex. 15, Tr. 15). We disagree. The specific job description stated that no lifting or carrying was required. (Ex. 11, Tr. 7). Therefore, we conclude that the modified job required sedentary work. This is true even though by claimant's own testimony he is capable of light work. Former OAR 436-35-310(3); Cleophas C. Chambliss, supra.

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 (sedentary), or 3. Former OAR 436-35-310(3).

Impairment

The insurer only disputes the Referee's assignment of 5 percent for a chronic condition resulting in loss of repetitive use. Former OAR 436-35-320(4). Therefore, we address only this element of the Referee's impairment calculation. We adopt the Referee's reasoning and conclusion on the assignment of 5 percent for loss of repetitive use with the following comments.

The insurer contends that claimant did not establish that the loss of repetitive use diagnosed by Dr. Filarski was caused by the injury at its insured and not a previous injury for another employer. However, in support of its contention that the prior injury created a chronic condition, the insurer cites an exhibit that was not admitted into the record. (Ex. 1-4). Furthermore, Dr. Filarski released claimant to return to work without limitations after his prior injury. (Ex. 1-6, Tr. 4).

Therefore, claimant's total impairment is 13 percent, as calculated by the Referee.

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 3, the product is 15. When that value is added to claimant's impairment value 13, 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.

The insurer has not sought a reduction in the Determination Order award of 32 percent unscheduled permanent disability. Consequently, we affirm that award.

ORDER

The Referee's order dated February 13, 1991 is reversed. In lieu of the Referee's award of 49 percent (156.8 degrees), the Determination Order award of 32 percent (102.4 degrees) unscheduled permanent disability is reinstated and affirmed.

September 16, 1991 Cite as 43 Van Natta 1902 (1991)

In the Matter of the Compensation of
DEAN A. MINTUN, Claimant
WCB Case No. 88-03011
ORDER ON REMAND
Bischoff & Strooband, Claimant Attorneys
Nelson, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Liberty Northwest Insurance Corp. v. Mintun, 107 Or App 779 (1991). In our prior order, we found claimant's occupational disease claim for his right shoulder and neck condition compensable because claimant had established that his work activity was a material contributing cause of his condition. However, in a recent case, the court held that a claimant must establish that his employment was the major contributing cause of his condition or the worsening of his underlying condition. See Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991). Consequently, the court has remanded this matter to us for reconsideration in light of Aschbacher.

FINDINGS OF FACT

We adopt and republish the "Findings of Fact" contained in our May 30, 1990 Order on Review.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had proved that his work activities materially caused or worsened his adhesive capsulitis and tendinitis conditions.

On this basis, the Referee set aside the insurer's denial of claimant's occupational disease claim. Relying on Donna E. Aschbacher, 41 Van Natta 1242 (1989), we affirmed the Referee's order and noted that claimant need only prove that his work activities materially contributed to a symptomatic exacerbation.

The Court of Appeals recently held that to establish compensability of an occupational disease under former ORS 656.802, claimant must prove that his work activities were the major contributing cause of his condition or of the worsening of his underlying condition. See Aetna Casualty Co. v. Aschbacher, supra. In light of the court's decision, we review the record to determine compensability of claimant's occupational disease claim.

We adhere to and republish that portion of the "Conclusions of Law" in our prior Order on Review that agreed with the Referee's analysis of this claim as a condition resulting from a "series of traumatic events or occurrences" under former ORS 656.802(1)(c).

To establish that his condition is compensable under subsection (1)(c), claimant must prove that his work exposure included a series of traumatic events which were the major cause of the onset or worsening of the adhesive capsulitis and tendinitis conditions and required medical services or resulted in disability. See Aetna Casualty Co. v. Aschbacher, supra. Major cause means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening than non-employment conditions, explanations, or exposures. See McGarrah v. SAIF, 296 Or 145, 146 (1983); Dethlefs v. Hyster Co., 295 Or 309-310 (1983); David K. Boyer, 43 Van Natta 561 (1991).

We find that the causation issue is a complex medical question. Resolution of the issue requires expert medical evidence. See Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Here, the record contains three medical opinions on the issue of causation. Claimant underwent a biopsy for his noncompensable lymphoma condition on November 17, 1987. He returned to his regular job on November 19, 1987 and continued working through January 11, 1988. On November 24, 1987, claimant returned to Dr. Chandler, his treating physician for his lymphoma condition, complaining of right shoulder pain since the biopsy. (Ex. 52-1). At that time, Dr. Chandler attributed the shoulder pain to "post surgery soreness." (Ex. 52-2). On May 16, 1988, Dr. Chandler opined that claimant's "work exposure precipitated and continually aggravated his right shoulder condition." (Ex. 67).

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, we find persuasive reasons not to rely on Dr. Chandler's opinion. Chandler's May 16, 1988 opinion is conclusory. Furthermore, we attach little probative weight to this later change of opinion because it contained no medical analysis. Moe v. Ceiling Systems, 44 Or App 429 (1980); Raul A. Herrera, 40 Van Natta 1281 (1988).

Dr. Chandler referred claimant to Dr. Raether, M.D., for treatment of his right shoulder pain. Dr. Raether diagnosed adhesive capsulitis which he found could follow surgery and noted that claimant's work aggravated the process. (Ex. 60-2). However, he concluded that no major contributing cause was established for claimant's shoulder pain, although he opined that the capsulitis may have been precipitated by the biopsy based on the temporal connection. (Ex. 65). We find that Dr. Raether's opinions do not support a finding that

claimant's work activities were the major contributing cause of his capsulitis condition or of a worsening of that condition.

On May 4, 1988, Dr. McNeill, orthopedist, performed an independent medical examination. He concluded that the pain resulting from the biopsy predisposed claimant to tendinitis and capsulitis and that working with tendinitis "may have made him temporarily worse". (Ex. 66-1). However, the possibility of a temporary symptomatic worsening is insufficient to establish that claimant's work activities were the major contributing cause of claimant's condition or of a worsening of his condition. Aetna Casualty Co. v. Aschbacher, supra; Gormley v. SAIF, 52 Or App 1055 (1981).

Based on the aforementioned reasoning, we are unable to find that claimant's work exposure was the major contributing cause of the onset or worsening of claimant's underlying condition. Consequently, claimant has failed to carry his burden of proof. See Aetna Casualty Co. v. Aschbacher, supra.

Accordingly, on reconsideration, the Referee's order dated June 21, 1988 is reversed. The insurer's denial is reinstated and upheld. The Referee's attorney fee award is also reversed. Our prior attorney fee award is withdrawn.

IT IS SO ORDERED.

In the Matter of the Compensation of
GLENN A. SMITH, Claimant
WCB Case No. 88-15167
ORDER ON REMAND
Robert E. Nelson, Claimant Attorney
Meyers & Radler, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Wagner Mining Equipment Company v. Smith, 107 Or App 781 (1991). The court has reversed our prior order, which found claimant's claim for a low back condition compensable because claimant had established that his work was a material contributing cause of his disability or need for treatment. The court remanded for consideration in light of Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991), and Liberty Northwest Insurance Corporation v. Damm, 107 Or App 764 (1991), which held that a claimant must establish that his employment was the major contributing cause of the condition in order to prove an occupational disease under former ORS 656.802(1)(c). We proceed with our reconsideration.

FINDINGS OF FACT

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

Claimant was examined by Dr. Hershewe, D.O., on July 5, 1988.

Claimant sustained repetitive trauma to his low back while employed with the self-insured employer.

CONCLUSIONS OF LAW AND OPINION

In our prior Order on Review, we found that claimant's claim was a claim for an occupational disease. The employer argues that, because claimant's first onset of pain was sudden and occurred while claimant was not working, he suffered an injury, not in the course and scope of his employment. We do not agree, and continue to find that claimant suffered an occupational disease.

An injury is distinguished from an occupational disease both by the fact that the former is said to be unexpected, and the fact that where an occupational disease is gradual in onset, an injury is "sudden in onset." James v. SAIF, 290 Or 242, 248 (1981); Clark v. Erdman Meat Packing, 88 Or App 1 (1987); O'Neal v. Sisters of Providence, 22 Or App 9, 16 (1975).

In determining whether claimant's condition was "unexpected," we consider the likelihood that the condition would result from the kind, rate and duration of activity or exposure related to his employment as a welder. See O'Neal v. Sisters of Providence, supra at 17.

Both Dr. Baum, claimant's treating physician, and Dr. Duff, an independent examiner, acknowledge that claimant's work is physically strenuous. His work involves the pushing and pulling of heavy steel plates and lifting, bending and twisting while welding the metal. Claimant had worked at such employment for thirteen years prior to his first leg pain.

Claimant first experienced severe leg symptoms while off the job i.e., when he was riding in the passenger seat of a vehicle. However, such an event is not determinative. Instead, considering the kind, rate and duration of claimant's work activity, and Dr. Baum's opinion regarding the cause of claimant's condition, we conclude that the condition was not unexpected and is properly analyzed as an occupational disease.

The Referee found that claimant's work activities were the major contributing cause of his disc herniation. In so finding, the Referee relied on the opinion of Dr. Baum, claimant's treating physician. We also find Dr. Baum's opinion persuasive.

Dr. Baum was aware of claimant's physically strenuous work activities, although he originally did not know that claimant's herniated disc first manifested itself as leg pain while claimant was riding in a car on a nonwork-related trip. However, at a deposition, after Baum became aware of when claimant first had symptoms of the herniated disc, he persisted in stating that claimant's work exposure was the major contributing cause of a degenerative disc condition and subsequent herniated disc. Dr. Baum believed that claimant's work over several years contributed to a degenerative process which would eventually become apparent when some event occurred. Here, the event happened to occur while claimant was not at work but, nevertheless, the previous physically strenuous work activities, over a long period of time, precipitated the event.

Claimant's family physician, Dr. Janzen, also believed that it was highly probable that claimant's back condition was related to his work. Janzen has been claimant's physician for well over ten years, was aware of claimant's work activities and knew that, other than work, claimant led a very sedentary life.

In contrast to Dr. Baum and Dr. Janzen, after an independent examination, Dr. Duff believed that claimant's disc spontaneously ruptured and was not a result of an occupational disease. We are not persuaded by Duff's opinion in that the treating physician's familiarity with claimant far outweighs Dr. Duff's one-time exam.

Accordingly, on reconsideration, we continue to conclude that claimant's occupational disease claim is compensable. The Referee's order dated January 23, 1989 is affirmed and our prior order, as supplemented herein, is republished.

IT IS SO ORDERED.

In the Matter of the Compensation of
ELLA L. AMES, Claimant
WCB Case No. 90-16109
ORDER ON REVIEW
Burt, et al., Claimant Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Quillinan's order that declined to award an assessed attorney fee for her counsel's services in obtaining rescission of the self-insured employer's denial of her left hip stress fracture claim. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee, relying on Duane L. Jones, 42 Van Natta 875 (1990), concluded that no attorney fee was available for a denial rescinded prior to hearing. However, since the Referee's order, the legislature has effectively overruled Jones by amending ORS 656.386(1) to allow an attorney fee if an attorney is instrumental in obtaining compensation, even if a hearing is not held. See ORS 656.386(1) (amended June 1991). That amendment applies retroactively to cases in which the order was not final on or before the effective date of the act. SB 540, 3. Such is the case here.

In an alternative finding, the Referee concluded that claimant's counsel was instrumental in obtaining medical reports which led to the rescission of the employer's denial and resulted in compensation in the form of medical and temporary disability benefits. We agree with the Referee that claimant's counsel was instrumental in obtaining compensation for claimant without a hearing. We, therefore, conclude that an attorney fee for services prior to the hearing is warranted.

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 prior to the hearing concerning the compensability issue is $1,050, to be paid by the employer. 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.

Finally, the Referee awarded claimant's counsel an approved, out-of-compensation fee. Because we have determined that claimant's counsel is entitled to an assessed fee under ORS 656.386(1), we conclude that a fee under ORS 656.386(2) is no longer warranted, as that statute provides for a fee out of compensation "in all other cases", i.e., in cases in which an attorney fee has not been awarded on another basis. Accordingly, we reverse the Referee's approved attorney fee award.

ORDER

The Referee's order dated December 28, 1990 is reversed. That portion of the Referee's order that declined to award an assessed attorney fee for services concerning the self-insured employer's rescission of its denial prior to hearing is reversed. For services rendered in conjunction with the rescission of the denial, claimant's counsel is awarded an assessed attorney fee of $1,050,

payable by the self-insured employer. The Referee's approved attorney fee award is also reversed. In other words, claimant's total attorney fee award shall not exceed $1,050. In the event the employer has already paid all or any portion of the Referee's approved fee to claimant's attorney, such payments shall be offset against this assessed attorney fee award and the employer shall reimburse claimant in the amount of the approved fee previously paid, if any.

September 17, 1991 Cite as 43 Van Natta 1907 (1991)

In the Matter of the Compensation of
ROCKY L. COBLE, Claimant
WCB Case No. 90-10159
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Allen Ludwick (Saif), Defense Attorney

Reviewed by Board Members Neidig, Westerband, and Crider.

The SAIF Corporation requests review of Referee Michael Johnson's order that: (1) found claimant to be medically stationary on April 7, 1990; (2) directed it to pay temporary disability compensation for April 6, 1990; and (3) awarded 6 percent (9 degrees) scheduled permanent partial disability for a left knee condition, whereas a Determination Order had awarded 3 percent (4.5 degrees). In its brief, SAIF objects to the Referee's admission of claimant's testimony concerning the quantity of left meniscus surgically removed. In his brief, claimant argues that he was not medically stationary when his claim was closed and that the Referee should not have authorized SAIF to offset temporary disability which it paid against the permanent disability award. On review, the issues are premature closure, temporary total disability, offset, evidence, and extent of scheduled permanent disability, if claimant is medically stationary. 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.

The Referee found that claimant worked as a "laborer" for the employer. Instead, we find that claimant was working as a painter or painter's assistant at the time of his injury. [Exs. 1, 5-4].

The Referee found that Dr. Zirschky released claimant for work with minor restrictions on April 7, 1990. (O&O @2). Instead, we find that Dr. Zirschky released claimant to his regular work as a painter or painter's assistant on March 7, 1990.

CONCLUSIONS OF LAW AND OPINION

Applicable law

In deciding this matter, the Referee apparently applied the law in effect before the 1990 amendments. See Or Laws 1990 (Special Session), SB 1197.[1] We apply the law in effect after the amendments for the following reasons.

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[1] We base this conclusion on, among other things, the Referee's reliance on Fazzolari v. United Beer Distributors, 91 Or App 524 (1988).

Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in SB 1197, Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See Or Laws 1990 (Special Session), ch. 2, Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.[2]

Temporary total disability compensation

The Referee found claimant to be entitled to temporary disability compensation until April 7, 1990, based on his understanding that Dr. Zirschky's last "report," a chart note, issued that date. However, a comparison between the partially legible dates in the upper left hand corners of two copies of the same chart note convinces us that the note was authored in March, rather than in April. (Compare Exs. 4-4 & 9A). In reaching this conclusion, we also note that SAIF's copy of the note is date-stamped March 12, 1990. (Ex. 9A). For these reasons, and because April 7, 1990 was a Saturday, we conclude that Zirschky's note issued on March 7, 1990.

Regarding a carrier's entitlement to unilaterally terminate payment of temporary total disability compensation, ORS 656.268(3) provides:

> "Temporary total disability benefits shall continue until whichever of the following events occurs first:
>
> "a) The worker returns to regular or modified employment;
>
> "b) The attending physician gives the worker a written release to return to regular employment; or
>
> "c) The attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment."

In this case, claimant was working as a painter's assistant at the time of his injury. (See Exs. 1, 5-4). The March 7, 1990 chart note constitutes claimant's release to return to work, with restrictions from lifting or carrying over 50 pounds and from prolonged sitting or squatting. In the note, Zirschky also stated, "I can see no restriction that would keep him from painting or from using a ladder at this time. We will see him backin [sic] two months time to give him a full release for work." (Ex 9A).

Inasmuch as Dr. Zirschky could see no restriction which would keep claimant from painting, we conclude that claimant was released to his regular work as of the March 7, 1990 chart note. Under amended ORS 656.268(3)(b), SAIF was authorized to terminate payment of temporary total disability compensation after claimant's release to his regular work by the attending physician.

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[2] In reaching this conclusion, we recognize that, when determining claimant's entitlement to continued temporary disability payments in March 1990, former ORS 656.268(3) was in effect, and the insurer was required to conform its conduct to that statute. However, we find nothing anomalous in a decision by the legislature to apply amended ORS 656.268(3) retroactively to all existing claims, thereby requiring the insurer's liability to be determined by the amended statute.

Accordingly, SAIF'S procedural obligation to pay such compensation ended on March 7, 1990.

Because of the following conclusion on the premature closure issue we do not address the question of claimant's substantive entitlement to temporary disability benefits.

Premature closure

Claims shall not be closed if the worker's condition has not become medically stationary. ORS 656.268(1). An injured worker is considered medically stationary when no further material improvement of the compensable condition would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17).

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

The Referee found that Dr. Zirschky's March 7, 1990 chart note (Ex. 9A), established claimant's medically stationary status. In this regard, the Referee quoted the following portion of the note: "I would say he is stationary and don't expect any objective improvement." We do not agree with the Referee's conclusion, because we find that Zirschky anticipated additional improvement at that time.

In the same note, Zirschky stated that, although claimant already had full range of motion in his left knee, he expected some improvement in claimant's pain and predicted that he would give claimant a "full release for work" in 2 months. (Ex. 9A). Inasmuch as claimant's treating physician expected to remove claimant's remaining work restrictions at a future date, we are persuaded that he anticipated improvement, despite his "legal conclusion" that claimant was medically stationary on March 7, 1990. There is no medical evidence subsequent to Zirschky's chart note, except for the March 20, 1990 authorization for continued physical therapy. (Ex. 9B). On this record, we conclude that claimant has carried his burden of proving that he was not medically stationary when his claim was closed on April 20, 1990. Consequently, the claim was prematurely closed.

Because the claim was prematurely closed and there is no medical evidence referable to claimant's condition after the medically stationary date assigned by the Evaluation Division, the extent issue is not ripe for determination. Because the disputes concerning the evidence and offset issues are inextricably related to the extent issue, we do not address them at this time.

ORDER

The Referee's order dated January 4, 1991 is modified in part and reversed in part. That portion of the order that awarded claimant temporary disability compensation for April 6, 1990 is reversed. The April 20, 1990 Determination Order is set aside as premature. The claim is remanded to the SAIF Corporation for further processing. 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 by SAIF.

Board Chair Crider, dissenting.

The majority holds that this dispute concerning the insurer's April 5, 1990 termination of temporary total disability benefits is governed by the new rules governing procedural entitlement to temporary disability compensation which were enacted May 7, 1990 and were effective July 1, 1990. Because I believe the law which was in effect at the time of the unilateral termination governs, I dissent.

In Ida M. Walker, 43 Van Natta 1402 (1991), the Board held that the Legislature generally intended the 1990 amendments to the Workers' Compensation Law to apply retroactively; nevertheless, it held that when to apply the amendments retroactively would produce an absurd result, the Board would decline to do so. I dissented in that case because I believe that the Legislature did not intend retroactive application; moreover, I believe that if the Legislature did intend retroactive application, we are not free to flout that intention in order to avoid absurd results. I continued to take that view. Therefore, I would hold that the old law applies.

Assuming that the Board's formulation in Walker was correct (as I have in cases that followed), the old law should nevertheless be applied. The dispute in this case concerns the payment of benefits. Under the law in effect on April 5, SAIF had an obligation to keep paying benefits. To allow SAIF to avoid paying benefits that were actually due at that time because the law changed at a later time is unreasonable. For that reason, under Walker, the old law should be applied.

The old law did not permit an insurer to terminate temporary disability compensation before a worker became medically stationary unless the worker had actually returned to work. Claimant was neither medically stationary nor had she returned to work when SAIF terminated benefits. Consequently, claimant is procedurally entitled to additional compensation.

In the Matter of the Compensation of
JANYCE M. GATES, Claimant
Own Motion No. 88-0715M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Ackerman, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's July 17, 1991 Notice of Closure which closed her claim with an award of temporary disability benefits from October 7, 1988 through July 2, 1991. The notice states that claimant was medically stationary as of July 20, 1991. Claimant contends that she is entitled to additional benefits.

The Board issued its Own Motion Order in the above-entitled matter on December 8, 1988, reopening claimant's claim for a worsened condition related to her industrial injury of September 20, 1979. That order directed SAIF to close claimant's claim pursuant to OAR 438-12-055 when she became medically stationary. However, the Board was unaware that claimant had received a Determination Order on June 23, 1988, less than 180 days prior to our reopening. Claims which are reopened under the Board's own motion authority within the 180 day period for appealing from a prior Determination Order must be closed pursuant to ORS 656.268 rather than ORS 656.278. See Carter v. SAIF, 52 Or App 1027 (1981); Coombs v. SAIF, 39 Or App 293 (1979); Rosemary J. Harrell, 42 Van Natta 639

(1990). Here, the Board reopened claimant's claim within the 180 day appeal period. Accordingly, inasmuch as claimant's claim was not properly closed under ORS 656.268, we set aside SAIF's Notice of Closure and remand to SAIF for processing to closure pursuant to ORS 656.268 and OAR 438-12-055(2).

IT IS SO ORDERED.

September 17, 1991 Cite as 43 Van Natta 1911 (1991)

In the Matter of the Compensation of
RONALD D. HUGHES, Claimant
WCB Case No. 88-09277
ORDER ON REVIEW
Wilbur C. Smith, Jr., Claimant Attorney
Roy W. Miller (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Hoguet's order which: (1) declined to grant claimant's motion for continuance of the hearing for the introduction of rebuttal testimony; and (2) upheld the SAIF Corporation's denial of claimant's left knee injury claim. On review, the issues are the Referee's evidentiary ruling and course and scope of employment. We affirm.

FINDINGS OF FACT

Claimant is a 23-year-old landscape laborer who injured his left knee on January 27, 1988 while pushing his car. Dr. Treible examined claimant on February 9, 1988 for left knee pain and swelling, diagnosing "[g]ive way phenomenon (L) knee." Claimant did not submit an 801 form to SAIF at that time. On August 25, 1988, following reinjury to his knee, claimant was examined by orthopedic surgeon Dr. Isaacson, his current treating physician, who diagnosed possible anterior cruciate ligament rupture with subsequent chronic instability. MRI confirmed this diagnosis and, in addition, identified a vertical tear of the posterior horn of the lateral meniscus.

While employed by the insured, claimant drove to work in his own vehicle; he was not paid for travel to or from work. Employees were permitted to park on the insured's back lot as no on-street parking was available. Claimant would punch-in on the time clock and then join other employees to travel in a company-owned vehicle to various job sites away from the insured's property. On January 27, 1988, claimant completed his work day, returned to the insured's premises and punched-out. After driving out of the insured's parking lot, his car stalled. Claimant injured his left knee while pushing his car on a public street.

SAIF denied the claim on April 8, 1988. The hearing was set for August 4, 1988; reset to October 19, 1988; reset again and finally held on November 14, 1988. After SAIF's witnesses testified, claimant requested a one-week continuance in order to call rebuttal witnesses. The Referee denied the motion.

FINDINGS OF ULTIMATE FACT

The Referee did not abuse his discretion when he declined to grant claimant's motion for continuance of the hearing for introduction of rebuttal testimony.

Claimant's injury did not occur in the course and scope of his employment with the insured.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Issue

A Referee "may continue a hearing . . . [u]pon a showing of due diligence if necessary to afford reasonable opportunity for the party bearing the burden of proof to obtain and present final rebuttal evidence. . . ." See OAR 438-06-091(3). Here, the Referee declined to grant claimant's motion for a continuance.

Following testimony by SAIF's witnesses, claimant requested a one week continuance in order to call rebuttal witnesses. The Referee denied the motion. Claimant argues that the Referee abused his discretion as he had, or at least gave, no reason for denying claimant's motion. We disagree.

OAR 438-06-091(3) is couched in permissive language and contemplates that the exercise of authority to continue a hearing rests within a referee's discretion. Sue Bellucci, 41 Van Natta 1890 (1989); see Randy L. Kling, 38 Van Natta 10446 (1986). Further, 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 former ORS 656.283(7).

Claimant was aware that SAIF had denied the compensability of his left knee condition on the basis that his injury did not occur during the course and scope of his employment. Therefore, claimant reasonably should have anticipated that SAIF's witnesses would testify to facts that would support SAIF's contention that his injury did not occur as alleged, such that claimant would need to present witness(es) who could testify that his injury did occur as alleged or who at least could place claimant at the alleged place of injury at the time the injury occurred. The hearing was set and reset three times before it was finally held. Claimant's assertion that he was "surprised" by the testimony notwithstanding, we find no basis to conclude that claimant was not afforded an opportunity to obtain and present rebuttal evidence. See OAR 438-06-091(3) and (4).

Under the circumstances, we conclude the Referee did not abuse his discretion by denying claimant's request for continuance. "Substantial justice" was served. See former ORS 656.283(7).

Compensability

The Referee found the credibility of the witnesses to be determinative to the issue of compensability. Based upon his observations of all the witnesses' attitudes, appearances and demeanors, the Referee found SAIF's witnesses more credible than claimant, accepting SAIF's version of the circumstances surrounding claimant's injury. Therefore, the Referee concluded, claimant's injury did not occur on the employer's property and, thus, claimant was not injured while in the course and scope of his employment. We agree.

Claimant asserts that the testimony of SAIF's three witnesses is inconsistent and contradictory. Therefore, he contends, upon a complete review of the record, the Board can only find them to be not credible. When the Referee makes specific findings on credibility based upon attitude, appearance and demeanor, great weight and deference should be given to the Referee. Bush v. SAIF, 68 Or App 230, 233 (1984). However, we are not statutorily mandated to accept the Referee's credibility findings. Erck v. Brown Oldsmobile, 311 Or 519, 526

(1991). After our de novo review of the record, we find no reason to reject the Referee's credibility findings.

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 former ORS 656.005(8)(a); Rogers v. SAIF, 289 Or 633 (1980). Generally, if the employer exercises some control over the place where the injury is sustained, compensability is established. Cope v. West American Ins. Co., 309 Or 232, 239 (1990); Betsy C. Crick, 42 Van Natta 1198 (1990); Sheri V. Hiltner, 42 Van Natta 1039 (1990).

Claimant asserts that his injury occurred after work in the insured's parking lot. He contends that when he tried to drive home after work he found his battery was dead, requiring him to pushed his car backwards in order to jump-start it off of another company vehicle. SAIF's witnesses, on the other hand, testified claimant drove his car off the company lot, down to the first intersection on a public street where it stalled, where he then pushed it down the road for two blocks. SAIF's witnesses further testified that when claimant discussed his knee injury, he either claimed it was not work-related or specified that it occurred while pushing his car on the street.

We find SAIF's witnesses' testimony to be believable and that any alleged inconsistencies or contradictions in their testimony is not of enough significance to destroy their credibility. Therefore, we, like the Referee, find that claimant's injury occurred not in the insured's parking lot but rather on a public street over which the employer exercised no control. Consequently, we conclude that claimant has failed to establish that his injury arose "out of and in the course of employment;" thus, his left knee condition is not compensable. See former ORS 656.005(8)(a).

ORDER

The Referee's order dated December 14, 1988 is affirmed.

September 17, 1991 Cite as 43 Van Natta 1913 (1991)

In the Matter of the Compensation of
PEDRO PEREZ, Claimant
WCB Case No. 90-11292
ORDER ON REVIEW
Myrick, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The self-insured employer requests review of those portions of Referee Spangler's order that: (1) set aside its partial denial of claimant's claim for a current myofascial pain syndrome condition; (2) increased claimant's unscheduled permanent partial disability award for a left shoulder condition from 15 percent (48 degrees), as awarded by a Determination Order, to 17 percent (54.4 degrees); (3) awarded 5 percent (9.6 degrees) scheduled permanent partial disability for loss of use or function of the left arm and 5 percent (7.5 degrees) scheduled permanent partial disability for loss of use or function of the left hand, whereas a Determination Order had awarded no scheduled disability. On review, the issues are compensability and extent of permanent disability, if the current condition is compensable.

We affirm and adopt the order of the Referee, with the following supplementation and comment.

The medical evidence establishing the necessary causal relationship between claimant's current condition and his compensable injury is supported by objective findings, as required by ORS 656.005(7)(a). (See Exs. 11-1-2, 17-1, 19-1-2, 21-1). For this reason, as well as the reasons expressed by the Referee, claimant's condition is compensable. See Suzanne Robertson, 43 Van Natta 1505 (1991).

Inasmuch as we agree with the Referee's finding that claimant's 1988 work injury is the major cause of his current myfascial pain syndrome, we need not decide whether that condition is a primary or secondary consequence of the compensable injury. See Julie K. Gasparino, 43 Van Natta 1151 (1991).

Claimant's attorney is entitled to a reasonable assessed fee for his services on review concerning the compensability and extent issues. 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 fee for claimant's counsel's services on review concerning these issues is $1,400, 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 complexity of the issues, and the value to claimant of the interest involved.

ORDER

The Referee's order dated September 27, 1990 is affirmed. For services on review, claimant's attorney is awarded a reasonable assessed fee of $1,400, to be paid by the self-insured employer.

In the Matter of the Compensation of
YVONNE C. SCOTT, Claimant
WCB Case No. 90-15850
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Janice Pilkenton (Saif), Defense Attorney

Reviewed by Board Members Crider and Neidig.

The insurer requests review of Referee Myzak's order that awarded claimant 47 percent (150.4 degrees) unscheduled permanent disability for a low back injury, whereas a Determination Order had awarded no permanent disability. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

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

The parties stipulated to the values to be assigned to claimant's age, education and skills. The parties also agreed that claimant had a chronic condition limiting repetitive use. In addition, the Referee concluded that

claimant had returned to modified work in the light category. On review, the insurer contests only that portion of the Referee's order pertaining to impairment.

In rating impairment, the Referee relied solely on impairment findings endorsed by the attending physician. She did so in reliance on ORS 656.245(3)(b)(B), which provides:

> "A medical service provider who is not a member of a managed care organization is subject to the following provisions....
> (B)... Except as otherwise provided in this chapter, only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability."

On review, the insurer notes that ORS 656.726(3)(f) was amended in 1990 to provide that, "Impairment is established by a preponderance of medical evidence based upon objective findings." Oregon Laws 1990, ch. 2, section 40. The insurer contends that ORS 656.245(3)(b)(B), read together with ORS 656.726(3)(f)(B), does not preclude consideration of the reports of examining physicians rating impairment. In this case, the insurer argues, the report of the Orthopaedic Consultants is the most persuasive.

The proper reconciliation of the new provisions in sections 245 and 726 of the Workers' Compensation Law is not self-evident. However, we need not reach the issue in this case because only the amendments to section 245 apply to this case. Claimant requested a hearing after July 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the litigation savings clause contained in SB 1197, Section 54(2) does not apply. The amendments to section ORS 656.245 are not subject to a special exception to the Act's general applicability provision. Hence, ORS 656.245, as amended, applies to all claims existing or arising on or after July 1, 1990. Or Laws 1990 (Special Session), ch. 2, 54(1). The amendments to ORS 656.726, on the other hand, apply only to claims in which the worker became medically stationary after July 1, 1990. Or Laws 1990 (Special Session), ch. 2 54(3). Claimant became medically stationary on May 11, 1990. Therefore, ORS 656.726, as amended, does not apply to this case.

The insurer argues that, in this case, the treating doctor, Dr. Kadwell, did not rate claimant's range of motion. The insurer contends that it was actually the physical therapist who rated claimant's range of motion. Finally, the insurer argues that, following an examination in March 1990, Dr. Kadwell found that claimant's range of motion was "quite normal." The insurer contends that Dr. Kadwell's subsequent agreement with the range of motion findings by the physical therapist is inconsistent.

We have previously held that the findings of a physical therapist may be used in rating impairment where the treating doctor has reviewed and ratified such findings. Don O. Adams, 43 Van Natta 972 (1991). We took this approach when applying a version of the administrative rules regarding the rating of disability which required that impairment ratings be made by physicians. We conclude that no different approach is required under ORS 656.245(3)(b)(B).

In this case, there is evidence that claimant treated with Dr. Kadwell from early 1990. Although Dr. Kadwell reported in March 1990 that claimant's range of motion was quite normal, her last chart notes in July 1990 indicate that claimant was having increased symptoms in her left sacroiliac joint and buttock since she went back to work. In addition, the record shows that Dr. Kadwell referred claimant to the physical therapist and subsequently reviewed

and agreed with the range of motions made by the physical therapist in September 1990. Exs. 27, 28.

Under the circumstances, we agree that the Referee properly considered the range of motion findings made by the physical therapist and ratified by claimant's treating doctor.

Because the insurer requested the reduction of claimant's permanent disability award as granted by the Referee, and we have affirmed the Referee's order, claimant is entitled to a reasonable attorney fee pursuant to ORS 656.382(2). See Kordon v. Mercer Industries, 308 Or 290, 295-96 (1989). 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 extent of disability is $600, 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 December 31, 1990 is affirmed. For services on Board review, claimant's counsel is awarded a reasonable assessed fee of $600, to be paid by the insurer.

In the Matter of the Compensation of
JAMES A. ARCHIBALD, Claimant
Own Motion No. 89-0423M
OWN MOTION ORDER ON RECONSIDERATION
Welch, et al., Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our August 5, 1991, Own Motion Order which denied his request for temporary disability benefits on the ground that he was not in the work force at the time of surgery. He contends that he was in the work force but was medically unable to work at the time of surgery. Alternatively, claimant requests that this matter be referred for an evidentiary hearing before a Referee.

We are persuaded that this forum affords claimant, through the submission of documentary evidence, an adequate opportunity to develop the record fully regarding his medical condition and work efforts prior to surgery. Therefore, we decline to refer this matter for an evidentiary hearing.

On the merits, claimant alleges that a prior Determination Order found him temporarily and totally disabled until March 8, 1988, and that, thereafter, he was unable to find a job before his psychological condition worsened in January 1989, and he underwent knee surgery in April 1989. However, that Determination Order, which issued on March 8, 1988, and closed a 1977 injury claim with the SAIF Corporation, found claimant temporarily and totally disabled only through December 8, 1987. Thereafter, as we discussed in our prior order, the record contains persuasive evidence that claimant was employable in managerial and supervisory occupations relating to his past work experience. Claimant has not submitted any persuasive medical evidence to prove that he was totally disabled throughout 1988. There is also no evidence that he made reasonable efforts to find work during that time. Indeed, the evidence suggests that he told a vocational expert to whom he was sent for assessment that he was not seeking work.

Accordingly, we find that claimant was not in the work force at the time of his worsening in January, 1989, or the surgery in April 1989. See Fred Lotfi, 43 Van Natta 430 (1991); see also Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

Accordingly, our order dated August 5, 1991, as amended August 21, 1991, is abated and withdrawn. As supplemented herein, we adhere to and republish our order dated August 5, 1991, as amended August 21, 1991. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

September 18, 1991 Cite as 43 Van Natta 1917 (1991)

In the Matter of the Compensation of
DAVID J. DEERING, Claimant
WCB Case No. 90-00730
ORDER OF ABATEMENT
Douglas D. Hagen, Claimant Attorney
Wallace & Klor, Defense Attorneys

Claimant has requested reconsideration of our August 27, 1991 Order on Review that found that his request for hearing was untimely filed. Specifically, claimant contends that the insurer's denial was mailed to the wrong address. Further, claimant argues that, even if he did receive the denial in the middle of November, his request for hearing was filed within sixty days of receipt. We abate our prior order to allow further consideration.

In our prior order, we found as fact that the record on review contained no envelope or postmark indicating the date on which claimant mailed his request for hearing. Further review of this matter on reconsideration discloses an envelope addressed to the Board from claimant bearing a postmark date of January 8, 1990. Copies of the postmarked envelope are being provided to the parties' counsel along with this order.

Assuming without deciding that the insurer's denial was mailed to a correct address for claimant, that denial operated as notification to claimant as of the date of mailing. Wright v. Bekins Moving & Storage Co., 97 Or App 45 (1989). As we found in our prior order, the record establishes that the denial was mailed on November 7, 1989. Claimant had 60 days from that date within which to file his request for hearing from the denial. ORS 656.319(1)(a). The sixtieth day from November 7, 1989 was Saturday, January 6, 1990. As noted above, the envelope from claimant to the Board containing claimant's request for hearing is postmarked as of the next business day, Monday, January 8, 1990.

In light of this discovery, we abate our August 27, 1991 order. The parties are requested to file written memoranda discussing the effect, if any, of our discovery of the postmarked envelope on the timeliness issue. The insurer is requested to submit its memorandum within 10 days from the date of this order. Claimant is requested to file his response within 10 days of the date of mailing of the insurer's memorandum. Thereafter, we shall proceed with our reconsideration of this matter.

IT IS SO ORDERED.

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

This matter is before the Board on remand from the Court of Appeals. Stevens Equipment Co. v. American Fabricators, 106 Or App 354 (1991). The court has reversed our prior order, John R. Garver, 42 Van Natta 844 (1990), which found Stevens Equipment responsible for claimant's low back condition. In finding Stevens Equipment to be responsible, we had reasoned that Stevens Equipment had not carried its burden of proving that claimant's 1988 injury while working for Stevens Equipment did not independently contribute to his low back disability. The court reversed, concluding that since Stevens Equipment had denied responsibility for claimant's low back disability, the burden of proof did not rest with Stevens Equipment. Consequently, the court has remanded for reconsideration.

FINDINGS OF FACT

We republish the "Findings of Fact" set forth in our April 11, 1990 Order on Review.

CONCLUSIONS OF LAW AND OPINION

In cases where there has been an accepted compensable injury followed by an increase in disability during or after employment with a later carrier, responsibility is fixed with the carrier which 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. Spurlock v. International Paper Co., 89 Or App 461 (1988); Hensel Phelps Const. v. Mirich, 81 Or App 290 (1986). The last carrier is responsible if the later employment independently contributed, even slightly, to a worsening of the underlying condition. Mission Insurance Co. v. Dundon, 86 Or App 470 (1987).

Here, claimant had injured his low back in 1980, and again in 1985. The employer on the risk, American Fabricators, accepted the low back claim. On February 23, 1988, claimant sustained a back injury while employed for Stevens Equipment. At hearing, Stevens Equipment accepted a mid-back injury, but argued that claimant's low back disability was merely an exacerbation of the previous low back injury with American Fabricators.

We find that the last employer against whom claimant had an accepted claim for a low back injury was American Fabricators. Therefore, American Fabricators is presumptively responsible. In order to avoid responsibility for the 1988 injury, it has the burden of establishing that claimant's subsequent employment independently contributed to his low back condition. Whether claimant suffered an aggravation or new injury is a question of fact. See Delta McClean Trucking v. Wyncoop, 106 Or App 319 (1991).

We adopt the Referee's analysis of the medical evidence, and find that the medical evidence does not establish that there has been an independent contribution to a worsening of claimant's underlying low back condition. We conclude, therefore, that American Fabricators remains the responsible employer because it has failed to meet its burden of proving that the 1988 injury independently contributed to a worsening of claimant's low back condition.

Accordingly, on reconsideration, we affirm the Referee's order dated September 1, 1988. Our prior award of a $1,500 attorney fee for services on review payable by Stevens Equipment is withdrawn. As modified herein, we republish our April 11, 1990 order, as reconsidered April 23, 1990. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

September 18, 1991 Cite as 43 Van Natta 1919 (1991)

In the Matter of the Compensation of
FRANK HAM, Claimant
WCB Case No. 90-16564
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The insurer requests review of Referee Brown's order that awarded claimant 4 percent (12.8 degrees) unscheduled permanent disability for his low back condition, whereas a Determination Order awarded no permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings," with the exception of his fifth (5) finding of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the range of motion findings of a physical therapist could not be accepted for purposes of rating claimant's impairment under the "standards," and there was no evidence that claimant's treating physician had adopted the physical therapist's range of motion findings. We agree with the Referee and we adopt his conclusions and opinion on that issue. However, we conclude that claimant has not shown an entitlement to a permanent disability award under the standards.

On November 28, 1989, Dr. Ewald, claimant's treating doctor, declared claimant medically stationary. At that time, Dr. Ewald reported that claimant had decreased thoracolumbar flexion (from 90 degrees to 80 degrees). (Ex. 4-2). On November 30, 1989, Dr. Bolton, M.D., examined claimant and reported that he had "excellent range of back motion." Dr. Bolton did not report that claimant had decreased flexion and instead, reported that there was "no evidence of permanent impairment." (Ex. 5-4). On December 21, 1989, Dr. Ewald concurred with Dr. Bolton's report. (Ex. 7).

Because Dr. Ewald's final report concurs with an opinion of "no permanent impairment," we are unable to conclude that claimant has shown an entitlement to an award under the standards. Former OAR 436-35-270(2). We, therefore, reverse the Referee on the issue of permanent disability.

ORDER

The Referee's order dated January 24, 1991 is reversed. The April 30, 1990 Determination Order is affirmed.

In the Matter of the Compensation of
RUSSELL L. RAGLAND, Claimant
WCB Case No. 90-16841
ORDER ON RECONSIDERATION
Merrill Schneider, Claimant Attorney
Norman Cole (Saif), Defense Attorney

Claimant has requested reconsideration of that portion of our September 5, 1991 Order on Review that awarded his counsel an assessed attorney fee of $150 for services rendered in conjunction with the rescission of the SAIF Corporation's denial. Claimant contends that the $150 assessed attorney fee should be increased, as he expended three hours of time on claimant's case.

Although the time devoted to the case by claimant's counsel is one factor to be considered under OAR 438-15-010(4), the value of the interest secured for claimant is also considered. Here, the value of the interest secured for claimant by counsel was a $25 medical bill payment.

Under the circumstances, we conclude that, considering the minimal value of the interest to claimant, in addition to the other factors set forth in OAR 438-15-010(4), a $150 attorney fee for services rendered in conjunction with SAIF's prehearing rescission of the denial is reasonable. Consequently, we decline to increase claimant's assessed attorney fee of $150.

Accordingly, our September 5, 1991 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our September 5, 1991 order, effective this date.

IT IS SO ORDERED.

In the Matter of the Compensation of
EUGENE C. BROWN, Claimant
WCB Case No. 90-13039
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Acker, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Harri's order that: (1) concluded that his temporary total disability rate should be calculated by averaging weekly earnings over the past 26 weeks; and (2) increased his scheduled permanent disability award for the loss of use and function of his left leg (knee) from 8 percent (12 degrees), as awarded by a Determination Order, to 21 percent (31.5 degrees). On review, the issues are rate of temporary disability and extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Temporary disability

We affirm and adopt the Referee on the issue of temporary disability, with the following supplementation.

In determining whether a claimant's inactivity constitutes an "extended gap" for purposes of calculating temporary disability, we consider such factors as the length of the break in work and whether the break has caused a change in the work relationship between the claimant and the employer. Dena L. Barnett, 43 Van Natta 1776 (1991); Craig E. Hobbs, 39 Van Natta 690 (1987). Such a determination is made on a case-by-case basis, considering such additional factors as whether the work was steady or seasonal. Barnett, supra; Sally M. Turpin, 37 Van Natta 924 (1985).

Here, the Referee concluded that, although claimant's hours were irregular due to the market and weather conditions, he had regularly worked for the employer for several years under such circumstances. The Referee concluded that claimant's two weeks with no earnings and seven weeks with less than $200 earnings did not constitute "extended gaps" for purposes of former OAR 436-60-020(7)(c). We agree.

We conclude that the record does not demonstrate that the work relationship was altered or wage expectations changed during the weeks claimant did not work or the weeks he earned less than usual. In fact, claimant's wage was variable, as he was hired under an incentive plan. (Ex. 1). Claimant testified that, although he was hired on a regular basis, the hours were not regular and it was not unusual for him to miss an occasional week of work. (Tr. 16).

Under the circumstances, we agree with the Referee that claimant's two weeks of inactivity and his seven weeks of earnings under $200 do not constitute "extended gaps." Therefore, we conclude that the insurer properly calculated claimant's temporary disability rate based upon an average of the 26 weeks preceding his injury.

Extent of scheduled disability

We adopt the Referee's "Conclusions and Opinion" on the issue of extent of scheduled disability.

ORDER

The Referee's order dated January 2, 1991 is affirmed.

September 19, 1991 Cite as 43 Van Natta 1921 (1991)

In the Matter of the Compensation of
ANITA L. CLIFTON, Claimant
WCB Case No. 90-19998
ORDER ON RECONSIDERATION (REMANDING)
Coons & Cole, Claimant Attorneys
Steve Cotton (Saif), Defense Attorney
Thomas E. Ewing, Assistant Attorney General

On September 12, 1991, we filed with the Court of Appeals a Notice of Withdrawal of our July 8, 1991 Order of Dismissal, which dismissed the SAIF Corporation's request for Board review of a Referee's order. See ORS 183.482(6); ORAP 4.35; Glen D. Roles, 43 Van Natta 278 (1991). We rarely exercise our authority to withdraw an appealed order. Ronald D. Chaffee, 39 Van Natta 1135 (1987). However, we took such an action in this instance to clarify our intentions in dismissing SAIF's request for review and, in doing so, to prevent prejudice to the parties caused by any further delays in the appellate process. We proceed with our reconsideration.

The relevant facts are as follows. On June 7, 1991, the Referee issued an Opinion and Order granting claimant permanent total disability. On June 12, 1991, SAIF requested Board review of the Referee's order. The request stated that claimant's compensation would not be stayed pursuant to ORS 656.313. On June 20, 1991, SAIF filed an "amended" request for Board review, stating that claimant's compensation would be stayed pursuant to ORS 656.313.

On July 5, 1991, SAIF filed a motion for reconsideration with the Referee. SAIF asked the Referee to modify the order to permit an offset of permanent partial disability against claimant's permanent total disability award. Simultaneously with the motion for reconsideration, SAIF filed a withdrawal of its request for Board review of the Referee's order.

On July 8, 1991, we acknowledged SAIF's withdrawal and dismissed its request for Board review. Our order further stated that "the order of the Referee is final by operation of law." That same day, the Referee's June 7, 1991 order was abated to consider SAIF's motion for reconsideration. The abatement order stated that, upon dismissal of SAIF's request for review, jurisdiction over the Referee's order had once again vested with the Hearings Division.

On July 23, 1991, the Referee issued an Order on Reconsideration. SAIF was granted permission to offset certain permanent partial disability benefits against claimant's permanent total disability award.

Claimant objected to the Referee's reconsideration order. Among other reasons, claimant reminded the Referee that the Board's dismissal order had stated that the Referee's order was "final by operation of law."

On August 2, 1991, the Referee issued an order entitled "Order Rescinding Both Order of Abatement and Order on Reconsideration." Relying on the Board's statement in its dismissal order that the Referee's order was "final by operation of law", the Referee concluded that he was without authority to undermine the Board's decision. Consequently, the Referee withdrew the abatement and reconsideration orders.

On August 7, 1991, SAIF petitioned the Court of Appeals for judicial review of the Board's July 8, 1991 dismissal order. On August 8, 1991, SAIF requested Board review of the Referee's July 23, 1991 reconsideration order and August 2, 1991 rescission order.

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). Timely request for Board review is a jurisdictional prerequisite for our review. ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983). However, upon dismissal of a request for review, where no other party has requested review in a timely manner, we no longer have jurisdiction to proceed. Eder v. Pilcher Construction, 89 Or App 425 (1988). Under such circumstances, authority to reconsider a Referee's order returns to the Hearings Division provided that the 30-day period pursuant to ORS 656.289(3) has not already expired. Ramey S. Johnson, 40 Van Natta 370, 371 (1988).

Here, the 30th day after the Referee's June 7, 1991 Opinion and Order was July 7, 1991. Inasmuch as July 7, 1991 was a Sunday, the last day for reconsideration or appeal of the order was Monday, July 8, 1991. ORCP 10A; ORS 174.120. SAIF had requested Board review shortly after the Referee's order. However, at its request, its appeal was dismissed on July 8, 1991, the last day before the Referee's order became final under ORS 656.289(3). That same day, the Referee's June 7, 1991 order was abated for reconsideration. Since the Referee's order

was withdrawn for reconsideration after the dismissal of SAIF's request for Board review and prior to the expiration of the 30-day period pursuant to ORS 656.289(3), we conclude that the abatement order was issued with statutory authority. See Ramey S. Johnson, supra.

In reaching this conclusion, we acknowledge that our July 8, 1991 dismissal order stated that the Referee's order was "final by operation of law." Yet, the statement was an inaccurate description of the Referee's order on the date of our order. As a result of that inaccuracy, the Referee has rescinded both the abatement order and his eventual reconsideration order. Thus, there is currently no final, appealable Referee's order addressing the amount of claimant's compensation for Board review. See Price v. SAIF, 296 Or 311, 315 (1984); Lindamood v. SAIF, 78 Or App 15, 18 (1986). Under such circumstances, we consider it appropriate to return this matter to the Referee to once again address SAIF's motion for reconsideration and claimant's response. Thereafter, the Referee shall issue a final, appealable order.

Accordingly, our July 8, 1991 dismissal order is withdrawn. On reconsideration, SAIF's request for Board review is dismissed and this matter is remanded to Referee Spangler for further action consistent with this order.

IT IS SO ORDERED.

September 19, 1991 Cite as 43 Van Natta 1923 (1991)

In the Matter of the Compensation of
LLOYD L. CROCKETT, Claimant
WCB Case Nos. 90-05762 & 90-12356
ORDER DENYING REPUBLICATION
Karen M. Werner, Claimant Attorney
Roberts, et al., Defense Attorneys

Claimant has requested republication of our August 22, 1991 Order on Review. Contending that neither his current attorney nor his former attorney received a copy of the Board's order, claimant seeks republication of our order. We deny the request.

The Board may republish an order if it finds that it failed to mail a copy of its prior order to a party. Berliner v. Weyerhaeuser Company, 92 Or App 264, 266-67 (1988); Mary J. Gates, 42 Van Natta 1813 (1990). An attorney is not a party. ORS 656.005(19); Berliner, supra, page 266, n. 1; Frank F. Pucher, Jr., 41 Van Natta 794, 795 (1989).

Here, claimant first asserts that neither his current nor former attorney received a copy of the Board's August 22, 1991 order. A review of the file establishes that claimant's former attorney was not mailed a copy of the Board's order. However, such an action was taken in direct response to the following directive from claimant's current and former attorneys. Specifically, in a document entitled "Notice of Association of Attorneys," the attorneys directed that "[a]ll notices, letters, orders, etc., should hereafter be forwarded to [claimant's current attorney]."

Assuming that both of claimant's attorneys should have received a copy of the Board's order and did not actually receive such a copy although the Order indicates a copy was mailed to his current attorney, that does not invalidate the order. See Berliner, supra; **Pucher, supra. Rather, to prompt the reissuance of our order as claimant requests, he must establish that a copy of the order was not mailed to him. The record does not support such a finding.

The Board's order and file indicates that copies of the order were mailed to all parties, as well as their representatives. Moreover, there has been no contention from either claimant or the employer that this mailing to the parties was defective. Such circumstances persuade us, at a minimum, that copies of the Board's August 22, 1991 order were mailed to all parties to the proceeding.

We are persuaded that a copy of our August 22, 1991 order was mailed to claimant and all other parties to the proceeding. Consequently, claimant's motion for republication is denied. The parties' rights of appeal shall continue to run from our August 22, 1991 order.

IT IS SO ORDERED.

September 19, 1991 Cite as 43 Van Natta 1924 (1991)

In the Matter of the Compensation of
JENNIFER A. HUBER, Claimant
WCB Case No. 90-19529
ORDER ON REVIEW
Bennett & Durham, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Tenenbaum and Crider.

The self-insured employer requests review of Referee Hoguet's order that set aside its denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

FINDINGS OF ULTIMATE FACT

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

CONCLUSIONS OF LAW AND OPINION

"In deciding this matter, the Referee applied the law as amended by Or Laws 1990 (Special Session), Ch 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990."

ORS 656.802(1) defines an occupational disease to include:

> "(c) Any series of traumatic events or occurrences which requires medical services or results in physical disability or death."

In order to establish the compensability of an occupational disease, ORS 656.802(2) provides that:

"The worker must prove that employment conditions were the major contributing cause of the disease or its worsening. Existence of the disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings."

In applying those provisions to the case before him, the Referee first found that claimant had experienced no difficulties with her hands or wrists before she began working for the employer. The Referee then determined that claimant's work with the employer was the major contributing cause of her current bilateral wrist and hands symptoms, which were diagnosed as carpal tunnel syndrome and established by medical evidence supported by objective findings. Based on those determinations, the Referee concluded that claimant had established a compensable disease, relying on Georgia-Pacific Corp. v. Warren, 103 Or App 275 (1990). We agree.

On review, the employer first contends that claimant had a preexisting carpal tunnel disease, and that her carpal tunnel syndrome was not compensable, because she had failed to prove a worsening of her underlying condition. See Weller v. Union Carbide, 288 Or 27 (1979); AMFAC, Inc. v. Ingram, 72 Or App 168 (1985). It relies on the opinion of Dr. Moffett, claimant's treating family practitioner, who, in a letter dated August 13, 1990, suggested that claimant "may have an underlying carpal tunnel syndrome in one or both wrists[.]" (Ex. 8).

We are not persuaded by that tentative diagnosis. In the same letter, Dr. Moffett also suggested that claimant's condition was caused by tendonitis in the wrists and not early carpal tunnel syndrome. (Ex. 8). Moreover, he admitted that his opinion was offered prior to diagnostic testing and, consequently, was evidently based more on the history related by claimant than on concrete medical evidence. Considering these factors, we give his opinion little weight. Gormley v. SAIF, 52 Or App 1055 (1981).

In further support of its contention, the employer also relies on Dr. Leonard's statement that claimant might have an underlying "predisposition" to carpal tunnel syndrome. (Ex. 11-3). The employer's reliance is misplaced. As noted by the court in Preston v. Wonder Bread, 96 Or App 613, 616 (1989), "a predisposition is a 'condition of special susceptibility to a disease,' not a disease in and of itself." Quoting Stedman's Medical Dictionary 1133 (23rd ed 1976)., 25th Ed. (1974). (emphasis omitted.) Accordingly, we do not read Dr. Leonard's report as stating that claimant has an existing underlying disease process.

The employer next challenges the Referee's reliance on Georgia-Pacific Corp. v. Warren, supra. It contends that the Referee improperly relied upon factual findings in that case to support his conclusion here. We disagree. Our reading of the Referee's order persuades us that the Referee decided this case on its particular facts, and that he cited Warren only for the court's holding that the carpal tunnel syndrome at issue in that case, described as a "complex of symptoms," was the disease for which the claimant sought compensation. We believe that that holding was useful to the Referee's determination that the medical evidence in this case also leads to the same conclusion that claimant's symptoms are the disease.

In short, claimant seeks compensation for her bilateral hand and wrists symptoms, which are attributable to carpal tunnel syndrome and established by medical evidence supported by objective findings. In the persuasive opinion of Dr. Leonard, the syndrome was brought on by claimant's work activities with the employer. He attributed no part of it to a preexisting condition and made no

reference to an underlying carpal tunnel disease. Accordingly, we agree with the Referee that claimant has established a compensable occupational disease.

Because the employer requested review and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an assessed fee under 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 $750 is a reasonable assessed fee for claimant's counsel's efforts concerning the issue of compensability 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 issue presented, and the value of the interest involved.

ORDER

The Referee's order dated January 9, 1991 is affirmed. For services rendered on Board review, claimant's counsel is awarded an assessed attorney fee of $750, payable by the self-insured employer.

September 19, 1991 Cite as 43 Van Natta 1926 (1991)

In the Matter of the Compensation of
LARRY E. KADRMAS, Claimant
WCB Case No. 90-12728
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Livesley's order that affirmed a Determination Order which awarded a total of 33 percent (49.5 degrees) scheduled permanent disability for loss of use or function of the right forearm. On review, the issue is extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

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

As a result of his compensable injury, claimant has loss of range of motion in the right forearm and loss of flexion in the right thumb. Claimant also has a chronic condition limiting repetitive use of his right forearm.

CONCLUSIONS OF LAW AND OPINION

In determining the extent of claimant's permanent disability, we apply the standards for evaluating permanent disability as adopted by the Director pursuant to ORS 656.726(3)(f). Specifically, we apply the standards in effect on April 26, 1990, the date of the Determination Order.

Decreased range of motion in forearm

Claimant sustained permanent, ratable loss of range of motion in the right forearm, as a result of his compensable injury. For 58 degrees of dorsiflexion, claimant is entitled to a value of .4 percent. Former OAR 436-35-080(1). For 53 degrees of palmar flexion, claimant is entitled to a value of 2.7 percent. Former OAR 436-35-080(3). For 1 degree of radial deviation, claimant is

entitled to a value of 3.8 percent. Former OAR 436-35-080(5). For 27 degrees of ulnar deviation, claimant is entitled to a value of .6 percent. Former OAR 436-35-080(7). Claimant's values for loss of range of motion in the forearm are added (not combined) for a total value of 7.5 percent.

Decreased flexion of the right thumb

As a result of his compensable injury, claimant sustained permanent loss of flexion in the right thumb. For 40 degrees of metacarpophalangeal flexion, claimant is entitled to a value of 18 percent. Former OAR 436-35-050(3).

Claimant contends that his thumb value should be converted into loss of the hand. We disagree. Former OAR 436-35-070(5) provides that "loss of or loss of use of two or more digits may be converted to a value for loss of the hand" (emphasis added). Here, claimant suffers from the loss of use of one digit. Therefore, former OAR 436-35-070(4) is inapplicable and conversion to the hand is not appropriate under this provision. See Marisol Verduzco, 42 Van Natta 1739 (1990). We conclude that claimant has sustained 18 percent permanent loss of use or function of his right thumb.

Grip strength

The insurer contends that the Referee erred by awarding a value for loss of grip strength as the evidence does not show how much of claimant's lost grip strength is due to reduced range of motion. We agree that, under the circumstances, claimant is not entitled to an award for decreased grip strength.

Loss of grip strength is ratable under the standards provided that the loss is attributable to nerve damage, atrophy, or other anatomical changes due to the compensable condition. Former OAR 436-35-110(3); Martha L. Brunner, 42 Van Natta 2587, 2589 (1990). The measurement of such a loss is required to be provided by a physician. Former OAR 436-35-005(1); Robert C. Killion, 42 Van Natta 2109, 2110 (1990).

Here, a physical therapist found that claimant's grip strength on the right was 53 percent of his left grip strength. In addition, claimant's treating doctor, Dr. Butters, noted that claimant's grip strength had improved with physical therapy. However, the record does not show that Dr. Butters measured claimant's grip strength or attributed any loss of grip strength to nerve damage, atrophy or other anatomical change due to his compensable condition. Consequently, we conclude that claimant is not entitled to an award under former OAR 436-35-110.

Chronic condition limiting repetitive use

The parties do not dispute, and we agree, that claimant is entitled to a value of 5 percent for his right forearm for a chronic condition limiting repetitive use. Former OAR 436-35-010(7).

Computation

Here, claimant has impairment values in the right forearm and right thumb. To arrive at a total impairment value, we first convert claimant's 18 percent impairment in the thumb to an impairment value for the forearm. In order to make this conversion we use former OAR 436-35-120(4), inasmuch as hand and forearm impairments are valued equally by statute. See ORS 656.214(2)(b). Accordingly, claimant's right thumb impairment equals 7 percent forearm impairment. See former OAR 436-35-070(4). This impairment of the forearm, 7, is then combined with the impairment value for loss of range of motion in the forearm, 7.5,

and chronic condition limiting repetitive use of the forearm, 5, to arrive at a total impairment value of 18.2. That value is rounded to the next highest whole number, which is 19. Claimant's scheduled permanent disability award for loss of use or function of the right forearm is, therefore, 19 percent.

Clear and convincing evidence

Claimant contends that he is entitled to an award outside the standards for pain that restricts various activities. We agree with the Referee that claimant has not shown clear and convincing evidence of permanent disability greater than that indicated by the "standards," and we adopt the Referee's conclusions and opinion on this issue.

The insurer has not requested a reduction in claimant's award. Accordingly, we affirm the Referee's award of 33 percent scheduled permanent disability for loss of use or function of the right forearm.

ORDER

The Referee's order dated November 28, 1990 is affirmed.

September 19, 1991 Cite as 43 Van Natta 1928 (1991)

In the Matter of the Compensation of
DERICK A. MASON, Claimant
WCB Case Nos. 90-13125 & 90-13124
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Livesley's order which: (1) did not award a separate attorney fee pursuant to ORS 656.382(1) for the insurer's unreasonable termination of time loss benefits; and (2) did not assess an attorney fee pursuant to ORS 656.382(1) for the insurer's unreasonable delay in authorizing surgery. On review, the issue is 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

Attorney Fees/Termination of Temporary Disability Benefits

Claimant contends that the Referee improperly applied current law to this claim. We do not agree.

In deciding this matter, the Referee applied the law as amended by Or Laws 1990 (Special Session), Ch 2. Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker,

43 Van Natta 1402 (1991). Accordingly, we, too, analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

Pursuant to ORS 656.262(10), and because there were amounts of compensation then due, the Referee awarded claimant a penalty for the insurer's unreasonable termination of temporary disability benefits and concluded that claimant's attorney is entitled to one-half of the penalty assessed in lieu of an attorney fee. We affirm and adopt this portion of the Referee's order. Nicolasa Martinez, 43 Van Natta 1638 (1991); Harry E. Forrester, 43 Van Natta 1480 (1991).

Attorney Fees/Unreasonable Delay in Authorizing Surgery

Applying current ORS 656.262(10), and because there were no amounts then due, the Referee concluded that claimant's attorney is not entitled to an attorney fee for the insurer's unreasonable delay in authorizing surgery. The Referee concluded that, in this case, ORS 656.382(1) does not provide a separate route for an attorney fee award distinct from ORS 656.262(10). We agree, for the reasons stated above, that the current version of ORS 656.262(10) applies to this matter. However, we disagree with the Referee's conclusion that, under the circumstances here, no attorney fee is assessable under ORS 656.382(1).

ORS 656.382(1) authorizes the assessment of an attorney fee if a carrier refuses to pay compensation due under a referee, Board or court order or "otherwise unreasonably resists the payment of compensation." Where an insurer engages in conduct which constitutes unreasonable resistance to the payment of compensation, but does not violate ORS 656.262(10) or there are no amounts then due upon which to assess a penalty, so that claimant's attorney would not be entitled to one-half of an "additional amount" under ORS 656.262(10), a claimant's attorney is entitled to an attorney fee under ORS 656.382(1) for such unreasonable resistance. See Harry E. Forrester, supra; Nicolasa Martinez, supra.

In the present case, as the Referee concluded, the insurer's delay in authorizing claimant's surgery was an unreasonable resistance to the payment of compensation. However, as claimant concedes, there are no "amounts then due" upon which to assess a penalty under ORS 656.262(10). Accordingly, claimant's attorney is entitled to an attorney fee under 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 in establishing the insurer's unreasonable resistance to the payment of compensation in the form of surgery authorization is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the matter (as represented by the record) and the value of the interest involved.

ORDER

The Referee's order dated January 10, 1991 is affirmed in part and reversed in part. That portion of the order which declined to award an attorney fee pursuant to ORS 656.382(1) for the insurer's unreasonable resistance to the authorization for surgery is reversed. Claimant is awarded an assessed fee of $500, to be paid by the insurer. The remainder of the order is affirmed.

In the Matter of the Compensation of
DIANNE M. BACON, Claimant
WCB Case No. 90-14553
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Tooze, et al., Defense Attorneys

Reviewed by Board Members Westerband and Moller.

The self-insured employer requests review of those portions of Referee Thye's order which: (1) set aside its partial denial of claimant's current left arm condition; and (2) found that claimant's claim had been prematurely closed. In her brief, claimant contends that the Referee erred by: (1) upholding the self-insured employer's partial denial of her left radial entrapment in the supinator area, reflex sympathetic dystrophy and hypoperfusion conditions; (2) failing to award claimant's counsel 25 percent of the increased compensation created by his finding of premature closure; and (3) declining to assess a penalty and attorney fee for an allegedly unreasonable claim closure and denial. On review, the issues are compensability, premature closure, penalties and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

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

Claimant's initial injury occurred on February 15, 1989.

ULTIMATE FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the conclusions and reasoning concerning the compensability of claimant's left arm, left radial entrapment, reflex sympathetic dystrophy and hypoperfusion conditions as set forth in the Referee's order.

Premature Closure

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

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). In determining whether a claim has been properly closed, a determination of whether claimant was medically stationary on the date of closure must be made without considering subsequent changes in his or her condition. Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985).

We agree with the Referee that Dr. Smith, claimant's treating physician at the time of claim closure, offers the most persuasive opinion in regard to claimant's condition at the time of closure. We note that Dr. Smith's opinion is supported by Dr. Long, who began treating claimant shortly after claim closure.

Attorney Fees

The Referee found that claimant's claim was prematurely closed. However, he did not award an approved attorney fee. We have herein affirmed the Referee's finding that claimant's claim was prematurely closed. Inasmuch as our finding of premature closure will result in increased temporary disability benefits, we conclude that claimant's counsel is entitled to an attorney fee payable from this increased compensation. ORS 656.386(2); Earl F. Childers, 40 Van Natta 481, 485 (1988). Consequently, in accordance with the aforementioned points and authorities, as well as claimant' retainer agreement, we conclude that claimant's counsel is entitled to 25 percent of the increased temporary disability benefits created by the Referee's order, not to exceed $1,050. This award is in addition to, rather than in lieu of the assessed attorney fee awarded by the Referee for services concerning the employer's denial.

Penalties and Attorney Fees

We adopt the conclusions and reasoning concerning the penalty and attorney fee issues as set forth in the Referee's order.

Attorney Fees/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 issues of premature closure and compensability of claimant's current left arm condition is $1,200, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (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 December 27, 1990 is modified in part and affirmed in part. Claimant's counsel is awarded 25 percent of the increased temporary disability benefits created by the Referee's order, not to exceed $1,050. The remainder of the order is affirmed. For services on review concerning the issues of premature closure and compensability of claimant's current left arm condition, claimant's counsel is awarded an assessed attorney fee of $1,200, payable by the self-insured employer.

September 23, 1991 Cite as 43 Van Natta 1931 (1991)

In the Matter of the Compensation of
JANICE M. BRODEK, Claimant
WCB Case No. 90-16051
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Janice Pilkenton, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Leahy's order which upheld the insurer's denial of her injury claim for a thoracic strain. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant worked for the employer in quality control. Her job consisted of monitoring insulated electrical wire for damage and acceptability while the wire was wrapped onto a 10-inch plastic spool. On March 26, 1990, claimant attempted to prevent a stack of spools from falling when she twisted her back and experienced immediate pain between her shoulder blades. Claimant reported this incident to her supervisor who assigned a co-worker to drive claimant to the emergency room.

The emergency room physician diagnosed an acute thoracic strain and recommended that claimant remain off work until March 29, 1990. The physician referred claimant to physical therapy. On March 28, 1990, claimant underwent a physical therapy evaluation which revealed range of motion limitations in the thoracic area of the spine. On March 29, 1990, she began treating with Dr. Plewes, chiropractor, who released her from work. Dr. Plewes diagnosed thoracic sprain/strain and thoracic radiculitis. He reported that claimant was experiencing muscle spasms and restricted ranges of motion in the thoracic region.

In July 1990, the insurer denied claimant's claim.

Dr. Plewes had treated claimant prior to the March 26, 1990 incident. Claimant was treated for a lumbar and thoracic strain from August 1988 through July 1989. Claimant was also treated for a cervical strain from February 7, 1990 through March 17, 1990.

ULTIMATE FINDINGS OF FACT

The March 26, 1990 incident is a material contributing cause of claimant's disability and need for medical treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the March 26, 1990 injury was not a material contributing cause of her thoracic condition or need for medical treatment. We disagree.

The sole issue in this case is whether claimant has established a compensable injury. Because a hearing was convened after July 1, 1990, her claim is properly analyzed under the 1990 revisions to the Workers' Compensation Act. See Ida M. Walker, 43 Van Natta 1402 (1991).

At the outset, the insurer contends that claimant has a preexisting thoracic condition and, therefore, must establish that the March 26, 1990 incident was the major contributing cause of her thoracic sprain under ORS 656.005(7)(a)(B). Although claimant did receive some treatment to a portion of her thoracic spine in 1988, there is no evidence which establishes that she has a thoracic condition which preexisted the March 26, 1990 injury. Further, she had not sought treatment for any part of her thoracic spine since July 1989. Accordingly, ORS 656.005(7)(a)(B) is not applicable.

Therefore, in order to establish a compensable injury, claimant must show an accidental injury arising out of and in the course of employment. ORS 656.005(7)(a). The injury must be established by medical evidence, supported by objective findings. Id. Suzanne Robertson, 43 Van Natta 1505 (1991). Claimant's disability or need for treatment is compensable if the industrial injury is a material contributing factor. Julie K. Gasperino, 43 Van Natta 1151 (1991); Mark Weidle, 43 Van Natta 855 (1991).

Here, claimant experienced a sharp pain between her shoulder blades following the March 26, 1990 work incident. She was taken to the emergency room where a thoracic strain was diagnosed. Thereafter, both a physical therapist and Dr. Plewes reported restrictions in thoracic range of motion. In addition, Dr. Plewes reported muscle spasms in the thoracic region. Dr. Plewes diagnosed a thoracic strain and thoracic radiculitis and opined that the March 26, 1990 incident was the major cause of claimant's thoracic condition and need for medical treatment. There is no contrary medical evidence.

The insurer contends that Dr. Plewes is not persuasive on the basis that his opinion is inconsistent with prior records. We disagree. Although Dr. Plewes reported that claimant's current condition was at a different area of the spine than he treated previously, his records indicate that claimant was treated for a thoracic strain in 1988. Dr. Plewes did treat a portion (T7-T12) of claimant's thoracic spine in 1988. At that time, however, the primary treatment was focused on claimant's lumbar spine. This treatment ended in July 1989. Following the March 26, 1990 incident, Dr. Plewes' treatment was from the T10 to the T1 levels of the spine.

In light of claimant's unrebutted testimony regarding the March 26, 1990 incident as well as the fact that claimant's current thoracic condition primarily involves different levels of the thoracic spine than did her condition in 1988, we find no persuasive reason to discount Dr. Plewes' opinion. Therefore, we accept Dr. Plewes' statement that claimant's current thoracic condition was different than the condition he treated in 1988.

Under these circumstances, we conclude that claimant has established that the March 26, 1990 incident was a material contributing cause of her thoracic condition and need for medical treatment. We further conclude that Dr. Plewes' opinion establishes claimant's injury by objective findings. Accordingly, claimant has established a compensable injury.

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 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 January 23, 1991 is reversed. The insurer's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of $2,500, payable by the insurer.

September 23, 1991 Cite as 43 Van Natta 1933 (1991)

In the Matter of the Compensation of
RUTILLO CERVANTES, Claimant
WCB Case No. 91-07874
INTERIM ORDER OF DISMISSAL
Michael B. Dye, Claimant Attorney
C. Douglas Oliver (Saif), Defense Attorney

Claimant has withdrawn its request for review of the Referee's order. Consequently, claimant's request for review is dismissed.

However, inasmuch as the SAIF Corporation has filed a cross-request for review, we retain jurisdiction over this case. Consequently, this order shall be interim and eventually will be incorporated into a final appealable order. Under these circumstances, SAIF is now the appellant. The following revised briefing schedule shall be implemented. SAIF's appellant's brief shall be due 21 days from the date of this order. Claimant's respondent's brief shall be due 14 days from the date of mailing of SAIF's brief. SAIF's reply brief shall be due 14 days from the date of mailing of claimant's brief. Thereafter, this case will be docketed for review.

IT IS SO ORDERED.

September 23, 1991 Cite as 43 Van Natta 1934 (1991)

In the Matter of the Compensation of
ANITA J. YAW, Claimant
WCB Case Nos. 90-13758 & 90-09498
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Mills' order which granted claimant permanent total disability. On review, the issue is permanent total disability. We affirm.

FINDINGS OF FACT

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

Because of her psychological conditions, it would be futile for claimant to seek employment. But for her psychological condition, claimant would be willing to seek work.

CONCLUSIONS OF LAW AND OPINION

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

We agree that claimant has failed to complete vocational training programs but conclude that her failure is due to her psychological condition, rather than to a lack of motivation as is suggested by the insurer. Elsie B. Greenough, 43 Van Natta 1859 (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 $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 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, 1991 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,200, to be paid by the insurer.

In the Matter of the Compensation of
REX H. YOUNG, Claimant
WCB Case No. 90-07060
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Foss, et al., Defense Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Brazeau's order which upheld the SAIF Corporation's denial of his occupational disease claim for allergic contact dermatitis. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the Referee's order with the exception of the last paragraph.

FINDINGS OF ULTIMATE FACT

Claimant's work exposure at SAIF's insured was the major contributing cause of his disability and need for medical treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that while claimant's work exposure was the major contributing cause of claimant's symptoms, the work exposure had not worsened his underlying sensitivity. The Referee therefore upheld SAIF's denial. We disagree.

At the outset, we agree with and adopt the Referee's conclusion that claimant's work exposure was the major contributing cause of her allergic contact dermatitis symptoms. We now proceed to the issue of whether these symptoms are compensable as an occupational disease.

In order to prevail on an occupational disease claim, claimant must show that his work exposure was the major contributing cause of either the onset of the condition, or in the case of a preexisting condition, a worsening of the underlying condition. Former ORS 656.802(1)(a); Dethlefs v. Hyster Co., 295 Or 298, 309-10 (1983). If the medical evidence supports the conclusion that the manifested symptoms are the disease, the condition may be compensable. Georgia-Pacific Corp v. Warren, 103 Or App 275, 278 (1990).

Dr. Maeyens, claimant's treating physician, reported that claimant suffered from allergic contact dermatitis. He characterized this condition as a sensitivity to one or more irritants. Dr. Maeyens opined that, prior to his employment with SAIF's insured, claimant had become sensitized to mercaptobenzothiazole and mercapto mix which are found in rubber products. Dr. Maeyens explained that once claimant became sensitized, his underlying sensitivity would not change nor could it be treated. However, any time claimant came into contact with the irritants, he would have further outbreaks of allergic contact dermatitis. He concluded that claimant's work exposure at SAIF's insured caused claimant's disability and need for medical treatment.

Dr. Parker agreed with Dr. Maeyen's opinion. He opined that claimant had become sensitized to mercaptobenzothiazole and mercapto mix and that exposure to these irritants caused claimant's allergic contact dermatitis symptoms. He

agreed that there was no medical treatment for claimant's sensitivity, but only for allergic symptoms when claimant came into contact with the irritant.

Both Dr. Maeyens and Dr. Parker agree that once claimant became sensitized, the underlying sensitivity would not change or require medical treatment. Both physicians also agree that any medical treatment or disability would result from and be for claimant's allergic contact dermatitis symptoms. Claimant is not seeking treatment for his underlying sensitivity, but for his clinical condition characterized as allergic contact dermatitis. Furthermore, claimant's condition is disabling because of his symptom complex, not his underlying sensitivity. Under these circumstances, we conclude that claimant's allergic contact dermatitis symptoms are the disease for which he seeks compensation. See Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498, 501-02 (1990); Warren, supra at 278.

Inasmuch as we have adopted the Referee's finding that claimant's work exposure was the major contributing cause of his contact dermatitis symptoms, claimant has established a compensable occupational disease.

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 $2,700, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's appellate briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 11, 1991 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of $2,700, payable by the SAIF Corporation.

September 24, 1991 Cite as 43 Van Natta 1936 (1991)

In the Matter of the Compensation of
JAN CERVENCIK, Claimant
WCB Case No. 90-02588
ORDER ON REVIEW
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant, pro se, requests review of Referee Mills' order that: (1) upheld the self-insured employer's denial of his aggravation claim; (2) declined to award penalties and related attorney fees for the employer's allegedly unreasonable denial; and (3) did not address issues involving the employer's alleged "de facto" denial of medical services. On review, the issues are aggravation, medical services, and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

Exhibit 41 is an itemized billing statement from Dr. Christensen, chiropractor. This statement was date stamped as received by claimant's counsel on May 1, 1990. By letter dated May 2, 1990, claimant's counsel provided the

employer's counsel with a copy of that exhibit. Hearing in this matter was convened on June 6, 1990.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions and Opinion" with the following supplementation on the medical services issue.

Pursuant to former ORS 656.262(6), the employer had 60 days to accept or deny claimant's medical services claim. The record does not establish the employer's receipt of Dr. Christensen's billing statement until sometime on or after May 2, 1990. Hearing was convened on June 6, 1990, less than 60 days later. The statutory scheme does not permit a hearing on compensability of a claim prior to timely acceptance or denial, or prior to the expiration of the time within which the carrier may investigate and consider the claim without risking penalties. Syphers v. K-W Logging Inc., 51 Or App 769, rev den 291 Or 151 (1981). We conclude that litigation of the medical services issue at the hearing would be premature. Moreover, our conclusion is supported by the parties' post-hearing correspondence which indicates confusion as to the nature of the issues claimant raises with regard to the claim, as well as the employer's alleged denial of that claim.

ORDER

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

September 24, 1991 Cite as 43 Van Natta 1937 (1991)

In the Matter of the Compensation of
NASSER GOLIAN, Claimant
WCB Case No. 90-08587
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Westerband and Crider.

The insurer requests review of Referee Peterson's order that set aside its denial of claimant's aggravation claim for a right shoulder condition. If the claim is compensable, the insurer requests that the Referee's attorney fee award be reduced. On review, the issues are aggravation 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.

Claimant suffered diminished earning capacity, due to his worsened right shoulder symptoms and condition.

Claimant's worsening was more than any waxing and waning of injury-related symptoms contemplated by the previous 5 percent unscheduled permanent partial disability award.

CONCLUSIONS OF LAW AND OPINION

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

To establish a compensable worsening of his unscheduled condition, claimant must show that increased symptoms or a worsened underlying condition resulted in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds; Lucas v. Clark, 106 Or App 687 (1991). Because claimant received a disability award prior to his worsening, he bears the additional burden of establishing "that the worsening is more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award." ORS 656.273(8).

Claimant has worked at three office jobs since the last arrangement of compensation. His right shoulder pain forced him to take hourly breaks from his work. Consequently, his production level went down and he was fired from each job due to his insufficient production. (Tr. 19). Inasmuch as claimant's worsened symptoms resulted in job loss, we conclude that claimant has diminished earning capacity due to his worsening.

There is no medical evidence predicting that claimant's right shoulder symptoms will or will not wax and wane. The March 28, 1988 stipulation, whereby claimant received a 5 percent unscheduled permanent partial disability award, did not address the question of whether future waxing and waning of symptoms were contemplated. Therefore, we find that the stipulation did not compensate him for future waxing of his condition. Consequently, we find that claimant has established that his worsening exceeds the disability for which he was previously compensated. See Louis A. Duchene, 41 Van Natta 2399 (1989). For these reasons, as well as those articulated by the Referee, we conclude that claimant has carried his burden of proving a compensable worsening of his injury-related condition under ORS 656.273.

The insurer challenges the Referee's $2,500 attorney fee award for claimant's attorney's services at the hearing level in prevailing against the aggravation denial. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we conclude that a reasonable attorney fee for claimant's counsel's services at hearing concerning the aggravation denial issue is $1,800, 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), the complexity of the issue, and the value of the interest involved. Accordingly, we modify the Referee's attorney fee award from $2,500 to $1,800.

The insurer requested review, and we have found that claimant's compensation should not be disallowed or reduced. Hence, claimant's attorney is also entitled to an assessed for services on review. ORS 656.382(2). After considering the aforementioned factors, we conclude that a reasonable fee for claimant's counsel's services on review concerning the aggravation issue is $600, to be paid by the insurer.

ORDER

The Referee's order dated October 31, 1990 is affirmed in part and modified in part. In lieu of the Referee's $2,500 attorney fee award for services at hearing concerning the aggravation issue, claimant's attorney is awarded $1,800, to be paid by the insurer. The remainder of the Referee's order is affirmed. For services on Board review concerning the aggravation issue, claimant's attorney is awarded $600, also to be paid by the insurer.

In the Matter of the Compensation of
JANET K. KRAXBERGER, Claimant
WCB Case No. 90-05729
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Lane, Powell, et al., Defense Attorneys

Reviewed by Board Members Crider and Tenenbaum.

The self-insured employer requests review of those portions of Referee Schultz's order that: (1) set aside its denial of claimant's aggravation claim for a psychological condition; (2) assessed a penalty and a related attorney fee for unreasonable failure to pay claimant interim compensation on claimant's physical aggravation claim; and (3) awarded an attorney fee for prevailing on the psychological aggravation issue. In the event that the Board reverses the Referee's assessment of a penalty and attorney fee based on the employer's failure to pay interim compensation on her physical aggravation claim, claimant requests the assessment of a penalty and attorney fee for the employer's failure to pay interim compensation on her psychological aggravation claim. On review, the issues are aggravation, penalties, penalty-related attorney fees, and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Applicable Law

Claimant first requested a hearing in this matter before May 1, 1990, and the hearing was "convened and continued" pursuant to notice on June 25, 1990. Accordingly, we analyze this matter under the law in effect prior to the 1990 amendments to the Workers' Compensation Act. Or Laws 1990 (Special Session), ch. 2, 54(2); John K. French, 43 Van Natta 836 (1991).

Aggravation - Psychological Condition

We adopt the conclusions and reasoning concerning claimant's psychological aggravation claim as set forth in the Referee's order. On review, the employer contends that claimant's worsened psychological condition is not compensable because claimant has not proven the elements of former ORS 656.802(2). However, subsection .802(2) governs only compensability of an initial claim for a mental disorder, i.e., a "mental-mental" claim. It does not apply where, as here, the mental disorder is the sequela of a physical condition. Nordstrom, Inc. v. Gaul, 108 Or App 237 (1991).

Therefore, the employer's contention that the worsening of the compensable psychological condition was due to stressors which were not real and objective is irrelevant.

Penalty and Related Attorney Fees - Interim Compensation

The Referee concluded that Dr. McMahon's February 20, 1990 letter constituted a valid aggravation claim for claimant's physical condition and that, although the claim was not compensable, claimant was entitled to interim compensation from the date she left work until she requested a hearing on the "de facto" denial. Finding that the employer unreasonably failed to pay interim compensation, the Referee then assessed a penalty and attorney fee under ORS 656.262(10).

On review, the employer contends that the Referee erred by awarding a penalty and fee because Dr. McMahon's letter was not sufficient to constitute a claim for an aggravation. We agree. A worker is entitled to additional compensation for "worsened conditions resulting from the original injury," and a physician's report indicating a need for further medical services or additional compensation is a claim for compensation. Former ORS 656.273(1), (3). Not every medical report, however, is an aggravation claim. In Krajacic v. Blazing Orchards, 84 Or App 127 (1987), the court held that a physician's report must, at a minimum, request additional compensation for something more than a continuation of conditions resulting from the compensable injury. The report need not prove that the claimant's condition worsened; however, it must indicate a change in her condition. See also Avalos v. Bower, 89 Or App 546 (1988).

In this case, Dr. McMahon's letter indicated that, while he usually treated claimant twice a month for recurrent shoulder pain, he had treated her on three occasions during the months of December 1989 and February 1990. While he stated that she had entered the clinic in February "in a worsened condition," he qualified that statement by indicating that she had "increased symptomatology" with "no intervening injury." (Ex. 43-1). He offered no new diagnosis and made no recommended changes in her treatment. Instead, he reported that claimant had had a "flare up of her condition" and that she was medically stationary. In closing, he requested the payment of the additional visits in excess of two visits per month, and stated that he believed that claimant would be treating within the guidelines "in the very near future." (Ex. 43-2).

On this record, we conclude that Dr. McMahon's letter was not sufficient to put the employer on notice that an aggravation claim had been filed. His letter does not suggest the need for further treatment for anything more than continuing symptoms, and there is no indication that there was a change in claimant's condition since the last arrangement of compensation. Accordingly, a penalty and attorney fee is not warranted based on those circumstances.

Nonetheless, we agree with claimant that a penalty and attorney fee are appropriate for the employer's failure to pay interim compensation pending acceptance or denial of her psychological aggravation claim. In his March 14, 1990 letter to the employer, Dr. Fleming clearly stated that claimant had been rendered unable to work from an aggravation of her psychological condition. (Ex. 50). With that notice, the employer was required to begin interim compensation payments within 14 days. Former ORS 656.273(6). Moreover, claimant is entitled to interim benefits through July 27, 1990, the date of the employer's formal denial. See Roger G. Prusak, 40 Van Natta 2037 (1988). Because the employer failed to make any payments, and has offered no reason to justify its actions, claimant is entitled to a penalty and related attorney fee under former ORS 656.262(10) and 656.382(1). See Berkey v. Fairview Hospital, 94 Or App 28 (1988).

Attorney Fees

The employer requests that if the Board reinstates and upholds the denial, the assessed attorney fee be reversed as well. Inasmuch as we have affirmed the Referee on that issue, the attorney fee also is affirmed.

The employer initiated the appeal; we have found that claimant's right to compensation should not be disallowed. Therefore, claimant's attorney is entitled to an assessed fee. 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 $750 is a reasonable assessed fee for claimant's counsel's efforts concerning the issue of claimant's psychological aggravation claim. 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 presented, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for defending on the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated December 26, 1990 is affirmed in part and modified in part. In lieu of the Referee's assessed penalty and fee for the employer's failure to pay interim compensation pending acceptance or denial of claimant's physical aggravation claim, the self-insured employer shall pay claimant a penalty equal to 25 percent of all interim compensation owed through July 27, 1990, and a penalty related attorney fee of $250, for failing to pay interim compensation pending acceptance or denial of claimant's psychological aggravation claim. For services rendered on Board review, concerning the psychological aggravation issue, claimant's counsel is awarded an assessed fee of $750, to be paid by the employer. The remainder of the order is affirmed.

In the Matter of the Compensation of
DOUG D. LAGRAVE, Claimant
WCB Case No. 90-08793
ORDER ON RECONSIDERATION
Claudette L. Yost, Claimant Attorney
Cowling & Heysell, Defense Attorneys

The self-insured employer has requested reconsideration of our September 6, 1991 Order on Review. Specifically, the employer contends that we erred in directing it to pay the permanent disability benefits awarded by the February 1, 1990 Determination Order. Claimant has also requested reconsideration contending that he is entitled to an assessed attorney fee for services on Board review.

The employer contends that our decision in this matter is inconsistent with our previous decision in Joel I. Harris, 36 Van Natta 829 (1984). We disagree.

In Harris, supra, we held that the proper penalty for unilateral termination of temporary disability benefits was 25 percent of the unpaid benefits, rather than prohibiting the carrier from taking an offset allowed under the administrative rules. Id. at 834. In the instant case, the issue before us was whether the employer was required to pay permanent disability benefits pursuant to a Determination Order. Therefore, our decision in Harris, supra is not applicable to this matter. Accordingly, we adhere to our conclusion that the self-insured employer is required to pay permanent disability benefits awarded under the February 1, 1990 Determination Order.

With regard to claimant's request, we find no basis for an assessed attorney fee under either ORS 656.382 or 656.386. Under these circumstances, we decline to award an assessed fee in this matter. Forney v. Western States Plywood, 66 Or App 155 (1983).

Accordingly, our September 6, 1991 order is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our September 6, 1991 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS F. SCOTT, Claimant
WCB Case No. 90-14333
ORDER ON REVIEW
Baldwin & Brischetto, Claimant Attorneys
Susan Ebner (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum and Crider.

The SAIF Corporation requests review of that portion of Referee Schultz's order that granted permanent total disability, whereas a Determination Order awarded 50 percent (160 degrees) unscheduled permanent partial disability for claimant's chronic chemically induced dermatitis. On review, the sole issue is permanent total disability.

We affirm and adopt the order of the Referee, with the following supplementation and comments.

On review, SAIF contends that there is no evidence in the record supporting the Referee's findings that claimant's job opportunities are limited by potential employers' concerns about the appearance of claimant's skin or their fears that his condition may be contagious. SAIF also contends that claimant failed to establish that a continued work search would be futile or that he remains willing to work but for his compensable condition. In addition, SAIF argues that claimant failed to mitigate his damages, by continuing to work in environments which caused flare-ups, despite his knowledge that exposure to chemicals in the work environment regularly caused disabling exacerbations. We disagree.

Byron McNaught, vocational rehabilitation counselor, opined that, if claimant's rash is visible (as it sometimes is), it might discourage potential employers from hiring claimant. (Tr. 103-4). Claimant testified that, when his hand condition is bad, "people have a tendency to go ooh or ick." (Tr. 128). He expressed doubt that people would "like" receiving change from him, if he worked as a cashier when his hands were broken out. (Tr. 128-9). Claimant stated: "People look at me like, what have you got, you know; are you contagious. Just like you [the Referee] said, you know. A lot of people say, are you contagious you know, and you know it [finding work] was hard." (Tr. 39). Considering this evidence, we conclude that the record supports the Referee's finding that claimant's chances of employment are hampered by the appearance of his condition.

We also agree with the Referee's conclusion that it would be futile for claimant to seek work. In reaching this conclusion, we are persuaded in part by claimant's credible testimony, his years of seeking work and his periods of employment, which were impacted and cut short by disabling exacerbations. We also note McNaught's opinion that, if employers were aware of the amount of sick leave claimant would probably need, this would be an additional barrier to finding and keeping a job. (Tr. 112-13). McNaught's opinion in this regard is corroborated by claimant's testimony that, since the onset of his skin problems, he obtained work only by "bugging" an employer and then only after the employer "got to know" him. (Tr. 37-39).

Claimant's employability is determined with reference to a hypothetically normal labor market, and without considering the sympathy of a particular employer. See Harris v. SAIF, 292 Or 683, 695 (1982); see also Jacqueline I. Johnson, 43 Van Natta 270, 271 (1991), citing Edna R. Ford, 42 Van Natta 45 (1990). Here, there is no persuasive evidence regarding the availability of any job appropriate to claimant's limitations. Therefore, McNaught's opinion

that those jobs exist is highly speculative and not persuasive. See Richard Johnson, 42 Van Natta 2019 (1990) (Job availability cannot be based on speculation). For these reasons, as well as those related by the Referee, we conclude it would be futile for claimant to seek work.

Claimant testified that he would rather work than stay at home. (Tr. 69). Based on his credible expression of willingness, which is corroborated by his attempts to work over the years, we also agree with the Referee's determination that claimant has established that he is willing to work, or would be working but for his compensable condition.

Finally, inasmuch as the chemicals which trigger claimant's flare-ups are present in home and work environments, we are not persuaded that claimant failed to mitigate the effects of his condition by working. Moreover, even if working as a logger after being informed that his then-current condition was work-related might be characterized as "failure to mitigate," we are not so persuaded in this case. We are loathe to criticize an injured worker for trying to continue working in spite of a disabling condition. Although claimant is permanently precluded now from performing the jobs he performed in the past, we note that his condition continued to worsen after he stopped working in 1988. (Tr. 60). There is no evidence that claimant's continued attempts to work after his diagnosis are the cause of his current inability to work.

Therefore, considering the record as a whole, we conclude, as did the Referee, that claimant has proven entitlement to permanent total disability compensation.

Claimant's attorney is entitled to a reasonable assessed fee for successfully defending against the insurer's appeal. 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 $2,000, 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 issue, and the great value to claimant of the interest involved.

ORDER

The Referee's order dated December 27, 1990 is affirmed. Claimant's attorney is awarded a reasonable assessed fee of $2,000 for services on review concerning the permanent total disability issue, payable by the SAIF Corporation.

September 24, 1991 Cite as 43 Van Natta 1943 (1991)

In the Matter of the Compensation of
MARY B. SKARICA, Claimant
WCB Case No. 89-05966
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The insurer requests review of that portion of Referee Bethlahmy's order that set aside its denial of claimant's claim for an upper extremities condition. Claimant cross-requests review of that portion of the Referee's order

that upheld the insurer's partial denial of claimant's claim for an adult onset diabetes condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Upper extremities condition

The Referee concluded that claimant's upper extremities abnormalities were compensable. We agree.

This matter was in litigation before July 1, 1990, and shall be determined pursuant to the law in effect before the legislative amendments became effective on July 1, 1990. See Or Law, Ch. 2, 54(2). For an occupational disease claim, the date of "injury" is the date upon which 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 potentially causal employment conditions occurred in June 1988. We therefore find former ORS 656.802, as amended effective on January 1, 1988, and before its amendment on July 1, 1990, applies.

In order to be compensable as an occupational disease, claimant must prove that her condition arose out of and in the course of her employment. Former ORS 656.802(1)(c). To establish that her condition arose out of and in the course of her employment, claimant must prove that her work exposure was the major contributing cause of her condition. Former ORS 656.802(1)(c); Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991).

Claimant's treating physician was internist, Dr. Harris. He referred claimant to Dr. Long for her upper extremity abnormalities. Claimant first saw Dr. Long in October 1988, and thereafter on six more occasions. Dr. Long evaluated and diagnosed multiple upper extremity problems, conducted EMG testing, and provided medical treatment for these various ailments. This relationship continued up to the date of hearing. Thus, we conclude that Dr. Long is in a superior position in which to evaluate claimant's upper extremity problems.

Claimant's upper extremities problems can be roughly described as those involving the median, ulnar and radial nerves. It was Dr. Long's opinion that claimant's bilateral median and ulnar nerve lesions were caused by her work activities as an LPN. Furthermore, he opined that the June 11, 1988 compensable injury contributed indirectly to the development of symptoms of left carpal tunnel syndrome. (See Ex. 46-6). With respect to the carpal tunnel syndrome diagnosis, Dr. Long considered claimant's median lesions on the left side to be, in a general sense, the same as carpal tunnel syndrome. With regard to the right side, Dr. Long believed that claimant did not have "clinically typical symptoms" which would support a diagnosis of carpal tunnel syndrome. (See Ex. 46-5).

Dr. Long also diagnosed a bilateral radial nerve problem. (See Ex. 46-6-7). In this respect he noted that claimant's symptoms on the right were minimal. However, he opined that a major reason for claimant's chronic shoulder problem on the left was due to the presence of a radial nerve lesion. Dr. Long stated that the radial nerve lesion was an occupational disease resulting from chronic hand and arm use, which was "clearly worsened and made dramatically symptomatic" by the compensable June 11, 1988 injury. (See Ex. 46-28).

With respect to causation of the aforementioned conditions, Dr. Long found significant claimant's work activities involving patient care. He noted that claimant was required to work with equipment and to physically move patients. Moreover, claimant credibly testified that she was required to repetitively use her arms and hands in the performance of her job duties. On a daily basis claimant was crushing medications, lifting and turning patients, pushing heavy medicine carts and otherwise performing patient care duties. Thus, we conclude that the history relied on by Dr. Long to assess and evaluate claimant's condition was accurate.

We find Dr. Long's opinions and conclusions well-reasoned and persuasive. We also note that surgeon, Dr. Melvin, in his October 1989 report, was in substantial agreement with the medical views held by Dr. Long. (See Ex. 38). Dr. Melvin also found it probable that claimant's median and ulnar nerve lesions were caused from claimant's nursing work, and that the June 1988 compensable injury worsened claimant's left radial nerve entrapment. Moreover, like the Referee, we find the opinion of the Orthopaedic Consultants to be conclusory and, therefore, unpersuasive.

We note there is no evidence of significant off-work activities responsible for claimant's condition. Nor does Dr. Long suggest that other factors are primarily responsible. Thus, we conclude that claimant's work activities were the major contributing cause of claimant's upper extremities abnormalities, which were aggravated by the June 1988 compensable injury. Accordingly, we conclude that claimant has shown that her occupational disease is compensable.

Adult onset diabetes

We adopt the Referee's opinion and conclusion 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 for claimant's counsel's services on review concerning the compensability of claimant's upper extremities condition is $650, to be paid by the employer. 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. Further, we note that claimant is not entitled to an assessed attorney fee for services related to her unsuccessful appeal of the Referee's decision concerning her diabetes condition.

ORDER

The order of the Referee dated September 17, 1990 is affirmed. For services on Board review, claimant's counsel is awarded an attorney fee of $650, payable by the insurer.

September 24, 1991 Cite as 43 Van Natta 1945 (1991)

In the Matter of the Compensation of
MIRIAM WAINTRUP, Claimant
WCB Case No. 90-18039
ORDER ON REVIEW (REMANDING)
Dwight P. Billman, Claimant Attorney
Lester Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Quillinan's order which dismissed claimant's request for hearing for lack of jurisdiction. On review, the issue is dismissal. We remand.

FINDINGS OF FACT

In September 1990, claimant filed a Request for Hearing. On October 9, 1990, the Hearings Division issued a Notice of Hearing which set a hearing for January 18, 1991. On January 28, 1991, the Referee entered an Order of Dismissal which dismissed claimant's Request for Hearing for lack of jurisdiction.

On February 27, 1991, claimant requested Board review of the Referee's order.

FINDING OF ULTIMATE FACT

The record has been incompletely and insufficiently developed.

CONCLUSIONS OF LAW AND OPINION

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

Here, the Referee's order indicates that the "matter is dismissed for lack of jurisdiction before the Hearings Division of the Workers' Compensation Board." The order does not provide any facts or conclusions supporting the lack of jurisdiction ruling. Furthermore, because the case was dismissed without a hearing, no transcript exists. Accordingly, we find nothing in the record which indicates that the Referee did not have jurisdiction over this matter. Under such circumstances, we conclude that the record before us has been incompletely and insufficiently developed.

We, therefore, remand this matter to Referee Quillinan to conduct further proceedings to determine whether dismissal is justified. If the Referee finds that dismissal is justified, a final order shall issue setting forth the Referee's reasoning. Should the Referee find that claimant's hearing request should not be dismissed, the matter shall proceed to hearing on the merits of the issues raised in claimant's hearing request and upon closure of the hearing record, the Referee's order shall issue.

ORDER

The Referee's order dated January 28, 1991 is vacated and this matter is remanded to Referee Quillinan for further proceedings consistent with this order.

September 26, 1991 Cite as 43 Van Natta 1946 (1991)

In the Matter of the Compensation of
JESSE ASH, Claimant
WCB Case No. 90-08256
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Hallock & Bennett, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Neal's order that: (1) awarded claimant's attorney one-half of a penalty under ORS 656.262(10) for the insurer's untimely payment of medical services; and (2) did not assess a carrier-paid attorney fee pursuant to ORS 656.382(1) for the same conduct. Claimant contends that he is entitled to a carrier-paid attorney fee pursuant to

ORS 656.382(1). We review the request to determine whether we have jurisdiction to review the matter. On review, the issues are jurisdiction and penalties and attorney fees. We vacate the Referee's order and dismiss claimant's request for hearing.

FINDINGS OF FACT

On or about June 24, 1989, claimant suffered an injury to his eye. Claimant's claim was initially denied and subsequently ordered accepted by Referee's order dated November 17, 1989. On July 5, 1989, the insurer received a medical bill in the amount of $144.90. A second medical bill in the amount of $47.97 was received by the insurer on March 20, 1990.

Claimant filed a request for hearing on April 17, 1990. The hearing request raised the issues of medical services, penalties, and attorney fees. The first medical bill was paid on May 16, 1990. The second medical bill was paid on June 12, 1990. The insurer concedes that the medical bills were untimely paid. The insurer's failure to timely pay the medical bills was unreasonable.

The hearing in this matter was convened on October 18, 1990. The sole remaining issue at hearing was penalties and attorney fees.

CONCLUSIONS OF LAW AND OPINION

In deciding this matter, the Referee applied the law as amended by Or Laws 1990 (Special Session), Ch. 2. The hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See, e.g., Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we too analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

The Referee found that the insurer's untimely payment of the medical bills was unreasonable. Relying on amended ORS 656.262(10), she ordered the insurer to pay an additional amount equal to 25 percent of the late paid medical bills, with one-half of that amount going to claimant and one-half going to claimant's attorney. Claimant contends that, in addition to the penalty assessed pursuant to ORS 656.262(10), he is also entitled to a carrier-paid attorney fee pursuant to ORS 656.382(1). Claimant contends that ORS 656.382(1) provides a separate route for an attorney fee award distinct from ORS 656.262(10) when claimant must request a hearing in order to prompt the insurer to pay unpaid medical bills.

Former ORS 656.262(10) authorized the assessment of an attorney fee under ORS 656.382(1) if a carrier unreasonably refuses to pay compensation. However, the legislature amended ORS 656.262(10) during its 1990 Special Session. See Or Laws 1990 (Special Session), Ch. 2, 15. In place of the language authorizing the assessment of an attorney fee under ORS 656.382(1), ORS 656.262(10)(a) provides that, if the worker is represented by an attorney, the attorney shall receive one-half the penalty "in lieu of an attorney fee." In addition, revised ORS 656.262(10) provides that the director has "exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount described in this subsection."

Here, the factual basis asserted in support of the ORS 656.382(1) fee -- the insurer's refusal to pay medical bills for a claim found compensable under an unappealed Board order -- is identical to the factual basis for which a

penalty is assessable under ORS 656.262(10)(a). Moreover, there are amounts "then due" on which to assess a penalty under ORS 656.262(10). Under such circumstances, the simultaneous assessment of an attorney fee under ORS 656.382(1) would contravene the legislative intent expressed in ORS 656.262(10)(a) that claimant's attorney receive one-half the penalty, "in lieu of an attorney fee." Nicolasa Martinez, 43 Van Natta 1638 (1991); Harry E. Forrester, 43 Van Natta 1480 (1991). Accordingly, as litigated here, claimant is not entitled to a separate fee under ORS 656.382(1).

In light of our determination that claimant has no valid claim to an assessed attorney fee under ORS 656.382(1), we next address the issue of jurisdiction. The issue of jurisdiction was raised by the Referee at hearing and noted by the insurer's counsel as one of the grounds for opposition to claimant's hearing request. (Tr. 2). However, even if the issue of jurisdiction had not been raised at the hearing, it is our duty to raise a want of jurisdiction on our own motion. See Southwest Forest Ind. v. Anders, 299 Or 205 (1985).

In the absence of entitlement to a fee under ORS 656.382(1), the sole remaining viable issue at the time set for hearing was penalties and attorney fees under ORS 656.262(10). Pursuant to the statute, the director has exclusive jurisdiction of such a proceeding. ORS 656.262(10)(a); Ronald A. Stock, 43 Van Natta 1889 (1991). Accordingly, the Referee lacked jurisdiction over this matter.

ORDER

The Referee's order dated October 19, 1990 is vacated. Claimant's request for hearing is dismissed.

In the Matter of the Compensation of
CAROLE J. DAMM, Claimant
WCB Case No. 90-13344
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Tenenbaum and Crider.

The insurer requests review of those portions of Referee Otto's order that: (1) set aside its "de facto" denial of claimant's psychological condition; and (2) assessed an attorney fee for the insurer's allegedly unreasonable resistance to the payment of compensation. The issues on review are compensability and penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's "FINDINGS OF FACT," with the following supplementation. The insurer appealed Referee Shebley's Opinion and Order to the Court of Appeals, which reversed and remanded for reconsideration in the light of Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991). On reconsideration, we concluded that claimant's low back condition was not compensable. Carole J. Damm, 43 Van Natta 1804 (1991).

Claimant's noncompensable low back condition was the major contributing cause of her depression and need for psychological treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, because the law of the case at the time of hearing established that claimant's underlying low back condition was

compensable, the consequential psychological condition is also compensable, and proceeded to set aside the insurer's "de facto" denial of claimant's dysthymic depression condition. The Referee also awarded claimant an assessed fee of $300 for the insurer's unreasonable resistance to the payment of compensation.

In deciding this matter, the Referee properly applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Because claimant's occupational disease claim failed, see Carole J. Damm, supra, her claim for a consequential condition based on that claim must of necessity fail as well. See ORS 656.005(7)(a)(A); Robert E. Leatherman, 43 Van Natta 1678 (1991). Claimant makes no claim that her psychological condition arose out of her employment, independent of her back condition. There is therefore no basis upon which to find her psychological condition compensable. Accordingly, we reverse.

ORDER

The Referee's order dated November 20, 1990 is reversed. The insurer's de facto denial is reinstated and upheld. The assessed fee of $1,400 awarded to claimant's attorney is reversed. The assessed fee of $300 awarded to claimant's attorney for the insurer's unreasonable resistance to the payment of compensation is reversed.

September 26, 1991 Cite as 43 Van Natta 1949 (1991)

In the Matter of the Compensation of
TRAVIS J. DEARBORN, Claimant
WCB Case No. 90-03206
ORDER ON REMAND
Allen T. Murphy, Jr., Claimant Attorney
Beers, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. The court has reversed our prior order, which affirmed a Referee's order that declined to award a carrier-paid attorney fee when the insurer rescinded its denial of claimant's bilateral flexor tenosynovitis claim prior to hearing. On its own motion, the court has reversed and remanded for reconsideration in light of Jones v. Oregon State Correctional Institute, 108 Or App 230 (1991). We proceed with our reconsideration.

Considering that claimant's counsel submitted a February 7, 1990 hearing request concerning the insurer's January 10, 1990 denial and subsequent hearing requests regarding the insurer's claim processing, and in light of the insurer's May 24, 1990 rescission of its denial, we conclude that claimant's attorney was instrumental in obtaining compensation for claimant through the rescission of the insurer's denial prior to the scheduled hearing. Consequently, we hold that claimant is entitled to an insurer-paid attorney fee under revised ORS 656.386(1).

After considering the factors set forth in OAR 438-15-010(4), we conclude that a reasonable attorney fee concerning the rescission of the insurer's denial is $600, to be paid by the insurer. In reaching this conclusion, we have particularly considered the nature of the proceedings, the time devoted to the case (as represented by the record and claimant's attorney's statement of services), and the risk that claimant's attorney's efforts might go uncompensated.

Accordingly, on reconsideration, we reverse the Referee's June 18, 1990 order. Claimant's attorney is awarded $600, to be paid by the insurer.

IT IS SO ORDERED.

In the Matter of the Compensation of
LEROY FRANK, Claimant
WCB Case No. 90-09297
ORDER ON REVIEW
Max Rae, Claimant Attorney
Garrett, et al., Defense Attorneys

Reviewed by Board Members Westerband and Neidig.

The insurer requests review of Referee Baker's order that set aside its denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following exception and supplementation. The February 23, 1988 Stipulation Order contained no language regarding future waxing and waning of symptoms of the condition.

FINDINGS OF ULTIMATE FACT

Claimant experienced a symptomatic exacerbation of his low back condition since his last arrangement of compensation (the February 23, 1988 Stipulated Order). This symptomatic exacerbation resulted in diminished earning capacity to a level below that fixed at the time of the last arrangement of compensation. The Stipulated Order contemplated future periods of increased symptoms accompanied by a diminished earning capacity. Claimant's symptomatic worsening is not more than the waxing and waning of symptoms contemplated by the Stipulated Order.

CONCLUSIONS OF LAW AND OPINION

The Referee found "[t]here was no stipulation that the award was in contemplation of any waxing and waning of symptoms." Although he does not discuss the issue further, it appears that the Referee decided that since the Stipulation Order contained no language regarding any contemplation of future exacerbations, no such future exacerbations were contemplated by the award. On this basis, the Referee held that claimant's muscle spasms, documented by his chiropractor, proved a worsened condition resulting from the original injury by medical evidence supported by objective findings.

The Referee found that claimant "testified in a credible manner". We defer to that finding. Humphrey v. SAIF, 58 Or App 360, 363 (1982).

Applicable Law

Claimant requested a hearing in this case after May 1, 1990. The hearing was convened after July 1, 1990. Neither party contends that the law in effect prior to that date applies. Therefore, we conclude that the 1990 amendments to ORS 656.273 apply. Or Laws 1990, Special Session, Ch. 2, 54; see Ida M. Walker, 43 Van Natta 1402 (1991).

Prior to the 1990 amendments, we applied the aggravation analysis set forth in Edward D. Lucas, 41 Van Natta 2272 (1989), reversed on other grounds, Lucas v. Clark, 106 Or App 687 (1991). See Larry L. Bowen, 43 Van Natta 1164 (1991). That analysis is based on the holdings in Smith v. SAIF, 302 Or 396 (1986), Gwynn v. SAIF, 304 Or 345 (1987), and Perry v. SAIF, 307 Or 654 (1989). Under that analysis, claimant was required to show increased symptoms or a worsened underlying condition and a resultant diminishment of earning capacity since the last award or arrangement of compensation. In those cases in which the last

award or arrangement of compensation anticipated future periods of increased symptoms or exacerbation of the physical condition, accompanied by a diminished earning capacity, claimant needed to prove that his earning capacity was diminished longer or in greater degree than was anticipated, or that his earning capacity was diminished to the extent of total disability and resulted in 14 consecutive days of total disability or inpatient hospitalization. Edward D. Lucas, supra at 2275.

ORS 656.273(1)(a) and (b), as amended, eliminate the presumption that total disability of 14 consecutive days or inpatient hospitalization establishes an aggravation. Also, under the amended statute, the aggravation must not be due, in major part, to an injury not occurring within the course and scope of employment. ORS 656.273(1). In addition, ORS 656.273(8) codifies the requirement that the worsening must be more than a waxing and waning of symptoms contemplated by the previous award of permanent disability. Finally, the worsening must be established by medical evidence supported by objective findings. ORS 656.273(1).

We are not persuaded by claimant's argument that ORS 656.273(1) does not require medical evidence to establish a worsening, but only presents an example of the type of evidence that may be used to prove a worsening. In support of this argument, claimant compares the language of ORS 656.273(1) ("A worsened condition resulting from the original injury is established by medical evidence supported by objective findings.") with that of ORS 656.283(7) (A referee's findings of fact regarding the worker's impairment ". . . must be established by medical evidence that is supported by objective findings."). From this difference in language, claimant concludes that medical evidence is not required to establish an aggravation. We disagree.

Claimant cites no legislative history that supports this interpretation and we have found none. To the contrary, the legislative history establishes that medical evidence supported by objective findings is required to prove a worsening. In discussing the statutory changes affecting compensability during the floor debates in the Senate, Senator Kitzhaber noted "the additional requirement that the injury or disability be established by medical evidence supported by objective findings." Statement of Senator Kitzhaber, Senate Special Session, May 7, 1990, page 109 (emphasis added). Although Senator Kitzhaber was discussing Section 3, which included the definition of a compensable injury, rather than Section 18, which dealt with the requirements to establish an aggravation, the same language regarding "medical evidence supported by objective findings" is in both sections.

Furthermore, in discussing the definition of "objective findings" during the floor debate in the House, Representative Mannix stated that "[w]hat we are saying, in effect, is that a physician has to evaluate objectively your presentation." Statement of Representative Mannix, House Special Session, May 7, 1990, page 71. Contrary to claimant's contention that lay evidence would be sufficient to establish a worsening, Representative Mannix specifically stated that lay testimony not supported by a physician's evaluation would not be sufficient to establish a compensable claim. Id. at page 70. Thus, we conclude that the language "medical evidence supported by objective findings" creates an additional requirement to prove a worsening, not an alternative means of proof.

Subject to the changes discussed above, we find nothing in the amended statute or its legislative history to suggest that the legislature intended to modify the basic aggravation analysis set forth in Lucas. In particular, we reject the insurer's argument that ORS 656.273(8) provides that the "waxing and waning of symptoms" of the previously compensated condition cannot, of itself, amount to an aggravation, even where the record does not establish that the

prior award contemplated waxing and waning. We do not find any legislative history supporting this construction nor does the insurer cite any. Rather, we conclude that ORS 656.273(8) was added to codify existing case law requiring claimants to establish that an exacerbation resulted in greater diminished earning capacity than that which would result from waxing and waning contemplated in the last award of compensation. Gwynn v. SAIF, supra; Smith v. SAIF, supra.

Accordingly, we analyze this case under the aggravation analysis set forth in Lucas, as modified by the legislative changes discussed above.

Claimant's last arrangement of compensation was the February 23, 1988 Stipulated Order. The record contains no evidence of pathological worsening after the Stipulated Order. The Referee, instead, concluded that claimant sustained a symptomatic exacerbation of his low back condition after the stipulation, as established by objective findings of muscle spasm. See ORS 656.005(19).

The insurer argues that claimant suffered from muscle spasms at the time of the last award and, therefore, that any worsening must be established with objective findings other than muscle spasms. The record does not support the insurer's factual contention. When claimant's then treating chiropractor, Dr. Llewellyn, found claimant medically stationary on November 28, 1987, he noted that claimant had normal ranges of motion and no muscle spasms. (Ex. 2D-1). This was claimant's last examination before the February 23, 1988 Stipulated Order which awarded permanent partial disability. Thus, as of the last arrangement of compensation, claimant had no muscle spasms and normal range of motion. In contrast, beginning in November 1989, he suffered muscle spasms and reduced range of motion, as evaluated by Dr. Whitmire, treating chiropractor, and Dr. Miller, chiropractor. (Exs. 3A-1, 3E).

Although Dr. Whitmire stated that there were no new or changed objective findings, we cannot tell whether he was comparing claimant's current flare-up to his condition during previous flare-ups or to his condition at the date of the stipulation. This ambiguity notwithstanding, we find that Dr. Whitmire's opinion taken as a whole establishes that claimant experienced a symptomatic exacerbation of his low back condition since his last arrangement of compensation. We find that Dr. Whitmire's chart notes documenting decreased range of motion and muscle spasms during the current flare-up constitute medical evidence of a worsening supported by objective findings.

We further conclude that the exacerbation resulted in diminished earning capacity. At the time of the February 1988 Stipulated Order, claimant was capable of performing light/medium work. At that time, he was limited to lifting no more than 35 pounds with limits on repetitive bending and twisting. (Ex. 2D-2). By comparison, claimant was totally disabled after the November 1989 exacerbation. (Exs. 3G, 3J). Dr. Whitmire released him from work as of January 2, 1990 based on a physical capacity test that showed that claimant was capable of only sedentary work. (Exs. 3E-8, 3G). Accordingly, we conclude that claimant's symptomatic exacerbation resulted in diminished earning capacity to a level below that fixed at the time of the February 1988 Stipulated Order.

The record does not indicate and the insurer does not contend that claimant suffered any injury outside the course and scope of employment that was the major contributing cause of his worsened condition. ORS 656.273(1).

We next consider whether the Stipulated Order contemplated future periods of increased symptoms accompanied by diminished earning capacity. In Lucas v. Clark, supra, the court concluded that the Board did not have sufficient

evidence for its finding that the parties had contemplated future flare-ups in reaching their settlement because:

> ". . . Although several flare-ups had occurred before August, 1984, the stipulated order made no reference to the prognosis for claimant's back condition and made no additional award for that condition. Furthermore, until 1985, the record is clear that no doctor had predicted future or chronic flare-ups of that back condition. Obviously, the 1985 medical evidence regarding the possibility of future flare-ups was not available when the parties agreed to the stipulated order in 1984. Therefore, we remand to the Board for reconsideration in light of this determination." (Emphasis added).

Here, the February 23, 1988 Stipulated Order contemplated future waxing and waning. This is shown by Dr. Llewellyn's reports dated June 23, 1986, March 17, 1987, August 5, 1987 and November 28, 1987. All of these reports predicted that claimant would have recurrent problems with his low back because of the original injury and his work activities. (Exs. 1C, 2A-2, 2/C-2, 2D-2). Furthermore, prior to the stipulation, two other chiropractors predicted that claimant would continue to suffer exacerbations. (Exs. 1D, 1F). All of these reports were available to the parties before they entered into the stipulation which awarded claimant permanent disability. We, therefore, infer that the stipulation anticipated future periods of total disability. See Lucas v. Clark, supra.

We next consider whether the November 1989 exacerbation was more than mere waxing and waning of symptoms contemplated by the Stipulated Order. ORS 656.273(8). We conclude that it was not. Claimant had a history of flare-ups prior to the stipulation, caused by the lifting and bending required in his work as a janitor. These flareups had resulted in increased low back pain, muscle spasms, reduced ranges of motion, positive Kemp's test, pain radiating into the left buttock and hip, and disability resulting in time loss. (Exs. 1A, 1C, 1D, 1F, 2A, 2C). Before the stipulation, the great weight of medical evidence was that if claimant continued to do the work, he would have flareups. Recognizing that his condition was incompatible with his duties, claimant's then treating physician suggested that he avoid lifting more than 35 pounds. Claimant was helping five other custodians lift a 500 pound piano when he suffered the November 1989 exacerbation. (Tr. 39). The symptoms he experienced as a result were essentially the same as symptoms he had experienced with prior flareups. (Exs. 3A, 3D, 9B). Claimant changed his chiropractor who opined more forthrightly, that claimant should not work as a janitor given his limitations and the duties of the position. (Ex. 3A-1). Despite such greater forthrightness, we conclude that claimant has not shown that his November 1989 exacerbation was in excess of that contemplated by the stipulation.

ORDER

The Referee's order dated September 13, 1990 is reversed. The insurer's denial is reinstated and upheld. The Referee's attorney fee award is reversed.

In the Matter of the Compensation of
CHRISTINA M. HAMBLIN, Claimant
WCB Case No. 90-09971
ORDER ON REVIEW
Goldberg, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Crider and Tenenbaum.

Claimant requests review of Referee Podnar's order that: (1) upheld the insurer's denial of her aggravation claim for a current bilateral forearm condition; and (2) upheld the insurer's denial of her claim for medical services for that condition. In her brief, claimant seeks interim compensation for the period from January 11, 1990 through March 20, 1990, and objects to the Referee's exclusion of Dr. Long's credentials and certain medical journal articles. On review, the issues are evidence, aggravation, temporary disability, medical services and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings," except the second sentence on page 3, which is replaced as follows.

The neurological test results, offered in connection with claimant's alleged January 1990 aggravation claim, do not support the medical opinions which rely on them.

CONCLUSIONS OF LAW AND OPINION

Admission of Evidence

The Referee sustained the insurer's hearsay objection to documentary evidence detailing Dr. Long's credentials and medical journal articles authored by Long. We disagree.

Claimant offers the above mentioned evidence, pages 8 through 114 of exhibit 69, for its substantive value and to rebut challenges to the opinions, methodology and expertise of Drs. Long and Puziss, treating physicians. Claimant contends that the proferred evidence legitimates Long's methodology and supports Puziss' opinion (which is based on Long's tests) regarding claimant's alleged worsening and her asserted need for surgery. The insurer responds that the Referee properly excluded the disputed documents, because they are neither relevant nor material to the merits of this case.

At the outset, we note that referees are not strictly bound by formal rules of evidence. See ORS 656.283(7). Hearsay evidence may be admitted in workers' compensation proceedings, when there are sufficient indicia of reliability and when it is in the interest of substantial justice to do so. See Armstrong v. SAIF, 67 Or App 498, 501 n.2 (1984). However, a medical article is not generally admissible as substantive evidence of the matters asserted therein. This is so because such an article is hearsay evidence with no extraordinary indicia of reliability justifying admission without opportunity for cross-examination of the author. A journal article, offered alone, is usually admitted only if it forms the basis for an admitted expert opinion. Joseph J. Hahn, 42 Van Natta 1621 (1990).

In this case, the disputed journal articles arguably form the basis of Long's opinion, at least to the extent that they explain his test methodology. Moreover, because the evidence was offered through a medical report while the record remained open and Long was apparently available for cross-examination,

the insurer's remedy was to request an opportunity to cross-examine Long, rather than to seek exclusion of the documents. ORS 656.310(2).

Although we conclude that the Referee should have admitted Long's curriculum vitae and the disputed journal articles, and we admit this evidence on review, we also conclude that claimant was not prejudiced by its exclusion. In our view, Long's curriculum vitae and journal articles which he relied on do not cause his opinion concerning claimant's current problems to be more persuasive. In this regard, we note that Long himself doubted the reliability of his own January 1990 tests, stating that he suspected technical error. (Ex. 43-3). Whether or not Long's testing methods are generally reliable, the tests do not reliably reveal pathology in this case. Therefore, we accord very little weight to the tests and the opinions based on those tests. Under these circumstances, we would reach the same result with or without the disputed portions of exhibit 69.

Aggravation, Medical Services, Temporary Disability & Penalties

We adopt the Referee's "Conclusions," as supplemented herein, except that the last sentence of the third paragraph on page 5 is replaced as follows.

"In addition, sufficient doubt has been cast upon Dr. Long's tests so that the results indicating possible neuropathy are not regarded as supportive of claimant's aggravation or medical services claims."

ORS 656.273(1) provides:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence supported by objective findings."

In this case, we agree with the Referee's determination that claimant has not carried her burden of proving that her condition worsened since the last arrangement of compensation, a February 25, 1988 stipulation. In addition, we comment on the parties' dispute concerning objective findings.

The above mentioned statute requires a medical report claiming a worsened condition to include "medical evidence supported by objective findings." As we have explained, we accord little weight to Long's test results. Therefore, whether or not the findings related in Long's January 11, 1990 report qualify as "objective findings," those findings do not support the opinions offered as proof of the aggravation claim. Accordingly, we conclude, as did the Referee, that Long's January 1990 report does not constitute an aggravation claim.

ORDER

The Referee's order dated November 7, 1990 is affirmed in part and reversed in part. That portion of the Referee's order which refused to admit exhibit 69 into evidence is reversed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
HOWARD W. REMIOR, Claimant
WCB Case No. 90-09281
ORDER ON REVIEW (REMANDING)
Malagon, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Gruber's order that dismissed his request for hearing on the basis that exclusive jurisdiction of the matter rests with the Director of the Department of Insurance and Finance pursuant to ORS 656.262(10)(a). On review, the issues are jurisdiction and penalties and attorney fees. We remand.

FINDINGS OF FACT

On April 27, 1990, an earlier referee approved a Stipulated Settlement which provided for the insurer's payment of an additional 25 percent unscheduled permanent disability and for payment of temporary partial disability benefits for the period July 19 through November 21, 1988.

On May 1, 1990, claimant's attorney filed a Request for Hearing raising the issues of failure to timely reimburse mileage expenses and penalties and attorney fees.

On May 31, 1990, claimant filed a supplemental specification of issues raising the issue of penalties and attorney fees for the insurer's failure to pay the amounts due under the Stipulated Settlement.

On June 5, 1990, the insurer paid the amounts due under the Stipulated Settlement.

At hearing, claimant requested that the issue of whether he had received reimbursement for mileage be reserved for future determination. (Tr. 2, 3). The Referee declined to grant claimant's request. Instead, the Referee concluded that dismissal was appropriate, and that the dismissal would include "all issues and the Stipulation." (Tr. 4).

FINDINGS OF ULTIMATE FACT

Reimbursement of mileage expenses remained an issue at hearing along with penalties and attorney fees for the insurer's failure to timely pay compensation pursuant to the parties' stipulation.

CONCLUSIONS OF LAW AND OPINION

In deciding this matter, the Referee applied the law as amended by Or Laws 1990 (Special Session), Ch. 2. Claimant's request for hearing was filed on May 1, 1990 and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Section 54(2) does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See, e.g., Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we too analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990.

The Referee identified the sole issue as entitlement to a penalty and associated attorney fee for untimely payment of benefits pursuant to the

parties' Stipulation. Applying amended ORS 656.262(10), the Referee found that exclusive jurisdiction of this proceeding rests with the Director of the Department of Insurance and Finance. Therefore, he dismissed claimant's request for hearing. We agree that the applicable version of ORS 656.262(10) grants exclusive jurisdiction to the Director over proceedings solely involving the assessment of an "additional amount" under that provision. See Ronald A. Stock, 43 Van Natta 1889 (1991). However, we do not agree that the sole issue at hearing was the assessment of an "additional amount" under ORS 656.262(10).

Here, reimbursement of travel expenses was also an issue at hearing. Before going on the record at hearing, the insurer represented that it possessed documents establishing that claimant's travel expenses had previously been reimbursed. In response, claimant requested that the reimbursement matter be "reserved." Based upon the insurer's representation, the Referee denied that request and ruled that "all issues and the Stipulation" would be dismissed. However, the Referee directed that the insurer provide claimant's counsel with a copy of the insurer's reimbursement check so that claimant could "see his endorsement" of the check. (Tr. 4).

In his brief on review, claimant states that "following dismissal by the referee, [insurer] notified claimant's attorney that the 'evidence' available at hearing was inaccurate, and that in fact the mileage reimbursement had not been paid." The insurer does not contend otherwise. Instead, the insurer argues that, at hearing, claimant conceded payment of the mileage reimbursement. However, such a conclusion conflicts with claimant's attempt to reserve the issue.

Claimant, in his brief, also states that the insurer has subsequently made payment of the mileage expenses. Nevertheless, at the time of hearing, assessment of an "additional amount" under ORS 656.262(10) was not the sole issue. Rather, mileage reimbursement was also at issue. Therefore, we conclude that the Referee had jurisdiction over this matter.

Accordingly, we remand this matter to the Referee, who shall conduct further proceedings to develop the record on the mileage reimbursement issue, including whether payment has, in fact, been made. In addition, the Referee shall rule on the merits of claimant's penalty and attorney fee request in light of our decisions in Nicolosa Martinez, 43 Van Natta 1638 (1991) and Harry E. Forrester, 43 Van Natta 1480 (1991). Thereafter, the Referee shall issue a final, appealable order.

ORDER

The Referee's order dated October 10, 1990 is reversed. Claimant's request for hearing is reinstated and this matter is remanded to Referee Gruber for further proceedings consistent with this order.

September 26, 1991 Cite as 43 Van Natta 1957 (1991)

In the Matter of the Compensation of
KAREN A. VEGA, Claimant
WCB Case No. 90-05674
ORDER ON RECONSIDERATION
Ginsburg, et al., Claimant Attorneys
Susan Ebner (Saif), Defense Attorney

Claimant requests reconsideration of that portion of our July 30, 1991 Order on Review that reversed the Referee's assessed fee award of $1,512 for overturning the SAIF Corporation's May 14, 1990 medical services denial. On

August 27, 1991, we abated our order to allow SAIF an opportunity to respond. SAIF's response has been received.

Claimant contends that the assessed fee was awarded not only for her attorney's services rendered in overturning the May 14, 1990 denial, but also for services regarding the February 2, 1990 and February 26, 1990 medical service denials that were withdrawn and rescinded by SAIF at hearing. From that proposition, claimant reasons that she prevailed on two of three denials and is therefore entitled to two-thirds of the fee awarded. We disagree.

Attorney fees in workers' compensation cases are permitted only when authorized by statute. Brown v. EBI Companies, 289 Or 905 (1980). In this case, claimant's entitlement to attorney fees for SAIF's rescission of the earlier denials arises, if at all, from recently amended ORS 656.386(1), which provides that if "an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held, a reasonable attorney fee shall be allowed." Senate Bill 540 A-Engrossed (1991). (Emphasis supplied.). In this case, SAIF apparently withdrew its February 2, 1990 and February 26, 1990 denials at or shortly before hearing. There is no evidence, however, that, as a result of those actions, claimant received any compensation. Accordingly, no attorney fee may be assessed. Cf. Anthony J. Colistro, 43 Van Natta 1835 (1991).

Accordingly, our July 30, 1991 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our July 30, 1990 order effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

September 26, 1991 Cite as 43 Van Natta 1958 (1991)

In the Matter of the Compensation of
EVELYN A. WILLIAMS, Claimant
WCB Case No. 90-13573
ORDER ON REVIEW (REMANDING)
Rex Q. Smith, Claimant Attorney
Larry Schucht (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Otto's order that declined to approve a portion of the parties' stipulation which, in finding that claimant's attorney was instrumental in obtaining compensation without a hearing, provided for an out-of-compensation attorney fee to be paid from claimant's future temporary and permanent disability awards. On review, the issue is whether the stipulation is valid. We disapprove the stipulation and remand.

FINDINGS OF FACT

Claimant, through his attorney, requested a hearing concerning the SAIF Corporation's denial of her injury claim. Following further examinations, studies, and conferences (the latter included the participation of claimant's attorney), SAIF rescinded its denial.

The parties entered into a stipulation. Describing claimant's attorney's efforts in securing acceptance of the claim, the agreement acknowledged the potential of substantial future benefits for claimant arising from that

acceptance. The stipulation further noted that the "potential components" for attorney fees consisted of "one half of a 25 percent penalty pursuant to ORS 656.262(10)(a) if one accepts the contention that there has been an unreasonable refusal to pay compensation, and reasonable fees out of compensation authorized by ORS 656.386(2) and OAR 438-15-030."

The stipulation documented claimant's contention that SAIF's delay in accepting her claim was unreasonable. The agreement also contained SAIF's contention that its conduct was not unreasonable. To resolve the issue, SAIF agreed to pay a $750 carrier-paid attorney fee "without any admission whatsoever of unreasonableness." In addition, claimant agreed that her attorney would receive "25 percent of the temporary disability owing from the date of injury to the date of her signing this document, not to exceed $1,050 for said portion of the fee." Finally, claimant stipulated that her attorney would receive 25 percent of the permanent partial disability determined in the first Determination Order, not to exceed $2,800.

The Referee objected to the final provision of the stipulation concerning an approved attorney fee payable from claimant's future permanent disability, if any. The parties agreed that the Referee could delete via interlineation the objectionable provision and approve the remaining portions of the stipulation. It was further understood that claimant would seek Board review of the Referee's decision. Thereafter, the Referee approved the revised stipulation and claimant requested Board review.

CONCLUSIONS OF LAW

If claimant finally prevails against a denial of compensation, she is entitled to an attorney fee to be paid by the insurer. ORS 656.386(1). Such a fee is awardable even if no hearing has been held, provided that claimant's attorney was instrumental in obtaining compensation for claimant. SB 540 (Adopted June 19, 1991).

Here, the stipulation describes claimant's attorney's efforts in securing benefits for claimant without a hearing. However, rather than awarding an insurer-paid attorney fee, the stipulation provides for an out-of-compensation fee payable from claimant's temporary disability resulting from the stipulation and future, if any, permanent disability award.

Out-of-compensation attorney fees are granted when a Referee awards additional temporary or permanent disability compensation. OAR 438-15-040; 438-15-045. Such fees are payable from the increased awards. The present stipulation did not award additional compensation. Rather, the stipulation memorialized claimant's counsel's efforts which culminated in the rescission of SAIF's denial. Notwithstanding such efforts, inasmuch as the stipulation did not award claimant compensation, an attorney fee from claimant's compensation is not appropriate. Consequently, the parties' stipulation must be disapproved.

We also find the $750 insurer-paid attorney fee to be invalid. If an insurer has engaged in certain unreasonable conduct, claimant is entitled to up to 25 percent of the amounts "then due" at the time of the unreasonable conduct. ORS 656.262(10)(a). If claimant is represented, her attorney <u>shall</u> receive one-half of this amount, <u>in lieu of an attorney fee</u>. <u>Id</u> (Emphasis supplied).

The proposed stipulation does not award claimant's attorney a carrier-paid fee for prompting the rescission of SAIF's denial. The agreement also does not find that SAIF's conduct was unreasonable. In fact, the agreement expressly provides that the attorney fee is paid "[w]ithout any admission whatsoever of unreasonableness." Consequently, the underlying premise for an attorney fee in such circumstances is lacking.

Moreover, while providing that claimant "waives any claim to penalty under ORS 656.262(10)(a)," the stipulation grants claimant's attorney a $750 insurer-paid fee. Assuming that the premise for an attorney fee award for unreasonable conduct had been satisfied, the statute proves that claimant shall receive one-half of the additional amount due under the statute as a penalty and her attorney the other half of the additional amount, in lieu of an attorney fee. See ORS 656.262(10)(a). Since this portion of the stipulation lacks a statutory basis for the attorney fee award, it will not be approved.

In conclusion, it would appear that the impetus for this stipulation was the Board's holding in Duane L. Jones, 42 Van Natta 875 (1990), which held that a carrier-paid fee under ORS 656.386(1) was not awardable if a denial was rescinded prior to hearing. As previously noted, the Jones holding has effectively been superceded by enactment of SB 540, which amended ORS 656.386(1) to provide that such a fee is awardable "[i]f an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held . . ." Section 1. This statutory revision is applicable to all claims for which an order relating to the issue on which attorney fees are sought has not become final on or before the effective date of this 1991 Act, regardless of the date of injury. Section 3.

Under these circumstances, we find it appropriate to remand this matter to the Presiding Referee. This action will permit the parties to prepare a revised agreement drafted in accordance with law and in light of this recent statutory revision. The revised stipulation can then be submitted to the Presiding Referee for consideration. Should the Presiding Referee conclude that further proceedings are necessary, he shall conduct such proceedings in any manner designed to achieve substantial justice.

IT IS SO ORDERED.

September 27, 1991 Cite as 43 Van Natta 1960 (1991)

In the Matter of the Compensation of
BARRY M. BRONSON, Claimant
WCB Case No. 90-16125
ORDER DENYING MOTION TO DISMISS CROSS REQUEST
Ronald A. Fontana, Claimant Attorney
Roberts, et al., Defense Attorneys

Claimant has moved the Board for an order dismissing the self-insured employer's cross-request for Board review of a Referee's order. Claimant contends that the cross-request is untimely. We deny the motion.

FINDINGS OF FACT

The Referee's order on reconsideration issued August 2, 1991. On August 6, 1991, the Board received claimant's request for Board review of the Referee's order. On Tuesday, September 3, 1991, the employer mailed by certified mail its cross-request for Board review of the Referee's order to the Board. Monday, September 2, 1991, was Labor Day, a holiday.

CONCLUSIONS OF LAW AND OPINION

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). When one party timely requests Board review, the other parties have at least the remainder of the 30-day period and,

in any event, no less than 10 days within which to cross-request review. Id; Robert Casperson, 38 Van Natta 420 (1986).

Here, claimant's request for Board review was received on August 6, 1991, 4 days after the Referee's order. Thus, the employer had the remaining 26 days of the 30-day appeal period within which to file its cross-request. ORS 656.289(3). The 30th day after the Referee's August 2, 1991 order was September 1, 1991, a Sunday. The following day, Monday, September 2, 1991, was Labor Day, a holiday. Consequently, the final day to perfect an appeal from the Referee's order was Tuesday, September 3, 1991. ORCP 10A; ORS 174.120. The employer's cross-request was filed with the Board on September 3, 1991, the date it mailed by certified mail to the Board its request for review of the Referee's order. OAR 438-05-046(1)(b). Consequently, the employer's cross-request was timely.

Accordingly, claimant's motion to dismiss is denied. Under such circumstances, the briefing schedule shall be revised as follows. Claimant's appellant's brief shall be due 21 days from the date of this order. The employer's respondent's / cross-appellant's brief shall be due 21 days from the date of mailing of claimant's brief. Claimant's reply / cross-respondent's brief shall be due 14 days from the date of mailing of the employer's brief. The employer's cross-reply shall be due 14 days from the date of mailing of claimant's brief. Thereafter, this case shall be docketed for review.

IT IS SO ORDERED.

September 27, 1991 Cite as 43 Van Natta 1961 (1991)

In the Matter of the Compensation of
JEFFREY K. YOUMANS, Claimant
WCB Case No. C1-01972
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Hank McCurdy, Claimant Attorney

Reviewed by Board Members Neidig and Moller.

On September 17, 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.

Entitlement to an attorney fee in connection with a CDA is expressly subject to OAR 438-15-052. 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 proceeds in excess of $12,500. See OAR 438-15-052(1). Under extraordinary circumstances, a fee may be approved in excess of the strictures of OAR 438-15-052. Rollie Clark, 43 Van Natta 194 (1991).

Here, although the agreement recites that claimant's attorney shall be paid a reasonable fee not to exceed the maximum as determined by the administrative rule, the attorney fee exceeds the amount allowed under the rule. Specifically, the agreement provides that the insurer will pay claimant a total of $27,000 with $4,650 of that amount as an attorney fee. Based on our calculations, the proposed attorney fee exceeds the strictures of OAR 438-15-052(1) by $75. Moreover, the agreement does not indicate any extraordinary circumstances which would justify the excessive fee. Because the proposed disposition exceeds

the bounds of our rules, we find it is unreasonable as a matter of law. See OAR 438-09-020(2); Louis R. Anaya, 42 Van Natta 1843, 1844 (1990).

We also note that the proposed agreement fails to include claimant's social security number on the summary page. See OAR 436-60-145(3)(f). Neither does it provide information regarding the extent of the worker's vocational training or his work history. See OAR 436-60-145(4)(e).

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 any temporary or permanent disability that was stayed by the submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

Following our standard procedures, we would be willing to consider a revised agreement.

IT IS SO ORDERED.

September 30, 1991 Cite as 43 Van Natta 1962 (1991)

In the Matter of the Compensation of
JOSEPH E. DABACON, Claimant
WCB Case Nos. 90-03573, 90-03572 & 90-02010
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Westerband, Moller and Gunn.

Claimant requests review of Referee Kinsley's order that declined to assess penalties and related attorney fees for an allegedly unreasonable claims processing delay. On review, the issues are penalties and related attorney fees. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Opinion and Conclusions of Law," concluding that claimant is not entitled to penalties and related attorney fees. We supplement as follows.

The Referee declined to assess penalties and related attorney fees for an allegedly unreasonable delay in the payment of compensation. In making her determination, the Referee relied upon Kenneth R. Derrick, 42 Van Natta 274 (1990), ORS 656.262(3) and (10), and ORS 656.382(1). The Referee concluded that the SAIF Corporation had no statutory duty to pay compensation until the Director referred a claim concerning a noncomplying employer to it pursuant to ORS 656.054(1). Further, because SAIF timely processed the claims as processing agent for the noncomplying employer, there was no unreasonable delay in the payment of compensation by SAIF pursuant to ORS 656.054(1). We agree.

Claimant cites Anfilofieff v. SAIF, 52 Or App 127 (1981) for the proposition that SAIF is effectively the insurer for noncomplying employers. Claimant further

contends that, even though the noncomplying employer was not actually insured by SAIF during the time the injuries occurred, that fact should not insulate SAIF from liability for the employer's unreasonable conduct.

After our review of the record and relevant law, we find Anfilofieff distinguishable. The relevant issue in Anfilofieff was whether claimant was entitled to penalties, payable by SAIF, the processing agent for the noncomplying employer, for SAIF's denial which was based on the noncomplying employer's unreasonable conduct.

In Anfilofieff, SAIF denied the claim based on reports from the employer and its own investigation. The employer did not truthfully describe the cause of the injury or its relationship with claimant in its report to SAIF. By the time SAIF's investigator reviewed the scene of the injury, the scene of the injury had been altered to cover up the true facts. Further, the employer gave false information to the doctor as to how the injury occurred. Thus, the employer's conduct clearly was unreasonable and SAIF's denial, in turn, was based on that unreasonable conduct. Consequently, the court remanded the case to the Board for redetermination of appropriate penalties. Anfilofieff, 52 Or App at 135.

Claimant contends that Anfilofieff controls. We disagree. Here, the issue is entitlement to penalties and related attorney fees for the noncomplying employer's allegedly unreasonable delay in the payment of compensation. The issue in Anfilofieff was entitlement to penalties and related attorney fees for an allegedly unreasonable denial issued by SAIF on behalf of a noncomplying employer.

Payment of compensation, in cases involving noncomplying employers, is regulated by ORS 656.054(1). That statute provides, in part:

> "A compensable injury to a subject worker while in the employ of a noncomplying employer is compensable to the same extent as if the employer had complied with ORS 656.001 to 656.794. A claim for compensation shall be processed by the State Accident Insurance Fund Corporation in the same manner as a claim made by a worker employed by a carrier-insured employer, except that the time within which the first installment of compensation is to be paid, pursuant to ORS 656.262(4), shall not begin to run until the director has referred the claim to the State Accident Insurance Fund Corporation." (Emphasis supplied.)

Here, pursuant to ORS 656.054, claimant, as a subject worker for a noncomplying employer, was not due any compensation until the Director referred the claim to SAIF for processing on behalf of the noncomplying employer. The Referee specifically concluded, as do we, that there is no evidence to establish that SAIF failed to properly pay compensation once it was notified by the Director pursuant to ORS 656.054(1). Consequently, we conclude that no penalties or attorney fees should be assessed.

The present case is similar to Kenneth R. Derrick, supra. In Kenneth R. Derrick, we noted that claims processing requirements for noncomplying employers are set forth in ORS 656.054. Further, under that statute, the first installment of compensation is not due to be paid by SAIF until the Director refers the claim to SAIF. We held that SAIF had no statutory duty to make its first installment of compensation until the Director referred the claim to it. Finally, because SAIF promptly paid interim compensation payments after the Director referred the claim, timely accepted and processed claimant's claim to closure, and timely paid all compensation that was due, we held that, under those circumstances, there was no unreasonable delay in the payment of compensation by SAIF and no penalties and related attorney fees were assessed. Kenneth R. Derrick, supra.

Under the circumstances, we conclude that the noncomplying employer's delay in processing claimant's claims does not result in the imposition of penalties and related attorney fees to be paid by SAIF under ORS 656.054(1).[1]

ORDER

The Referee's order dated November 30, 1990 is affirmed.

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[1] The dissent's interpretation of the applicable statutes would lead to an anomolous result, and one which the legislature clearly did not intend. Delays in the payment of compensation are all but inevitable in most noncomplying employer cases, for the simple fact that the employer is noncomplying and does not process the claim. The dissent's interpretation would, in effect, make SAIF liable for the simple fact of the employer's noncompliance, even though the "delay" in question occurred at a time when SAIF was not the processing agent. We have found that SAIF reasonably processed the claim and timely paid compensation after it became the processing agent under ORS 656.054(1). That finding, which is based on the undisputed evidence, distinguishes this case from Anfilofieff v. SAIF, supra. It requires the conclusion, in our view, that claimant is not entitled to the assessment of penalties and related attorney fees payable by SAIF.

Board Member Gunn dissenting.

As in the earlier case (Kenneth R. Derrick, 42 Van Natta 274 (1990)), the majority creates a specific exception to ORS 656.262(3) for noncomplying employers. I believe that interpretation to be incorrect and in direct opposition to the clear language of 656.054(1): ". . . A claim for compensation made by such a worker shall be processed by the State Accident Insurance Fund Corporation in the same manner as a claim made by a worker employed by a carrier-insured employer, except that the time within which the first instalment of compensation is to be paid, pursuant to ORS 656.262(4), shall not begin to run until the director has referred the claim to the State Accident Insurance Fund Corporation." ORS 656.054(1).

One of the legal requirements for claim processing is ORS 656.262(3):

"(3) Employers shall, immediately and not later than five days after notice or knowledge of any claims or accidents which may result in a compensable injury claim, report the same to their insurer. The report shall include:

(a) The date, time, cause and nature of the accident and injuries.

(b) Whether the accident arose out of and in the course of employment.

(c) Whether the employer recommends or opposes acceptance of the claim, and the reasons therefor.

(d) The name and address of any health insurance provider for the injured worker.

(e) Any other details the insurer may require.

Failure to so report subjects the offending employer to a charge for reimbursing the insurer for any penalty the insurer is required to pay under subsection (10) of this section because of such failure.

> As used in this subsection, 'health insurance' has the meaning for that term provided in ORS 656.162. (Emphasis added).

The only exception to claims processing for noncomplying employers is for payment of temporary disability under ORS 656.262(4). To read in any other exception is beyond the clear language of the statute.

ORS 656.054(3) allows SAIF to recover from the noncomplying employer any costs associated with processing of the claim, including penalties and attorney fees based on the noncomplying employer's unreasonable conduct:

> "(3) In addition to, and not in lieu of, any civil penalties assessed pursuant to ORS 656.735, all costs to the Industrial Accident Fund of a claim processed under subsection (1) of this section shall be a liability of the noncomplying employer. Such costs include compensation, reasonable administrative costs and any attorney fees awarded to the claimant, but do not include assessments for reserves in the Insurance and Finance Fund. The director shall recover such costs from the employer. The director shall provide by regulation for the Insurance and Finance Fund to reimburse, on a periodic basis, the Industrial Accident Fund for any costs it incurs under this section. When the director prevails in any action brought pursuant to this subsection, the director is entitled to recover from the noncomplying employer court costs and attorney fees incurred by the director." (Emphasis added).

Here, the issue is the "unreasonable delay in acceptance or denial" of a claim in accordance with ORS 656.262(10). Claimant sustained work injuries in December 1988 and August 1989. He reported the injuries to the noncomplying employer shortly after they occurred. The noncomplying employer did not report the claims to the Department. Claimant contacted the Department about the claims in October 1989, but the Department took no action until December 21, 1989. On that day, it referred the claim to SAIF, based on incorrect Department records listing SAIF as the insurer. SAIF denied the claims because it did not insure the employer on the dates of injury. The Department did not timely investigate the claims as a potential noncomplying employer matter. Finally, on June 5, 1990, it issued an order declaring the employer to be noncomplying, and it referred the claim to SAIF to process pursuant to ORS 656.054. SAIF then accepted the claim as processing agent for the noncomplying employer.

As a result of this series of processing delays, claimant received no benefits for eighteen months following the first injury, and a year following the second injury. That delay is due to the failure of the employer to report pursuant to ORS 656.262(3). SAIF should be held responsible under ORS 656.262(1). SAIF can then collect any penalties or attorney fees assessed for that failure from the noncomplying employer pursuant to ORS 656.054(3).

The fact that the employer had let its insurance lapse and was not insured does not remove liability from SAIF. SAIF, as a quasi-state agency, has certain statutory advantages over private carriers. See ORS 656.753. SAIF also has certain statutory obligations, including that of processing and being legally responsible for claims of noncomplying employers. See ORS 656.054(1) and ORS 656.262(1). In Nix v. SAIF, 80 Or App 656 (1986), the Court of Appeals reversed a Board order declining to assess a penalty and related attorney fee against SAIF for its delay in paying interim compensation. The Board had reasoned that the delay was not unreasonable because it was due to the employer's failure to report the necessary information to SAIF. In reversing the Board and assessing a penalty and related fee, the court stated:

"That result cannot be squared with the statutory scheme, which provides that processing claims and providing compensation for a worker is the responsibility of the insurer. ORS 656.262(1). The Board held that, once SAIF had notice of the claim, it had acted reasonably by promptly processing it. Although SAIF may have proceeded correctly after receiving notice of the claim, the fact remains that claimant was not served by the Workers' Compensation system as he had a right to be."

Such is the case in the present dispute. Granted, SAIF was the insurer of record in Nix, whereas it is the processing agent for a noncomplying employer in the present case. Nevertheless, with the exception of payment of temporary disability, its processing obligations in the present case are the same as its obligations in processing claims for its own insureds.

The majority's decision leads to some absurd results that are not consistent with the purpose of Oregon's Workers' Compensation law.

One, noncomplying employers can escape certain penalties and attorney fees that would be applied to a carrier-insured or self-insured employer, given the same set of facts. It is particularly galling to note that, in this case, the employer had been insured by SAIF. From that experience, the employer knew or should have known of its legal reporting requirements.

Two, the legal representative's efforts (in this case which lead to the claim being processed and compensation paid, in spite of the Workers' Compensation Department), will not be compensated. This will have a chilling effect upon any legal counsel to pursue actions on behalf of workers if the employer is noncomplying or suspected to be a noncomplying employer.

Finally, the majority's decision does nothing to discourage the type of bureaucratic badminton that occurred in this case between the Workers' Compensation Department and SAIF. The Department knew or should have known by late 1989 or early 1990 that the employer was noncomplying.

September 30, 1991 Cite as 43 Van Natta 1966 (1991)

In the Matter of the Compensation of
JEANNE C. RUSCH, Claimant
WCB Case No. 91-06552
ORDER OF DISMISSAL (REMANDING)
Schwabe, et al., Defense Attorneys

The self-insured employer has requested Board review of Referee Howell's September 13, 1991 Interim Order. We have reviewed the request to determine whether we have authority to consider this matter. Because we conclude that the Referee's order is not a final order, we dismiss the request for review.

FINDINGS OF FACT

Claimant, pro se, requested a hearing concerning the employer's February 27, 1991 denial of her current low back condition, as well as her aggravation and related medical services claims. A hearing was held on August 22, 1991. At that hearing, the parties agreed to defer all "substantive issues" concerning claimant's claim, and to address at the hearing the sole issue of whether claimant had good cause for failing to request a hearing within 60 days from the date of the employer's denial. The parties further agreed that in the event

that the Referee found that claimant had shown "good cause," a new hearing would be scheduled to address the remaining issues.

On September 13, 1991, the Referee issued an Interim Order. The Referee concluded that claimant had shown "good cause" for her failure to timely file a request for hearing. In accordance with the agreed upon procedure, the Referee stated that consideration of the substantive issues would be rescheduled for hearing at a later date. On September 17, 1991, the employer mailed by certified mail its request for Board review of the Referee's order.

FINDINGS OF ULTIMATE FACT

The Referee's September 13, 1991 Interim Order did not finally deny or allow the claim, nor did it fix the amount of claimant's compensation.

CONCLUSIONS OF LAW

A final order is one which disposes of a claim so that no further action is required. Price v. SAIF, 296 Or 311, 315 (1984). A decision which neither denies the claim, nor allows it and fixes the amount of compensation, is not an appealable final order. Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139 (1974).

Here, the Referee's September 13, 1991 order neither finally disposed of, nor allowed, the claim. Moreover, the order did not fix the amount of claimant's compensation. Rather, the order was expressly designated as interim in nature and was designed to address a procedural issue to determine whether the consideration of substantive issues would be necessary. As a result of the Referee's decision regarding the procedural issue, further proceedings are required to determine claimant's entitlement to, and/or the amount of, compensation.

Inasmuch as further action before the Hearings Division was required as a result of the Referee's order, we conclude that it was not a final order. Price v. SAIF, supra; Lindamood v. SAIF, supra. Therefore, we lack jurisdiction to consider the employer's request for Board review.

Accordingly, this case is returned to Referee Howell for further action consistent with this order and the Referee's September 13, 1991 Interim Order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARKUS M. TIPLER, Claimant
WCB Case No. 90-15863
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Phillip Nyburg, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of Referee Livesley's order which increased claimant's scheduled permanent disability award for a right forearm injury from 7 percent (10.5 degrees), as awarded by a Determination Order, to 21 percent (31.5 degrees). In his brief, claimant requests a further increase of scheduled permanent disability. On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

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

Claimant underwent surgery for release of a right long trigger finger.

A Determination Order issued, on August 3, 1990, awarding claimant 7 percent (10.5 degrees) scheduled permanent disability.

CONCLUSIONS OF LAW AND OPINION

Because claimant became medically stationary prior to July 1, 1990, and his claim was closed by Determination Order on August 3, 1990, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability (WCD Admin. Order 7-1988). Former OAR 436-35-003.

Range of Motion

The insurer, relying on Linda F. Wright, 42 Van Natta 2570 (1990), argues that the range of motion figures found in the report prepared by Eugene Hand Rehabilitation Center may not be used to determine impairment because the impairment was not measured by a physician as required by former OAR 436-35-005(1). However, because Dr. Dreyer, claimant's physician, signed the report, we agree with the Referee that the physician had accepted the findings and adopted them as his own. See Don O. Adams, 43 Van Natta 972 (1991). Accordingly, those findings are properly used in determining claimant's impairment.

The Referee, in determining claimant's loss of range of motion in the right wrist and fingers, compared the loss with the range of motion of the contralateral joint in the left wrist and fingers pursuant to former OAR 436-35-010(3). The insurer argues that claimant's aberrant ranges of motion in his hands and fingers should not be used to grant an increased award but, rather, claimant's loss of range of motion should be compared to the norms established by the "standards." Because former OAR 436-35-010(3) states that movement in a joint is measured first by comparing to the degrees of motion possible in the contralateral joint, we conclude that the Referee properly used that comparison in calculating loss of range of motion impairment in claimant's wrist and fingers.

The insurer next argues that range of motion impairment in claimant's fingers should be limited to the right long finger because that is the only finger which required surgery. It argues that claimant has not proven that impairment

in the other fingers of the right hand is related to the compensable injury. We do not agree.

The Referee relied on Dr. Dreyer's ratification of the findings of the Eugene Hand Rehabilitation Center and concluded that the residuals set out in those findings resulted from the compensable injury. Claimant's credible testimony that he had never injured his hands before and Dr. Dreyer's ratification of the Hand Center's impairment findings persuade us that all of claimant's finger impairments are due to the compensable injury. Don O. Adams, supra at 973.

Because we agree that the Referee properly calculated claimant's wrist impairment and properly included the index and ring finger impairment in calculating loss of range of motion, and because neither party disputes the Referee's actual calculations of loss of range of motion for the right wrist and index, middle and ring fingers, we adopt the Referee's impairment values.

The Referee found 7 percent impairment for loss of range of motion in the right wrist (forearm). Loss of range of motion values for the index, middle and ring fingers were converted to an 11 percent loss of the hand/forearm.

Grip Strength

The Referee relied on Dr. Dreyer's ratification of the findings of the hand center concerning grip strength to indicate a ratable loss. The Referee concluded that rerouting of the ulnar nerve during surgery indicated anatomical change. The insurer argues that claimant's loss of grip strength is not ratable under the "standards" because there is no medical evidence establishing a loss due to nerve damage or anatomical changes. See former OAR 436-35-110(3)(a) and (d). We agree with the insurer.

The "standards" require that decreased grip strength be attributable to nerve damage, atrophy or other anatomical changes before a value can be assigned. In this case, although we note the measured loss of grip strength in claimant's right hand, we are unable to find expert medical evidence that establishes that the loss of grip strength is due to either nerve damage, atrophy or anatomical change. See Clark D. Griffith, 42 Van Natta 1112 (1990). We, therefore, disagree with the Referee's award of a 4 percent impairment value for loss of grip strength due to anatomical changes.

Chronic Condition Limiting Repetitive Use

Claimant testified that he has limited use of his hand when using various hand tools and power saws. He has had to give up his hobby of repairing lawnmowers because he cannot use his right hand as he did before. He is limited in performing certain household chores, and some he cannot do at all using his right hand and arm. Considering the aforementioned limitations, we agree with the Referee's award of 5 percent impairment for chronic conditions limiting repetitive use of claimant's right arm.

Computation of Scheduled Permanent Disability

When two or more parts of the same body part are impaired, each is rated separately and each rating is converted to a value for the impaired part which is closest to the body which, in this case, is the forearm. These converted values are then combined (not added). former OAR 436-35-120(4). We have adopted the Referee's finding that claimant had a total wrist (forearm) impairment of 7 percent. Former OAR 436-35-080 et seq. We have also adopted the Referee's conversion of the loss of range of motion values in the right index, middle and ring fingers to a total value of 11 percent loss of the hand. These

values are then combined with the 5 percent value for a chronic condition limiting repetitive use of the forearm, to arrive at a total impairment value of 21.3. That value is rounded to the next highest whole number, which is 22. Claimant's scheduled permanent disability award for loss of use or function of the right forearm is, therefore, 22 percent.

Finally, 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). Here, claimant estimated that limitations in the use of his right forearm and hand have left him with a loss of use of 50 percent. He has a measurable loss of grip strength, even though that loss has not been attributed to nerve damage or anatomical changes. Additionally, claimant's ulnar nerve surgery has left him with an extremely sensitive forearm.

Viewing the record as a whole, we conclude that claimant has established by clear and convincing evidence that his permanent scheduled right forearm disability exceeds that arrived at by application of the "standards." We conclude that claimant is entitled to a total award of 27 percent scheduled disability for loss of use or function of his right forearm. Former ORS 656.295(5); see Riley Hill General Contractor Inc. v. Tandy Corp., 303 Or 390, 407 (1987).

The insurer has requested review and we have found that claimant's compensation should not be disallowed or reduced. Therefore, claimant is entitled to an attorney fee under 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 fee for claimant's counsel's services on review in defending against the insurer's request for a reduction of claimant's scheduled permanent disability award 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 January 18, 1991, as reconsidered February 5, 1991, is modified. In addition to the Determination Order and Referee awards, claimant is awarded 6 percent (9 degrees) scheduled permanent disability, giving him a total award to date of 27 percent (40.5 degrees) scheduled permanent disability for a right forearm injury. Claimant's attorney is awarded a reasonable approved fee of 25 percent of the additional compensation resulting from this order, payable directly to claimant's attorney. However, the total out-of-compensation fee awarded under the Referee and Board orders shall not exceed $3,800. For services in defending against the insurer's request for review, claimant's counsel is also awarded an assessed attorney fee of $500, payable by the insurer.

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Cite as 106 Or App 343 (1991) March 13, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Tommy V. Arms, Claimant.

GEORGIA-PACIFIC CORPORATION, Petitioner,
v.
TOMMY V. **ARMS**, Respondent.
(WCB 88-03948; 88-07597; 88-07597; CA A64255)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 3, 1990.
Jerry K. Brown, McMinnville, argued the cause for petitioner. With him on the brief was Fish & Peterson, P.C., McMinnville.
James L. Edmunson, Eugene, argued the cause and filed the brief for respondent.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

EDMONDS, J.
Reversed and remanded for reconsideration.
Riggs, J., dissenting.

Employer seeks review of an order of the Workers' Compensation Board awarding claimant a penalty and attorney fees for an unreasonable denial. ORS 656.262(10); 656.382(1).[1] We reverse.

In December, 1980, claimant strained his back while working as a logger for employer. His claim was accepted, and he was eventually awarded 30 percent unscheduled permanent partial disability. In September, 1987, he began working for Black Brothers Logging. On January 27, 1988, he left work early and went to the hospital and was examined by Dr. Mackey. The emergency room records noted "c/o lumbar-sacral pain radiate to L. hip x 2 weeks. Logging today (CAT skinner) Hx of back operation." Mackey referred claimant to Dr. Gallo, a neuro-surgeon. Two days later, he returned to the emergency room and was treated by Dr. Kaib, who noted that claimant had previously visited the emergency room with "an acute exacerbation after driving a [C]aterpillar tractor."

Claimant saw Gallo on February 2, 1988. Her first report indicates that claimant had injured his back at work two weeks earlier. Claimant filed an aggravation claim with employer. On the basis of reports from Gallo and the

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[1] ORS 656.262(10) provides:
"If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

ORS 656.382(1) provides:
"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. To the extent an employer has caused the insurer to be charged such fees, such employer may be charged with those fees."

emergency room physicians, employer denied responsibility for claimant's medical treatment and disability. However, in a March 29, 1988, letter to claimant's attorney, Gallo said:

> "Apparently when I took my initial history on Mr. Tommy Arms, I misunderstood his history regarding his most recent exacerbation of back pain. I have spoken with him recently and we have sorted through my mistake. * * * Apparently I misunderstood him to say that he reinjured his back while at work. This was not the case. He was at home on a Sunday and was assisting a relative in transplanting some fruit trees. * * * This mistake is purely my own and I do not feel that the patient misled me on the initial consultation."

After that letter was forwarded to employer, it continued to deny the claim. In addition to the emergency room reports, it had a report from Dr. Zivin dated June 16, 1988, that said:

> "It is quite clear from the original emergency contacts that the patient told the physician at that time that the circumstances revolved about his work with Black Brothers Logging Company."

Also, it had information that claimant's son-in-law held a management position at Black Brothers Logging and had been instrumental in getting claimant hired.

At a hearing in July, 1988, the referee set aside employer's denial but did not award a penalty or attorney fees. On review, the Board affirmed the referee except that it awarded a penalty and attorney fees against employer for its failure to rescind its denial after receiving Gallo's March 29 letter. It found:

> "Claimant suffered an aggravation of his 1980 low back injury in January 1988, while at home digging and replanting fruit trees. *Due to a misunderstanding when claimant first went to the emergency room for back pain on January 27, 1988, it was noted that claimant had injured his back while working with one of SAIF's insureds, Black Brothers Logging, rather than at home. That mistake continued through a second emergency room visit and into the surgeon's initial examination report.* When claimant became aware of the error, he informed his surgeon, who in turn wrote a letter to claimant's attorney to rectify the misinformation and clarify the cause of injury.
>
> "The self-insured employer received a copy of the surgeon's clarifying letter on April 21, 1988, three months prior to hearing.
>
> "* * * * *
>
> "It is true that there was information in the two emergency room reports that would lead the employer and the surgeon to believe that claimant was injured at another employment. However, when claimant subsequently became aware of the misinformation, he immediately informed his surgeon who, in turn, informed claimant's attorney of the error by letter dated March 29, 1988. She noted that the error had resulted from *her* misunderstanding of claimant's history. The employer received a copy of the surgeon's letter on April 21, 1988, three months before hearing. [Emphasis in original.]
>
> "* * * * *
>
> "After *de novo* review of the record, we conclude that the *evidence received by the employer, which stated that claimant had not hurt his back at a subsequent employment, was sufficient to destroy any*

legitimate doubt on the part of the employer that it was responsible for claimant's surgery. Therefore, its continuing denial in the face of such evidence was unreasonable. Accordingly, we shall assess a penalty and associated attorney fee. ORS 656.262(10), 656.382(1)." (Emphasis supplied.)

When an employer has once reasonably denied 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 Company*, 93 Or App 588, 592, 763 P2d 408 (1988). The Board followed the correct legal standard: whether employer had a legitimate doubt as to its liability. Employer challenges the Board's findings, claiming that they are unsupported by substantial evidence and that they do not lead to the Board's conclusion.

The Board's finding that the emergency room physicians misunderstood the history that claimant gave them is not supported by substantial evidence. Although Gallo's second report supersedes the information in her first report, it does not refer to information employer had from earlier examinations by Mackey and Kaib or impugn the accuracy of the information claimant provided to them before he saw Gallo. Therefore, the Board's conclusion that Gallo's second report "destroyed" any legitimate doubt that was raised by the other information does not logically follow and the order is insufficient for our review. Accordingly, we remand to the Board to explain how it reached its conclusion.

Reversed and remanded for reconsideration.

RIGGS, J., dissenting.

The majority concludes that the Board was wrong in determining that employer's continued unreasonable denial of compensation justified an award of attorney fees and a penalty in favor of claimant. The majority is wrong.

If an employer fails to withdraw a denial of compensation after obtaining new medical evidence that removes any reasonable doubt concerning the legitimacy of the claim, the imposition of penalties and attorney fees is appropriate. *Brown v. Argonaut Insurance Company*, 93 Or App 588, 763 P2d 408 (1988). In this case, employer was told by Dr. Gallo, in writing, that part of her earlier history of claimant was incorrect. Gallo provided that correction to claimant's counsel, who in turn provided it to employer at least three months before the hearing. The majority makes much of the fact that there were two references by physicians in the emergency room that had stated claimant's history inconsistently with Gallo's corrected history. The majority also relies on the fact that Gallo's corrected history did not refer to the information from other physicians or "impugn its accuracy."

Whether or not Gallo had any obligation to acknowledge or refute medical information that she believed to be incorrect, employer failed to take appropriate action after receiving her corrected report. During the three months between the time when employer received Gallo's letter and the time of the hearing, it apparently did absolutely nothing to verify the accuracy of the emergency room notes if, indeed, it believed that there was any legitimate doubt concerning the corrected history that Gallo provided.

On these facts, the Board could, and did, correctly conclude that Gallo's corrected and timely report removed any legitimate doubt concerning the true history, at least in the absence of any effort by employer to determine the accuracy of the emergency room records in light of Gallo's corrected report. We review for substantial evidence, and we should affirm the Board. Because we do not, I respectfully dissent.

Cite as 106 Or App 354 (1991) March 13, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of John R. Garver, Claimant.

STEVENS EQUIPMENT COMPANY and LIBERTY NORTHWEST INSURANCE CORP., Petitioners,
v.
AMERICAN FABRICATORS, LIBERTY NORTHWEST INSURANCE CORP. and JOHN R. GARVER,
Respondents.
(88-08090, 88-07209; CA A65091)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 28, 1991.
Darrell E. Bewley, Salem, argued the cause for petitioners. With him on the brief was Pamela A. Schultz, Portland.
Jenny Ogawa, Salem, argued the cause for respondents American Fabricators and Liberty Northwest Insurance Corp. With her on the brief was Kevin L. Mannix, P.C., Salem.
No appearance by respondent John R. Garver.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
EDMONDS, J.
Reversed and remanded for reconsideration.

Stevens Equipment Company seeks review of an order of the Workers' Compensation Board assigning responsibility to it for claimant's low back condition.[1] We reverse.

Claimant initially injured his low back in 1980, while working for Layton Manufacturing Company, and was awarded five percent unscheduled permanent partial disability. In September, 1985, he injured his low back while working for American Fabricators (American). The 1985 injury claim was closed in 1987, with an award of five percent unscheduled permanent partial disability. In early February, 1988, claimant received an additional 10 percent unscheduled permanent partial disability for the 1985 injury.

While working for Stevens Equipment Company (Stevens), claimant injured his back on February 23, 1988. For the first time, he had mid-back pain as well as low back symptoms. Stevens denied responsibility for the claim, and American denied claimant's aggravation claim. At the hearing, Stevens accepted responsibility for the mid-back condition but continued to deny responsibility for the low back condition. The Board held:

> "Because the discrete incident affecting the mid and low back occurred while claimant was employed at Stevens, Stevens carries the burden to prove that the injury did not 'independently contribute' to the low back disability. *See Linda L. Wise*, 42 Van Natta 115 (1990). 'Independent contribution' means a worsening of claimant's underlying condition. *See Hensel Phelps Const. v. Mirich*, 81 Or App [290], 294[, 724 P2d 919] (1986).
>
> "Here, three physicians discuss the the [sic] effects of the new injury upon claimant's low back condition. Dr. Atkinson, M.D., claimant's treating physician, opined there was an exacerbation of the low back condition, but he was unable to tell whether or not

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[1] For reasons not apparent to us, this case has not come to us by way of the arbitration procedure described in ORS 656.307(2).

there was a pathological change in the condition. * * * Dr. Paluska, M.D. opined that claimant's new injury only caused an aggravation of a preexisting condition. * * * In addition, Dr. Chester, M.D. indicated that claimant's low back discomfort at the lumbosacral junction was, '...probably related to minor osteoarthritis (facet syndrome).' * * *.

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

Stevens contends that the Board wrongly assigned the burden of proof to it. Relying on *Spurlock v. International Paper Co.*, 89 Or App 461, 749 P2d 611 (1988), it argues that American, as the employer that had last accepted an injury claim, must prove that the employment at Stevens caused a worsening of the underlying condition in order to shift responsibility under the last injurious exposure rule. In *Spurlock*, we concluded that, when the evidence did not show that the claimant's underlying disease had worsened as a result of the subsequent employment, but only that the subsequent employment had exacerbated the symptoms of the disease, the first employer could not assert the last injurious exposure rule as a defense. That rule operates to assign liability to one employer in cases of successive incremental injuries and places full responsibility for compensation on the employer covering the risk at the time of the most recent injury that bears a causal relation to the disability. *Bracke v. Baza'r*, 293 Or 239, 244, 646 P2d 1330 (1982). The rule also relieves a claimant of the burden of proving medical causation, if he establishes that the disability was caused by work-related exposures. The rule does not shift responsibility if the disability is a result solely of the injury that happened during the earlier employment. *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 243, 675 P2d 1044 (1984).

American argues that the Board correctly assigned the burden of proof to Stevens, because the medical evidence as to causation was in equipoise and, therefore, Stevens, as the last employer, remained responsible. It relies on *Champion International v. Castilleja*, 91 Or App 556, 756 P2d 659, *rev den* 306 Or 661 (1988), where we said:

"The question is what the evidence must show in order to decide which employer is responsible. When, as here, the trier of fact is convinced that the disability was caused by successive work-related exposures but is unconvinced that any one employment is the more likely cause of the disability, the [last injurious exposure] rule operates to place liability on the last employer." 91 Or App at 560.

Before the last injurious exposure rule can apply under American's successive injury theory of the case, there must be evidence of a second injury that materially contributed to the claimant's disability. *Peterson v. Eugene F. Burrill Lumber*, 294 Or 537, 543, 660 P2d 1058 (1983); *Crowe v. Jeld-Wen*, 77 Or App 81, 87, 712 P2d 145 (1985), *rev den* 301 Or 76 (1986). In *Champion*, we assigned responsibility to the last employer with an accepted claim. Here, in

contrast, the Board found that Stevens has denied responsibility for claimant's low back disability, arguing that it was the result of the 1985 injury at American. The Board, therefore, erred when it placed the burden of proof on Stevens. *See Delta/McLean Trucking v. Wyncoop*, 106 Or App 319, ___ P2d ___ (1991).

Reversed and remanded for reconsideration.

Cite as 106 Or App 411 (1991) March 20, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Duane B. Meeker, Claimant.

LIBERTY NORTHWEST INSURANCE CORPORATION and CORNELL PUMP COMPANY,
Petitioners,
v.
DUANE B. **MEEKER**, AMERICAN INTERNATIONAL ADJUSTMENT COMPANY (AIAC), HARTFORD INSURANCE COMPANY, WAUSAU INSURANCE COMPANY, and INSURANCE COMPANY OF NORTH AMERICA (INA), Respondents.
(WCB Nos. 87-15341 & 87-02651; CA A63571)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 22, 1991.
Stafford J. Hazelett, Portland, argued the cause and filed the brief for petitioners.
Nelson R. Hall, Portland, argued the cause for respondent Meeker. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.
Craig A. Staples, Portland, argued the cause for respondent American International Adjustment Company (AIAC). With him on the brief was Roberts, Reinisch, Mackenzie, Healey & Wilson, P.C., Portland.
William D. Peek and Schwabe, Williamson & Wyatt, Portland, and Matthew K. Rossman, Stephen R. Frank and Tooze, Shenker, Holloway & Duden, Portland, filed the brief for respondents Insurance Company of North America and Hartford Insurance Company.
David O. Horne, Portland, filed the brief for respondent Wausau Insurance Company.
Before Buttler, Presiding Judge, and Richardson and De Muniz, Judges.

DE MUNIZ, J.
Affirmed.

The only question that we address in this workers' compensation review is whether claimant timely filed his occupational disease claim. The Board held that he did, and we affirm.

At the relevant time, ORS 656.807(1) provided, in part, that

> "[a]ll occupational disease claims shall be * * * filed * * * within 180 days from the date the claimant becomes disabled *or is informed by a physician that he is suffering from an occupational disease* whichever is later." (Emphasis supplied.)

Medical reports have shown since 1984 that claimant suffers from degenerative back disease. In 1986, at a hearing to determine the extent of disability due to a work related injury, claimant argued that disability from the degenerative condition should be considered. The referee held otherwise, because he found that the disease had not been worsened by the injury. The first medical report

to link claimant's degenerative back condition to his employment came from Dr. Baum in August, 1987. Claimant filed his claim for occupational disease in September, 1987.

In *Templeton v. Pope and Talbot, Inc.*, 7 Or App 119, 490 P2d 205 (1971), we considered the same question as is presented here. In determining that the claim was timely, we said:

> "The evidence taken at the time of the hearing discloses that the claimant had difficulties with his shoulder and neck for about two years prior to the time he filed his occupational disease claim on February 17, 1970. It also discloses that during this period he had been told by doctors that there was a relationship between his work and his physical difficulties. It fails to disclose any evidence that any doctor at any time prior to the filing of the claim specifically told him, simply and directly, that his condition arose out of his employment, or anything clearly to that effect."

See also Robinson v. SAIF, 69 Or App 534, 686 P2d 1053, *rev den* 298 Or 238 (1984). It is not enough, as employer contends, that the medical reports disclose that a claimant has a disease. The claimant must have been informed "simply and directly" that his disease arose out of his employment.

Affirmed.

Cite as 106 Or App 416 (1991) March 20, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Reubin B. Coleman, Claimant.

REUBIN B. **COLEMAN**, Petitioner,
v.
PACCAR-WAGNER MINING, Respondent.
(WCB No. 87-16252; CA A63165)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 15, 1991.
Michael D. Royce, Portland, argued the cause for petitioner. On the brief were Daina Upite and Royce, Swanson & Thomas, Portland.
G. Joseph Gorciak, Portland, argued the cause for respondent. With him on the brief was Terrall & Miller, Portland.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

DE MUNIZ, J.
Reversed and remanded for reconsideration.

Claimant seeks review of an order of the Workers' Compensation Board sustaining employer's denial of an occupational disease claim for a respiratory condition. Because we conclude that the Board's decision is not supported by its findings, we reverse and remand.

Claimant experiences respiratory symptoms when exposed to rust inhibitors used by employer. Several doctors have examined claimant, and all agree that his symptoms are brought on by the on-the-job exposure, either directly or because of a "neuropsychiatric" response. The point of dispute appears to concern the significance of the fact that the evidence does not show that claimant is allergic to the chemicals used in those products, only that he

experiences irritation when exposed to them. No doctor has ever suggested that claimant's symptoms are not brought on by the exposure.

The Board first found that the evidence does not establish that claimant has a preexisting respiratory condition. Relying on the opinion of Dr. Bardana, it then found that he has not established that his work exposure is the major contributing cause of his respiratory condition. Bardana reported that, although the on the job exposure had resulted in "transient mucous membrane irritational syndrome," he does not have an occupational disease. Bardana did not, as the Board's opinion suggests, attribute claimant's symptoms to off-the-job exposures, such as smoke, dog hair, exhaust, dust and exhaust or dust and oils. Rather, Bardana believed that claimant has a mild form of chronic sinusitis that became symptomatic as a result of, but was not changed by, his on-the-job exposure to rust inhibitors. If, as Bardana apparently believes, claimant has a mild form of chronic sinusitis, that is a preexisting condition; the Board's reliance on Bardana's opinion is inconsistent with its finding that claimant does not suffer from a preexisting condition. On remand, the Board must clarify that apparent inconsistency.

Reversed and remanded for reconsideration.

Cite as 106 Or App 421 (1991) March 20, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Gordon C. Green, Claimant.

GORDON C. **GREEN**, Petitioner,
v.
PELTON CONCRETE, and SAIF CORPORATION, Respondents.
(86-09604; CA A63997)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 16, 1991.
Robert J. Neuberger, Portland, argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.
Ann Kelley, Assistant Attorney General, Salem, argued the cause for respondents. With her on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

PER CURIAM---Reversed and remanded for reconsideration.

Claimant seeks review of an order of the Workers' Compensation Board reversing the referee's decision that he is permanently and totally disabled. Although we agree with employer that substantial evidence supports the Board's findings concerning permanent and total disability, we reverse and remand to the Board, because there is a preliminary issue that must be decided.

From the outset, claimant has contended that the determination order, which awarded him 30 percent permanent partial disability for loss of use of his right leg, was inadequate. In the alternative, he contended that the order had been entered prematurely. We conclude that he preserved the alternative issue for Board review. Because the referee found that claimant was permanently and totally disabled, she held that she did not need to address whether the claim had been prematurely closed. The Board, in reversing the referee, also failed to address whether the claim had been prematurely closed. Contrary to the

referee's reasoning, whether the claim was prematurely closed is a question that must be decided before any award of benefits can be made.

Reversed and remanded for reconsideration.

Cite as 106 Or App 423 (1991) March 20, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Rinaldo F. Sinclair, Claimant.

CHAMPION INTERNATIONAL, Petitioner,
v.
RINALDO F. **SINCLAIR**, Respondent.
(86-09427; CA A63843)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 8, 1991.
Brian L. Pocock, Eugene, argued the cause and filed the brief for petitioner.
Karen M. Werner, Eugene, argued the cause for respondent. With her on the brief were Richard T. Kropp and Emmons, Kropp, Kryger, Alexander & Egan, Albany.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

PER CURIAM
Reversed and remanded for further proceedings not inconsistent with this opinion.

Employer petitions for review of an order of the Workers' Compensation Board holding that claimant's condition has worsened since the last arrangement of compensation and that he is permanently and totally disabled as a result of a back injury that was superimposed on a compensable psychological condition.

Substantial evidence supports the Board's finding that it would be futile for claimant to seek work. However, the Board made no finding concerning claimant's willingness to work, and that is a prerequisite to entitlement to benefits for permanent and total disability. *SAIF v. Stephen*, 308 Or 41, 48, 774 P2d 1103 (1989).

Claimant correctly concedes that, in the event that he is determined on remand to be permanently and totally disabled, the Board should consider whether employer is entitled to an offset for permanent partial disability benefits paid before the effective date of the determination of permanent total disability. *V.W. Johnson & Sons v. Johnson*, 103 Or App 355, 797 P2d 396 (1990), rev den 311 Or 60 (1991).

Reversed and remanded for further proceedings not inconsistent with this opinion.

Cite as 106 Or App 477 (1991) April 3, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Richard H. Church, Claimant.

LIBERTY NORTHWEST INSURANCE CORP., and NORRIS & STEVENS, Petitioners,
v.
RICHARD H. **CHURCH**, KINSMAN INVESTORS, and UNITED PACIFIC INSURANCE, Respondents.
(WCB Case Nos. 88-08913, 88-08912, 88-0506 & 88-02266; CA A64096)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 22, 1991.
Stafford J. Hazelett, Portland, argued the cause and filed the brief for petitioners.
Ralph M. Yenne, Salem, argued the cause and filed the brief for respondent Church.
Craig A. Staples, Portland, argued the cause for respondents Kinsman Investors and United Pacific Insurance. With him on the brief was Roberts, Reinisch, Mackenzie, Healey & Wilson, P.C., Portland.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
DE MUNIZ, J.
Reversed and remanded for entry of an order that Kinsman Investors is claimant's employer.

Norris & Stevens, Inc., Realtors (N & S), seeks review of a decision of the Workers' Compensation Board determining that it, and not Kinsman Investors (Kinsman), is claimant's employer.

The Board's findings are supported by substantial evidence. Kinsman, a partnership, and N & S entered into a property management agreement whereby N & S agreed to manage, rent and direct operation of Kinsman's real property, including The Park Apartments. Under the agreement, N & S had the power to

> "employ, pay, direct and discharge all employees deemed by the agent necessary for the operation and maintenance of said premises; all such employees conclusively shall be and deemed to be for all purposes the employees of the owner and not employees of the agent and the agent shall not be responsible for any of their acts, defaults or negligence or for any error of judgment or mistake of law or of fact in connection with their employment, conduct or discharge."

Kinsman agreed to carry workers' compensation insurance for the employees and to hold N & S harmless from all claims.

Claimant completed an application for employment as an apartment complex manager. The application did not identify the name of the employer. Claimant signed an employment agreement in January, 1986, which provided:

> "It is understood that managers are employees of [The Park Apartments] which is managed by Norris & Stevens, Realtors who will provide sole direction and supervision as agents of owners."

The agreement further provided:

> "It is understood that Norris & Stevens, Realtors acting as agents for the owners, has the right to cancel this agreement forthwith for cause."

Again, the name of the owner of The Park Apartments was not disclosed. In May, 1987, claimant received a letter from a general partner of Kinsman, congratulating him on his good work.

Kinsman listed claimant as its employee on its tax forms and also acquired workers' compensation insurance for him. Claimant submitted wage requests to N & S. The Board found that claimant was paid by Kinsman for his work at The Park Apartments. Beginning in August, 1987, claimant also received payment from N & S for work done at the Plaza Shopping Center, a building under different ownership.

Claimant was injured in October, 1987, when he fell from a ladder while cleaning gutters at The Park Apartments. He filled out a claim form, which got sent to Kinsman. Kinsman's insurer deferred acceptance or denial of the claim and began paying interim compensation and providing vocational services. At that time, claimant told the vocational worker that his employer was N & S. In March, 1988, Kinsman denied responsibility for the claim on the ground that claimant was the employee of N & S. N & S denied responsibility for a claim that claimant then submitted to it and, because all parties agreed that the claim was compensable, the Workers' Compensation Division issued an order under ORS 656.307 designating Kinsman's insurer as the paying agency.

In affirming the referee's conclusion that claimant was the employee of N & S, the Board relied on these facts:

> "The property manager by contract had the responsibility to oversee the maintenance of the owner's property. They [sic] hired the claimant; they supervised him; they evaluated him and told him what he should do to improve his performance; they sent him instructions from time to time; and they eventually fired him.
>
> "Claimant was paid from a trust fund set up for Park Apartments. His wages were a business expense of the owner. The owner didn't have and/or never exercised direct control over the claimant. The trust fund was funded by rents from the apartment complex. The property manager could authorize repairs up to $750.00 without the owner's consent.
>
> "The claimant himself was under the impression that Norris & Stevens were his employers [sic]. His pay check was sent by Norris & Stevens or he picked it up in their [sic] office."

Kinsman contends, relying on *Newport Seafood v. Shine*, 71 Or App 119, 124, 691 P2d 132 (1984), that whether there is an employment relationship must be viewed from the worker's perspective and that the question is whether claimant considered N & S or Kinsman to be his employer. It contends that, because the Board found that claimant believed that N & S was his employer, it was his employer for purposes of workers' compensation law. Kinsman's reliance on *Newport Seafood* is misplaced. That case involved an application of the "loaned servant" doctrine. Its analysis has no bearing here.

The two elements necessary to create an employment relationship for the purposes of workers' compensation are a contract to pay remuneration for services and the right to direct and control the services of the worker. ORS 656.005(13); ORS 656.005(27); *Martelli v. R. A. Chambers and Associates*, 310 Or 529, 800 P2d 766 (1990). The Board's findings support only the conclusion that claimant was employed by Kinsman, not N & S. Although claimant may not have realized it, his written contract of employment was with Kinsman, as the owner of The Park Apartments. Although he may not have known it, he was paid by

Kinsman, and Kinsman exercised its power to control his daily work activities through its agent, N & S. Kinsman treated claimant as its employee for all purposes. The Board erred in holding that claimant was employed by N & S.

N & S is correct that claimant's benefits should be determined solely on the basis of the wages that he earned as manager of The Park Apartments. *Bolton v. Oregonian Publishing*, 93 Or App 289, 761 P2d 1354 (1988).

Reversed and remanded for entry of an order that Kinsman Investors is claimant's employer.

Cite as 106 Or App 488 (1991) April 10, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON

ARLAN W. **TAAL**, Appellant,

v.

UNION PACIFIC RAILROAD COMPANY, Respondent.

(A8811-05958; CA A64279)

Appeal from Circuit Court, Multnomah County.
William C. Snouffer, Judge.
Argued and submitted February 11, 1991.
James N. Westwood, Portland, argued the cause for appellant. With him on the briefs were Miller, Nash, Wiener, Hager & Carlsen, Thomas M. Schneiger and Bricker, Zakovics & Querin, P.C., Portland.
Thomas W. Brown, Portland, argued the cause for respondent. With him on the brief was Cosgrave, Vergeer & Kester, Portland.
Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P.J.
Reversed and remanded.

Plaintiff, a railroad worker, brought this action against his employer under the Federal Employers' Liability Act (FELA), 45 USC { 51 *et seq*, alleging that he suffers the occupational diseases of hearing loss and tinnitus. The complaint was filed on November 1, 1988. Defendant moved for summary judgment on the ground that the action is barred by the three-year limitation period of 45 USC { 56. The trial court granted the motion, and plaintiff appeals from the resulting judgment. We reverse and remand.

The issue is whether the evidence in the summary judgment proceeding leaves a material factual question as to whether plaintiff knew or should have known "the condition and its cause" before November 1, 1985. *See McCoy v. Union Pacific Railroad Co.*, 102 Or App 620, 623-24, 796 P2d 646 (1990), and authorities there cited. Defendant relied on a recorded interview with plaintiff by its claims agent, which took place in February, 1988. Plaintiff told the agent that he first noticed a hearing problem "in the middle of 1985," which he later explained, in response to the agent's question, meant "June, July or August, somewhere around there. I don't know exactly."

Plaintiff submitted his deposition, taken approximately one year after the interview with the agent, and contends that it created a material factual question and would support a finding that his discovery of the problem occurred after November 1, 1985. We quote from the deposition:

"Q. [By defendant's attorney] And in that statement [to the agent] it indicated that you first noticed a hearing problem in either June or July or August of 1985.
"A. [By plaintiff] Yes.
"Q. Did you indicate that at that time?
"A. At that time I did.
"Q. Are you telling me that that's not correct now or --
"A. That's correct, that's not correct?
"Q. That's not correct?
"A. Right.
"Q. And why do you say that?
"A. I looked at the doctor's statement.
"Q. Which doctor's statement?
"A. [Joseph] Petrusek
"Q. And what was it about Petrusek's statement that suggested that earlier statement about when you first noticed your hearing problem was incorrect?
"A. The date.
"* * * * *
"Q. Why did you conclude that it was not correct?
"A. The date that I took the examination.
"Q. So you concluded from looking at Dr. Petrusek's chart note, which shows that you saw him on November 7th, 1985, that the date of June, July or August of 1985 was not correct?
"A. That's right.
"* * * * *
"Q. When did you first notice a problem with your hearing?
"A. I don't know. Probably November 5th or 6th of '85.
"Q. And what brought it to your attention at that time?
"A. I was outside at my sister's place and she left and went to the house and I asked her why and she said the phone was ringing.
"* * * * *
"Q. And this was on the 5th?
"A. 5th or 6th, I don't exactly -- one or the other of those days.
"* * * * *
"Q. And then what happened?
"A. Well, the more I thought about it, I thought maybe I better do something, find out if I did have a problem, so I contacted Dr. Petrusek and had an examination the next day or so.
"Q. So you were able to schedule an examination with him on a day's advance notice? You hadn't scheduled that before?
"A. I don't remember. It wasn't very long.
"* * * * *
"Q. * * * And you never asked that another doctor refer you to Dr. Petrusek so that you could have yourself examined for a hearing problem?
"A. Dr. Kubler.
"Q. Oh, you did ask him to do that?
"A. Yeah.
"Q. And when did you ask him to do that?
"A. The day that I made the appointment [with Petrusek], somewhere around in that area there.
"* * * * *
"Q. So it would have been either November 5th or 6th that you went in to see Dr. Kubler? Or did you go in to see him?
"A. I don't remember, I don't remember exactly.
"* * * * *

"Q. * * * But in any event, when you did talk to Dr. Kubler, it was at that time that you wanted to have yourself tested because you felt you had a hearing problem at that time; is that correct?
"* * * * *
"A. That's the reason I talked to him.
"* * * * *
"Q. Mr. Taal, I just want to find out how sure you are as to when you talked to Dr. Kubler. And assume we find a record that shows that you talked to him about this hearing problem prior to November of 1985, would you have any strong dispute with that?
"A. No."

The parties stipulated at the hearing that plaintiff consulted Kubler before the end of October, 1985.

Defendant argues that, under *Clapp v. Oregonian Publishing Company*, 83 Or App 575, 732 P2d 928 (1987), and *Henderson-Rubio v. May Dept. Stores*, 53 Or App 575, 632 P2d 1289 (1981), plaintiff could not create a genuine issue of fact simply by using his deposition to contradict his earlier statements to the agent. Plaintiff relies on *Cope v. Western American Ins. Co.*, 95 Or App 114, 768 P2d 410 (1989), aff'd 309 Or 232, 785 P2d 1050 (1990), where we said:

"In *Henderson-Rubio*, the plaintiff was repeatedly asked during deposition to state the basis for his overtime wage claim. He specifically stated that it was based on his understanding of federal wage law, but that he was not aware of any company policy regarding the matter. After the employer filed a motion for summary judgment, the plaintiff filed an affidavit asserting that the employer had a policy regarding overtime wages. We held in that case that such an affidavit could not create a genuine issue of fact. However, we limited the case to its facts:

"'This is not a case where plaintiff's affidavit explains or adds to his deposition; neither does he claim that he was confused at the time of his deposition. Plaintiff's affidavit directly conflicts with his deposition testimony. He made no attempt to explain this inconsistency.' 53 Or App at 585.

"We explained further in a footnote:

"'Not all discrepancies contained in an affidavit justify a court's refusal to give credence to such evidence. *Our decision is limited to the facts of this and similar cases, where the two statements are clearly inconsistent and no attempt is made to explain the inconsistency.*' 53 Or App at 585 n 6.(Citations omitted; emphasis supplied.)

"In this case, plaintiff did offer an explanation for the inconsistency between her deposition testimony and the assertions made in her affidavit." 95 Or App at 119.

See also Georges v. Severson, 94 Or App 41, 764 P2d 586 (1988).

Similarly, here, plaintiff's deposition does offer an explanation for the inconsistency. Plaintiff stated that his earlier recollection of June, July or August as the time of discovery was corrected by his seeing in the chart notes that he did not consult Petrusek until November. Inferentially, his point is that he now recalls discovering the condition at or around the time that he saw Petrusek and that his prior remembrance of an earlier date was wrong.

Defendant argues, in essence, that plaintiff's explanation is unbelievable and a "sham." Defendant points out, in particular, that plaintiff told the claims agent in the interview that he had seen Petrusek in November, 1985. Therefore, his later reading of Petrusek's note could not have changed any recollections that he had at the time of the interview. Defendant analogizes the situation to *Clapp v. Oregonian Publishing Company, supra*, where we said:

> "In his deposition plaintiff did not at first unequivocally deny conversations with defendant's employes, and his affidavit contains a claim that he was confused when he gave the relevant deposition testimony. The claim of confusion has no factual predicate. The deposition questions were clear and understandable. In any event, plaintiff finally did unequivocally state that his belief that his dealership would be renewed was not based on anything defendant had told him. Plaintiff's affidavit does not create a genuine issue of fact when the deposition testimony reflects no confusion. The trial court properly granted summary judgment for defendant on this claim. Plaintiff's argument that the trial court's decision to disregard the affidavit constitutes a determination of fact is without merit. Plaintiff confuses credibility issues with the court's duty to ignore sham issues in determining the appropriateness of a summary judgment." 83 Or App at 580. (Citations omitted.)

We now disapprove that idea. The line between credibility questions and "sham" assertions of facts is non-existent. Credibility questions are for the fact finder; they are not for the court to resolve in dealing with contradictory evidence in a summary judgment setting. As stated in *Henderson-Rubio v. May Dept. Stores, supra*, 53 Or App at 585, the rule is that a later sworn statement cannot create a question of fact by contradicting an earlier one on a factual issue if the inconsistency is not explained or if there was no confusion at the time of the earlier statement. When there is an explanation or a protestation of confusion, it is not within the province of the trial court or us to disbelieve it for purposes of a summary judgment motion. There is no reason why contradictory evidence from the same party or witness is less capable than inconsistent evidence from separate sources to create a disputed fact question. It is the fact finder's role to decide which is true.

For the same reason, we reject defendant's argument that the deposition itself shows that plaintiff discovered his condition, at the latest, when he saw Kubler in October, 1985. That evidence may be in conflict with plaintiff's statements in the deposition that he first discovered his hearing problems on November 5 or 6, when he could not hear the telephone ring, or when he consulted Petrusek on November 7. Assuming that there is a conflict, it also is for the trier of fact to resolve. Plaintiff's deposition raises genuine issues of material fact as to when the discovery of his condition occurred, and the court erred by granting summary judgment. *See McCoy v. Union Pacific Railroad Co., supra*, 102 Or App at 624.

Plaintiff also argues that the court erred by rejecting his theory that the limitations issue--and possibly the liability issue--in this case is subject to the "negligent assignment" doctrine. *See McCoy v. Union Pacific Railroad Co., supra*, 102 Or App at 627, and authorities there cited. Because the issue may arise on remand, we address it. Plaintiff's argument is adversely answered by *McCoy*, 102 Or App at 627.

Reversed and remanded.

Cite as 106 Or App 654 (1991) April 17, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Non-complying Status of Gary-Adams-Trucking.

RALPH B. **WISE**, Petitioner,
v.
GARY-ADAMS-TRUCKING and SAIF CORPORATION, Respondents.
(WCB 89-11090; CA A62765)

Judicial Review from Director of Insurance and Finance.
Argued and submitted October 24, 1990.
James L. Edmunson, Eugene, argued the cause and filed the brief for petitioner.
Denise S. Frisbee and Bryant, Emerson & Fitch, Redmond, filed the brief for respondent Gary-Adams-Trucking.
David L. Runner, Assistant Attorney General, Salem, argued the cause for respondent SAIF Corporation. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P.J.
Affirmed.

Claimant seeks review of a final order of the Director of the Department of Insurance and Finance, issued pursuant to ORS 656.740(3), dismissing employer's request for review of the Director's proposed order that employer is a non-complying employer. Claimant contends that the Director erred by denying him attorney fees. We affirm.

Claimant was injured while working for employer. The Director issued a proposed order holding that employer had not complied with the workers' compensation laws. ORS 656.740(1). Employer requested review, ORS 656.740(3), and a hearing was set, but neither employer nor his counsel appeared. Claimant appeared with his attorney and was examined by counsel for the Director. Employer's counsel sent a letter the next day to the referee apologizing for not appearing and stating that employer's request for hearing had been withdrawn. The referee issued an order dismissing the request for review, which became a final order of the Director. ORS 656.740(3). Claimant requested attorney fees pursuant to ORS 656.382(2). The referee denied the request.

We express no opinion about whether ORS 656.382(2) authorizes attorney fees for a claimant for participation in a hearing regarding a noncomplying employer pursuant to ORS 656.740(3). The Director did not make a decision on the merits, so there is no predicate for an award of attorney fees under ORS 656.382(2), even if that statute otherwise authorizes them. *Terlouw v. Jesuit Seminary*, 101 Or App 493, 790 P2d 1215, rev den 310 Or 282 (1990); *Liberty Northwest Ins. Corp. v. McKellips*, 100 Or App 549, 786 P2d 1321 (1990); *Agripac, Inc. v. Kitchel*, 73 Or App 132, 698 P2d 69 (1985).

Affirmed.

Cite as 106 Or App 670 (1991) April 17, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Denise Kupetz, Claimant.
AETNA CASUALTY COMPANY and FIRST SECURITY REALTY, Petitioners,
v.
DENISE **KUPETZ**, Respondent.
(WCB No. 88-02897; CA A60868)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 17, 1990.
Allen W. Lyons, Portland, argued the cause for petitioners. With him on the briefs was Scheminske & Lyons, Portland.
Karen M. Werner, Eugene, argued the cause and filed the brief for respondent.
Before Richardson, Presiding Judge, and Newman and Deits, Judges.
NEWMAN, J.
Affirmed.
Deits, J. dissenting.

Employer seeks review of a Workers' Compensation Board order that adopted and affirmed the referee's order allowing claimant's claim. We affirm.

The referee made these findings:

"Claimant has had temporomandibular joint [(TMJ)] problems since 1979. She had surgery for this problem in July 1982 and again in April 1984.

"Claimant worked as a loan officer for the employer [First Security Realty] for about three and a half years. As part of her work, she inspected homes under construction, especially those homes in the Hillsboro area near her home. She often inspected the homes in Hillsboro on her way to or from work. Occasionally, claimant worked on Sundays, her scheduled day off work, but she did not work Saturdays because she was a Seventh Day Adventist and it was against her religion to work from sundown on Friday to sundown on Saturday. When she inspected homes, she usually filled out an inspection sheet. She might also inspect a home after the loan money was dispersed [sic] to see if the homes were marketable and there was no vandalism.

"In early October 1984, claimant worked on an account for a contractor named Mr. Bracco. He was unreliable and claimant's employer was particularly careful about seeing that he had performed his work in order to protect their loan.

"On October 5, 1984, in the morning, on her way to work, claimant inspected one of Mr. Bracco's houses in a development within a mile of claimant's home. Mr. Bracco was not there. Although Mr. Bracco had not hung two cabinets and two closet doors, plumber one toilet, installed a wall heater or completed the finished grading, she completed an in-house inspection record that indicated that the work was 100 percent completed. Completion of this form authorized payment of the loan balance.

"Mr. Bracco brought in a request for withdrawal of contract funds to claimant's office on the afternoon of October 5, 1984. Claimant's supervisor approved the draw because the inspection card indicated that the work was

complete, but claimant did not issue the check for the balance of the loan account on October 5, 1984, because the items not listed on the inspection record were not done. She informed Mr. Bracco that he needed to complete the items before payment.

"On Sunday, October 7, 1984, claimant and her husband rode their bikes from their house to the construction project. Claimant briefly looked at another home that had been completed and then rode to the Bracco house to see if the contractor had completed the tasks that had not been done on October 5, 1984. Claimant went in the house and checked on the contractor's work. She then got on her bike and fell on loose gravel, injuring her jaw, elbow, nose and knee.

"On October 7, 1984, claimant called a co-employee and told her that she had injured herself when she fell off a bike. She told her supervisor and other employees about her injury from falling from a bike on Monday October 8, 1984. She did not tell anyone that the injury occurred while she [was] on a bike trip to inspect a contractor's home, that she had inspected the Bracco home on the weekend or that her injury was in any way connected to her job. Claimant regularly received extra pay for overtime work, but did not request payment for her inspection on October 7, 1984.

"As a result of claimant's October 7, 1984 accident, she had additional TMJ problems. She told her physician about injuring her jaw in a bike accident, but did not mention the location of the accident or indicate that the accident occurred while she was inspecting a home for her job. She had another surgery in November 1984. She had difficulty getting Blue Cross to cover her medical expenses, because she had enrolled for the insurance during a non-open enrollment period as a result of her husband's loss of job insurance. She aggressively pursued coverage of her TMJ medical bills by Blue Cross.

"Claimant left her employment with the employer's predecessor in February 1987. She worked at another company until May 1987, when she quit because of a personality conflict with her boss. She had additional TMJ surgery in August 1987. She has continued to have problems and need treatment for her jaw.

"Sometime in November 1987, claimant spoke with her attorney on another matter and he suggested she file a Workers' Compensation claim. Claimant filed an 801 form on December 24, 1987. On January 21, 1988, the insurer denied claimant's claim on the ground that her injury did not occur on the job and the medical evidence indicated that she had a pre-existing condition.

"The only medical evidence in this case, provided after the denial was issued, has linked claimant's TMJ problems after October 1984 to her October 7, 1984 bike accident."

The referee found that claimant and her husband were credible. He concluded that claimant's injury arose in the course and scope of her employment, because the bicycle accident occurred when she was leaving the Bracco house after she had inspected it on October 7, 1984. He concluded that there was no question about medical causation, because the only medical evidence in this record--that of claimant's treating physician and a consulting physician--showed that claimant's TMJ problems after October, 1984, were linked

to the bike accident that occurred on October 7. The referee also concluded that employer had failed to prove that it was prejudiced by the late filing. The Board affirmed and adopted the order of the referee. It also stated that it agreed that insurer had failed to establish prejudice as a result of claimant's late filing.[1]

Employer assigns as error the Board's determination that employer did not establish that claimant's late filing actually prejudiced it. We will affirm if that finding is reasonable on the whole record and, therefore, is supported by substantial evidence. *Garcia v. Boise Cascade Corp.*, 309 Or 292, 787 P2d 884 (1990).[2] ORS 656.265(1) requires that a claimant give an employer notice of an accident resulting in an injury within 30 days. ORS 656.265(4) provides:

> "Failure to give notice as required by this section bars a claim under ORS 656.001 to 656.794 unless:
>
> "(a) The employer had knowledge of the injury or death, or the insurer or self-insured employer has not been prejudiced by failure to receive the notice."

The burden is on the employer to prove prejudice. *Inkley v. Forest Fiber Products Co.*, 288 Or 337, 348, 605 P2d 1175 (1980). Passage of time alone is not sufficient to establish prejudice; the employer must show actual prejudice. *Argonaut Ins. Co. v. Mock*, 95 Or App 1, 6, 768 P2d 401, rev den 308 Or 79 (1989). It must offer facts, not merely conclusory statements or speculation, to make its showing. *Nat. Farm. Ins. v. Scofield*, 57 Or App 23, 26, 643 P2d 1290 (1982).

It is important to identify precisely in what way employer asserts that it was actually prejudiced. It argues that it was hampered in its ability to investigate the case to determine whether the accident was work-related, because two co-employees testified that they could not remember whether claimant had told them that the accident occurred at the job site but they did not think that she had, and claimant's supervisor could not remember what she had told them.

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[1] Employer assigns as error that the Board affirmed the referee's order without opinion and, therefore, failed to set forth findings or a reasoned explanation to support its conclusion. The Board's order, however, is adequate for review. When the Board affirms the referee, it is not required to write its own findings and conclusions; it may adopt those of the referee. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988).

[2] In Garcia, the Supreme Court said:

> "If a finding is reasonable in light of countervailing as well as supporting evidence, the finding is supported by substantial evidence. *See Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206, 752 P2d 312 (1988).
>
> "Here, the Court of Appeals did not evaluate all the evidence to determine whether a reasonable person could have made the findings that the referee and the Board made on the evidentiary record. Instead, the court concluded that certain evidence supported findings different from those reached by the referee and that the referee (and the Board) thus erred. The Court of Appeals effectively has substituted its view of the evidence, contrary to ORS 183.482(8)(c). That was an incorrect application of the substantial evidence standard of review." 309 Or at 295.

The Board made findings concerning what claimant told her co-employees on October 7 and 8, 1984, about her injury of October 7. It found that she did *not* tell them that the accident occurred on the job. Employer does not challenge that finding. Indeed, two co-employees, employer's witnesses, testified consistently with claimant's testimony that she had not told them where she was injured or that the accident occurred while she was inspecting the house. What employer seems to suggest is that what the other co-employees forgot, and would have testified to if they could have remembered it, is that claimant told them that the bike accident had *not* occurred on the job. That is pure speculation. On this record, the Board could reasonably conclude that employer did not show that it was prejudiced by the failure of some co-employees to recall what claimant had said about the accident.

Although the documentation showed that claimant certified the house as 100 percent complete on Friday, October 5, she plausibly explained why she inspected the house again on Sunday, October 7. She testified that, on October 5, there were some house details still to be completed. Her supervisor corroborated claimant's testimony in part when he testified that houses sometimes were certified as 100 percent complete when details still remained unfinished. Moreover, employer does not challenge the Board's finding that some details of the house were still unfinished after claimant had certified it as complete, that the account with the building contractor was a problem account and that claimant issued the check after the certification in order to induce the contractor to complete the building. Employer also does not challenge the Board's finding that claimant did not issue the check on October 5 because certain work was unfinished. The builder, Bracco, could have confirmed or disputed parts of claimant's testimony, but employer made no effort to locate Bracco or to establish that he could not be located or be produced as a witness.

The documentation also showed that claimant had not claimed overtime for the inspection on October 7, although it was her usual practice to claim overtime for such inspections. Claimant does not dispute the showing in the documentation that she did not claim overtime. She testified, however, that, at times, rather than report overtime, she took compensatory time for overtime work. Her supervisor corroborated that testimony. Claimant explained the seeming discrepancies between her version of events and the documentary evidence. The Board could rationally conclude that the available documentation did not add significant weight to the lack of recollection of some of her co-employees.

In sum, if claimant had filed her claim within 30 days after the accident and had testified credibly to the same effect as she did here, employer would have been left with only the same impeaching factors that the Board could reasonably find were inadequate to show actual prejudice: that she certified the house as 100 percent complete, that she did not file a claim for overtime and that she did not tell anyone that she fell when she was inspecting the house. Essentially, therefore, employer is asserting that claimant is not credible. The referee and the Board, however, found that claimant and her husband are credible. The finding of credibility is, of course, central. The referee observed their demeanors, and the credibility finding is based, at least in part, on those observations. Claimant's testimony was plausible and internally consistent and was corroborated in part by her supervisor. Moreover, the issuance of the check to the builder on Monday, October 7, is consistent with her testimony. The Board's finding that claimant and her husband were credible binds us.

Employer also argues that the three-year delay impaired its ability to ascertain the extent of claimant's injury and its relationship to a preexisting condition. It asserts that the faded memories of other employees hampered it from obtaining information about claimant's medical history. The basis of that

assertion is that two employees, who work in the payroll department, testified that claimant had had some coverage problems with Blue Cross, the company's insurer. Neither witness could recall whether the problems were due to claimant's preexisting TMJ condition or some other cause. Both testified that they had no access now to the records of the earlier claim and that First Security Realty, employer, was now a different entity.

It is immaterial, however, that certain employees did not have access to claimant's records and that their memories had faded, because employer had access. It submitted as part of the record claimant's Blue Cross claim form for her surgery after the accident. Furthermore, claimant's complete medical history, dating back to 1980, including her treatment for TMJ before the accident, is part of the record.

Employer also argues that it was prejudiced by its inability to obtain a timely medical examination contemporaneous with the accident, because claimant had preexisting TMJ problems and it was also possible that intervening or nonemployment causes contributed to her condition after the bike accident.

Employer put nothing in the record, however, to establish how failure to obtain a contemporaneous examination prejudiced it. Claimant's treating physician and a consulting physician said that her injury on October 7 was the sole and major contributing cause of her subsequent medical problems. Employer does not assert that the diagnoses were in any way inaccurate or that a physician of employer's choosing would have interpreted the data differently. The Board found:

> "The only medical evidence in this case, provided after the denial was issued, has linked claimant's TMJ problems *after* October 1984 to her October 7, 1984 bike accident." (Emphasis supplied.)

Employer never asked for a medical examination or for a physician of its own choosing to review claimant's records, and it offered no expert opinion on the impact of a new jaw injury on her preexisting TMJ condition. Employer offered *no* evidence that supports its assertion that it was prejudiced because it could not obtain a medical examination shortly after the accident.

In the light of the whole record, including both the supporting and the countervailing evidence, the Board's finding that employer failed to show actual prejudice was reasonable. See Garcia v. Boise Cascade Corp., supra.

Affirmed.

DEITS, J., dissenting.

The majority holds that the Board did not err in concluding that employer was not prejudiced by claimant's three year delay in filing her claim for workers' compensation. I disagree.

As the majority correctly points out, the claim here is not barred if employer has not been prejudiced by the failure to receive timely notice of the claim. ORS 656.265(4). The burden to prove that the delay has caused prejudice is on employer, and mere passage of time is not sufficient to meet that burden. Argonaut Ins. Co. v. Mock, 95 Or App 1, 768 P2d 401, rev den 308 Or 79 (1989). However, employer did more than that here. As we stated in Argonaut, 95 Or App at 6, "the passage of time may have an impact on the ability to make a timely investigation or to seek current medical treatment and examinations." That is exactly what employer asserts occurred here.

One of the issues in the case was whether claimant was inspecting a house at the time of the bicycle accident and was, therefore, acting within the scope of her employment. Four of claimant's co-workers and a former supervisor were witnesses at the hearing. Employer called three of those witnesses. They were asked whether claimant had told them at the time of the accident that she had injured herself while on the job. Two co-workers testified that they spoke with her the next day. They could not remember the details of their conversations, but recalled that she had not said that it happened on a job site. Another co-worker talked on the telephone with claimant on the afternoon of the accident, and she could not recall if claimant said where or what they were doing. Her supervisor testified that he could not remember anything about the specifics of her accident because it had occurred almost four years before the hearing. Her co-workers' lack of recollection is particularly significant because, although it was claimant's usual practice to claim overtime for such inspections, the records showed that she had claimed no overtime for this work. Further, the documentation that was available concerning the house that claimant allegedly inspected showed that the house had been inspected in August and had been approved as complete two days before the October accident.[1]

The majority concludes that claimant offered a credible explanation for the inconsistencies in the records and, therefore, that employer was not prejudiced by the witnesses' inability to remember conversations that had occurred three years before the hearing. The point is, however, that we cannot know how the witnesses would have testified, had they been able to remember what was said at the time or what employer might have been able to discover if it had been able to conduct a timely investigation. The witnesses might have provided evidence that undermined claimant's credibility. It is these gaps in the witnesses' memories that prejudiced employer. Claimant's failure to file the claim until over three years after the accident interfered with employer's ability to determine whether the accident occurred in the course of her employment.

An additional issue at the hearing was the extent of claimant's injury and its relationship to a preexisting condition. Two of the witnesses had been responsible for payroll functions. They testified that claimant had filed a claim for her preexisting condition and had had some problems with the company's insurer, but they did not recall the details of the problems. They both stated that First Security, employer then, was a different entity now and that they now had no access to the records of the earlier claim. Although it is correct, as the majority points out, that many of claimant's past medical and insurance records are in the record, what is absent is the recollection of these co-employees as to the nature of claimant's problems that claimant had in obtaining medical coverage. One of the co-employees testified that she could not remember the problems that claimant had in obtaining coverage for her TMJ before the accident, but that it may have been that the insurer excluded TMJ or that coverage was not available because the condition was preexisting. Again, this information may have undermined claimant's credibility and may have been pertinent to determining the relationship of claimant's preexisting TMJ condition and the bike accident.

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[1] The majority contends that employer was not diligent in pursuing all of the witnesses that it could because it did not call Bracco, the builder. However, the failure to call Bracco does not necessarily reflect a lack of diligence. His testimony was only necessary to rebut claimant's theory, raised for the first time at the hearing, that she was holding funds "over his head" to ensure that he had completed the house before giving him a check.

Further, because of the delay in filing the claim, employer was unable to obtain its own medical examination contemporaneous with the accident. The majority concludes that this makes no difference, because claimant's physicians who examined and treated claimant concluded that, even though she had preexisting TMJ problems, all her jaw problems that developed after the bike accident were caused by the accident.

However, no one examined claimant at the time of the accident for the purpose of distinguishing the injury and its associated problems from the preexisting TMJ. Any examination made now likely would not reveal the effect, if any, of the preexisting condition. When a long-term condition is treated shortly before an injury and the same condition appears after the injury, it should not require medical testimony to show prejudice by the lack of a timely examination. Employer's inability to have claimant examined closer to the time of the accident seriously interfered with its ability to determine the relationship between her preexisting TMJ problems and her TMJ problems following the accident.

If, after reviewing all the evidence in the record, the Board's findings are "reasonable in light of countervailing as well as supporting evidence" in the record, then its findings are supported by substantial evidence. *Garcia v. Boise Cascade Corp.*, 309 Or 292, 787 P2d 884 (1990). Here, there was substantial countervailing evidence that, because of the delay in filing, employer was prevented from conducting a meaningful investigation of the claim and fully developing its case. The Board's conclusion that employer failed to establish that it was prejudiced is not reasonable in the light of countervailing, as well as supporting, evidence.

I would hold that employer did show that the passage of time seriously impeded its ability to investigate this claim and that it was prejudiced by claimant's delay. Accordingly, I dissent.

Cite as 106 Or App 687 (1991) April 17, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Edward D. Lucas, Claimant.

EDWARD D. **LUCAS**, Petitioner,
v.
DONALD H. **CLARK** and SAIF CORP., Respondents.
(WCB 85-09631; A63321)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 28, 1990.
James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Christopher D. Moore and Malagon, Moore & Johnson, Eugene.
David L. Runner, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.
Reversed and remanded for reconsideration.
Edmonds, J., dissenting.

Claimant seeks review of an order of the Workers' Compensation Board affirming the referee and denying claimant's aggravation claim.

Claimant suffered a compensable back and bilateral leg injury in April, 1977. In March, 1980, he received an award of 50 percent unscheduled permanent disability for his back, 30 percent scheduled permanent disability for his right leg and 15 percent scheduled permanent disability for his left leg. In April, 1981, he received temporary disability compensation for a protruded disc, which was surgically repaired in July, 1980. In April, 1982, his right leg disability award was increased to 50 percent. In November, 1982, March and November, 1983, and April, 1984, he experienced symptomatic flare-ups of his back and leg symptoms, which resulted in periods of total disability totalling at least 60 days.

In May, 1984, claimant raised multiple issues regarding aggravation claims, and on August 23, 1984, the parties stipulated to a settlement on these terms:

> "1. Since the last award or arrangement of compensation on his April 1977 claim, claimant has suffered a worsened compensable condition which became medically stationary before this hearing, and
>
> he shall be paid, for increased permanent disability in his right leg, an additional award of compensation equal to 15 degrees, 10 percent of the maximum for loss of use and function of a leg, thereby increasing the scheduled award for claimant's right-leg disability to a total of 60 percent of the maximum.
>
> "* * * * *
>
> "3. As a disputed-claim settlement of any and all other aggravation claims which have been or may be alleged for any time up to the date of this hearing, SAIF agrees to pay claimant the total amount of $500."

After the settlement, claimant experienced another symptomatic flare-up of his back condition in January, 1985, and filed this claim for aggravation of his 1977 injury. SAIF denied the claim, and the referee upheld the denial. On review, the Board affirmed the referee and made these findings of ultimate fact regarding claimant's mid-back symptoms:

> "Claimant's alleged aggravation in 1985 resulted in a symptomatic exacerbation, rather than a pathological exacerbation, of his mid back condition. That mid back exacerbation rendered him less able to work than at the time of the August 1984 Stipulated Order. That stipulation contemplated future periods of waxing and waning mid back symptoms resulting in periods of temporary total disability. The additional diminished earning capacity claimant experienced as a result of the mid back exacerbation did not exceed that contemplated by the August 1984 Stipulated Order in either degree or duration. Claimant's mid back exacerbation in 1985 did not result in total disability for more than 14 consecutive days."

The Board assumed that the parties had considered medical documentation of the earlier symptomatic back flare-ups and that, in the light of those flare-ups, future exacerbations were anticipated. It concluded, therefore, that the 1984 stipulation contemplated future periods of increased back symptoms accompanied by diminished earning capacity. The Board then concluded that claimant had not met his burden of proving that his back condition exacerbation and the resulting loss of earning capacity were greater than anticipated. We review for errors of law and for substantial evidence on factual issues. ORS 656.298(6); ORS 183.482(7), (8).

An aggravation claim must be based on worsened conditions since the last award or arrangement of compensation. ORS 656.273(1). A worsened condition occurs when the claimant's physical condition or symptoms become exacerbated and cause increased disability or diminished earning capacity. *Perry v. SAIF*, 307 Or 654, 657, 772 P2d 418 (1989). If the last award or arrangement of compensation included consideration of anticipated future exacerbations of the condition or symptoms, the claimant must prove that the worsening has been greater than was anticipated. *Gwynn v. SAIF*, 304 Or 345, 352-353, 745 P2d 775 (1987). Since *Gwynn*, we have said repeatedly that, if there was medical evidence of the possibility of future flare-ups, the assumption is that the parties considered that evidence, unless there are indications to the contrary. *International Paper Co. v. Turner*, 91 Or App 91, 754 P2d 589, rev den 307 Or 101 (1988); *Gwynn v. SAIF*, 91 Or App 84, 754 P2d 586 (1988); *Mathis v. Modoc Lumber Company*, 91 Or App 67, 754 P2d 589, rev den 306 Or 195 (1988).

There was no substantial evidence to support the Board's finding that the parties contemplated future flare-ups in reaching their settlement. Although several flare-ups had occurred before August, 1984, the stipulated order made no reference to the prognosis for claimant's back condition and made no additional award for that condition. Furthermore, until 1985, the record is clear that no doctor had predicted future or chronic flare-ups of the back condition. Obviously, the 1985 medical evidence regarding the possibility of future flare-ups was not available when the parties agreed to the stipulated order in 1984. Therefore, we remand to the Board for reconsideration in light of this determination.

Reversed and remanded for reconsideration.

EDMONDS, J., dissenting.

The majority holds that there is not substantial evidence in the record to support the Board's finding that, in reaching a settlement in 1984, the parties contemplated future flare-ups of claimant's back condition. In *Van Woesik v. Pacific Coca-Cola Co.*, 93 Or App 627, 629, 763 P2d 735, rev den 307 Or 571 (1988), we said:

> "The first issue on remand is whether the last arrangement of compensation, a stipulated agreement dated February 3, 1983, contemplated that claimant would have periodic symptomatic flareups [sic] of his underlying condition. See *Gwynn v. SAIF*, [304 Or 345, 745 P2d 775 (1987)]. The language of the agreement is silent on that question. We recently addressed a similar issue in *Mathis v. Modoc Lumber Company*, 91 Or App 67, 754 P2d 590, rev den 306 Or 195 (1988), and determined that, on the basis of medical evidence existing at the time of the stipulation, the permanent nature of the claimant's injury created a probability that disabling symptoms would come and go and that the stipulation contemplated future flareups [sic]. Similar reasoning is applicable here. Claimant's back condition is permanent and the medical evidence at the time of the stipulation showed that it was likely that claimant would continue to experience a waxing and waning of his pain symptoms. In October, 1982, for example, Dr. Renholds examined claimant and predicted that he would have episodes of increased symptoms requiring periods of physical therapy. We conclude that the parties contemplated periodic flareups [sic] at the time of the stipulation."

Here, the Board found:

> "The record contains medical reports documenting symptomatic mid back flare-ups in November 1982, March 1983, November 1983 and April 1984. The latter three exacerbations resulted in periods of total disability. There is nothing in the record to indicate that the parties did not consider medical documentation of these flare-ups when they entered into the August 1984 Stipulated Order. *Furthermore, in light of these prior exacerbations, future disabling mid back flare-ups were anticipated.* Accordingly we conclude that the August 1984 Stipulated Order contemplated future periods of increased mid back symptoms accompanied by diminished earning capacity." (Emphasis supplied.)

There is medical evidence that claimant's back symptoms preexisted the 1984 settlement. On April 3, 1981, November 4, 1982, February 3, 1983, March 3, 1983, April 9, 1984, and June 25, 1984, his back condition was characterized by medical examiners as "residual myelopathy."[1] The majority holds that, just because the settlement agreement made no reference to claimant's condition, the parties necessarily did not contemplate future flare-ups in reaching their agreement. That holding conflicts with the plain language of the agreement:

> "3. As a disputed-claim settlement of *any and all* other aggravation claims which have been or may be alleged for any time up to the date of this hearing, SAIF agrees to pay claimant the total amount of $500." (Emphasis supplied.)

The Board found on the basis of that language and the medical evidence, that there is a probability that the parties considered claimant's chronic back condition and its recurring symptoms in the settlement of his aggravation claims. There is substantial evidence to support the Board's findings on that issue and the majority errs in holding to the contrary.

I dissent.

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[1] The term "myelopathy" includes "[a]ny disease of the spinal cord." Stedman's Medical Dictionary 1045 (unabridged 2d lawyer's ed 1966).

Cite as 106 Or App 732 (1991) April 24, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Sidney H. Priest, Claimant.

SIDNEY H. **PRIEST**, Petitioner,
v.
CITY OF HERMISTON and LIBERTY NORTHWEST INSURANCE CORP., Respondents.
(87-12900; CA A63479)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 16, 1991.
Lawrence Baron, Portland, argued the cause for petitioner. On the brief were Robert K. Udziela, Dan O'Leary and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.
Jerald P. Keene, Portland, argued the cause for respondents. With him on the brief was Roberts, Reinisch, Mackenzie, Healey & Wilson, P.C., Portland.
Before Buttler, Presiding Judge, and Rossman and De Muniz,Judges.
BUTTLER, P.J.
Reversed; referee's order reinstated.

Claimant seeks review of a decision of the Workers' Compensation Board reversing the referee and holding that his claim for a low back injury is not compensable. Claimant has worked for employer for almost 26 years. He experienced compensable, nondisabling back strains in 1980 and 1982. On April 1, 1987, he felt pain in his back as he twisted while unloading a power trowel. He did not notify employer of that incident because he thought that the pain would resolve itself with time and exercise.

The pain became worse, and claimant finally went to Dr. Peterson, a chiropractor, for treatment. He did not tell Peterson about the April 1, 1987, incident. Peterson referred him to Dr. Howard, who performed a CAT scan and diagnosed a calcified herniated intervertebral disc. Howard referred claimant to Dr. Brett, who recommended immediate surgery.

Claimant had good results from the surgery. In June, 1987, after claimant learned of the results of his CAT scan, he filed a workers' compensation claim. The city recorder helped him fill out the claim form. On the form, claimant described the 1980 and 1982 injuries, but did not describe the 1987 incident. Claimant testified that he told the recorder about the 1987 incident but that they decided together not to mention it on the form, because they thought that claimant's condition had to be the result of the earlier injuries.

The 801 form that claimant completed and gave to employer had the name "Liberty Northwest Insurance Corporation" (Liberty) printed on it. Liberty had become employer's insurer on July 1, 1985. Claimant testified that he did not file a claim with employer's previous insurer, because he did not know that he was supposed to. Employer's pre-1985 insurers have never been joined in this proceeding and are not parties to this review.

On June 25, 1987, Liberty denied the claim, stating that it had "been unable to verify that your employment has caused or contributed to your current condition." The medical evidence is undisputed that claimant's employment with employer before 1985 is the cause of his back condition.

The referee found that, although claimant's failure to tell his treating doctors about the April, 1987, incident made it impossible to tell whether that incident had contributed to his condition requiring surgery, there was no

question but that claimant's condition was related to his employment. The referee held that the claim was compensable and, relying on *Runft v. SAIF*, 303 Or 493, 739 P2d 12 (1987), held that Liberty was responsible, because it had failed to join the insurance carriers that were on the risk before July, 1985. The Board reversed the referee, holding that, because claimant had failed to establish that an incident had occurred that had materially contributed to his condition while Liberty was on the risk, claimant had not shown that the claim was compensable as against Liberty.

The Board effectively treated claimant's employment after Liberty came on the risk as separate from his employment before that time. Thus, although claimant worked for a single employer during the entire period, the Board required that claimant establish a separate claim against Liberty.

We agree that, for purposes of assigning liability, the analysis has not distinguished between cases involving multiple employers and those involving multiple insurers. *See, e.g., Inkley v. Forest Fiber Products Co.*, 288 Or 337, 605 P2d 1175 (1980); 4 Larson, *Workman's Compensation*, Section 95 (1990). However, whether or not that failure to distinguish is sound, it has not been applied and would be of no help in the context of this injury claim, which was filed with the responsible employer. An injured worker has no reason to know, or even care, whether his employer has insurance or is self-insured, or whether the employer has had different insurers at different times. To assert a workers' compensation claim for an injury, the only requirement is that the worker file a claim with the employer. ORS 656.265 provides that "[n]otice of an accident resulting in an injury or death shall be given immediately by the worker or a dependent of the worker to the employer[.]" That statute requires the worker to notify the employer, not its insurer, of his injury.[1] The worker's claim is against his employer, not its insurer. ORS 656.005(6) defines a claim as "a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge." Claimant timely notified employer of his claim pursuant to the requirements of ORS 656.265. Accordingly, he satisfied his procedural obligation with respect to the filing of the claim.

Employers have the burden of processing a claim filed with them and forwarding necessary information to their insurer. ORS 656.262 provides, in part:

> "(3) Employers shall, immediately and not later than five days after notice or knowledge of any claims or accidents which may result in a compensable injury claim, report the same to their insurer. The report shall include:
> "(a) The date, time, cause and nature of the accident and injuries.
> "(b) Whether the accident arose out of and in the course of employment.
> "(c) Whether the employer recommends or opposes acceptance of the claim, and the reasons therefor.
> "(d) The name and address of any health insurance provider for the injured worker.
> "(e) Any other details the insurer may require."

It was employer's duty, not claimant's, to notify its insurer, which is responsible for processing the claim. Claimant's only remaining obligation was to establish the compensability of the claim, that is, its job-relatedness.

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[1] The requirement might be different for claims of occupational disease. ORS 656.807 provides, in part, that "[a]ll occupational disease claims shall be void unless a claim is filed with the insurer or self-insured employer[.]"

The Board correctly stated in its opinion that "[t]o establish a compensable accidental injury claim, claimant has the burden of proving that a work incident was a material contributing cause of his subsequent disability or need for treatment." Claimant had no obligation to show that an injury occurred while Liberty was on the risk. His obligation was to show that his present condition is related to his employment with employer. He has done that; even the Board's order reflects the fact that the injury is related to the work with employer.

The remaining question is whether, when Liberty sought to avoid responsibility for the claim, it had an obligation to join other potentially responsible insurers. Runft v. SAIF, supra. We conclude that it did. OAR 436-60-180, which, in substance, is the same rule discussed and relied on in Runft, provides, in part:

> "(2) Compliance shall designate by order which insurer shall pay a claim if the employers and insurers admit that the claim is otherwise compensable, and where there is an issue regarding:
> "* * * * *
> "(b) Which of more than one insurer of a certain employer is responsible for payment of compensation to a worker;
> "* * * * *
> "(4) Upon learning of any of the situations described in section (2), the insurer shall expedite the processing of the claim by immediately investigating the claim to determine responsibility and whether the claim is otherwise compensable.
> "(5) Upon learning of any of the situations described in section (2), the insurer shall immediately notify any other affected insurers of the situation. Such notice shall identify the compensable injury and include a copy of all medical reports and other information pertinent to the injury."

The record shows that, at the time that it denied the claim, Liberty was aware that claimant's condition was related to his employment and that, arguably, it was related to earlier injuries sustained while another insurer provided coverage. That, in substance, is the situation described in OAR 436-60-180(2)(b). Under subsection (5), Liberty had an obligation to notify the other potentially affected insurers. In Runft, the court held that the predecessor rule provided the basis for the requirement that, when an employer or insurer knows of the compensable claim and the potential dispute over responsibility, it must join the later, potentially responsible employer or insurer and that its failure to do so precludes it from relying on the last injurious exposure rule to avoid responsibility.

Liberty's argument that it lacks responsibility for the compensable injury is not based on the last injurious exposure rule, but on its contention that the injury related to events that occurred before its coverage became effective. Although the contention is different, the effect of allowing it would create the same situation that the court sought to avoid in Runft: The claimant who had established a compensable claim would go uncompensated, because the insurer of the employer against whom the claim had been filed neglected to carry out its responsibility under the administrative rule to join the potentially responsible insurers. We hold that Liberty, as the agent responsible for investigating and administering the claim and having knowledge of the potential dispute over responsibility, had an obligation to join other potentially responsible insurers and that its failure to do so prevents it from avoiding responsibility for the claim.

Reversed; referee's order reinstated.

Cite as 106 Or App 755 (1991) April 24, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Cissie L. St. Clair, Claimant and In the Matter of the Complying Status of Nugget Realty, Inc., dba Century 21 Nugget Realty, John P. Reaksecker, Individually, and Linda Williamson, Individually, Employer.

CITIZENS SAVINGS & LOAN and LIBERTY NORTHWEST INSURANCE CORPORATION, Petitioners,

v.

CISSIE L. **ST. CLAIR**, NUGGET REALTY, INC., dba Century 21 Nugget Realty, JOHN P. REAKSECKER, LINDA WILLIAMSON, and SAIF CORPORATION, Respondents.

(WCB Nos. 88-03192, 88-03193 & 88-05465; CA A65156)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 22, 1991.

David O. Wilson, Eugene, argued the cause for petitioners. With him on the brief was Employers Defense Counsel, Eugene.

James L. Edmunson, Eugene, argued the cause and filed the brief for respondent Cissie L. St. Clair.

Jeffrey E. Potter, argued the cause for respondents Nugget Realty, Inc., John P. Reaksecker and Linda Williamson. With him on the brief were Herb Lombard and Lombard, Gardner, Honsowetz, Brewer & Schons, Eugene.

Jerome Lidz, Assistant Attorney General, Salem, waived appearance for respondent SAIF Corporation.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

DE MUNIZ, J.

Affirmed.

Citizens Savings and Loan (Citizens) seeks review of a decision of the Workers' Compensation Board affirming the referee and holding that it must pay claimant benefits for her compensable injury.

The Board's findings are supported by substantial evidence. Citizens, a savings and loan association, contracted with Nugget Realty, Inc. (Nugget), a property management firm, to manage the Cottage Grove Hotel. Citizens had acquired the hotel by foreclosure or a deed in lieu of foreclosure and was not otherwise in the hotel business. Citizens directed Nugget to hire a resident manager for the hotel. Nugget advertised for a manager and, with Citizens' approval, hired claimant and her husband. They were provided with an apartment and $5.00 per hour for cleaning and maintenance work. Nugget directed claimant's activities. Nugget had to submit any proposals for repairs to the hotel to Citizens for approval. At Citizens' direction, Nugget established a bank account for the hotel, in which it deposited rental receipts and from which it paid claimant. Nugget provided Citizens with a monthly accounting of receipts and expenses.

Claimant was injured while carrying a sofa up a flight of stairs at the hotel. She filed a claim with both Nugget and Citizens. The Workers' Compensation Division determined that claimant was Nugget's employee and that Nugget was a noncomplying employer. It referred the claim to SAIF for processing, and SAIF accepted the claim as a disabling injury. Nugget requested a hearing on the issue of compliance only. It did not challenge the determination that claimant was its employee. Citizens also accepted the claim but three months later rescinded its acceptance. Claimant filed a request for hearing after the rescission, which was consolidated with Nugget's request for hearing.

Although the referee determined that Nugget was claimant's employer, it set aside Citizens' denial and found Citizens responsible for claimant's injury under ORS 656.029(1).[1]

Citizens appealed the referee's order. The Board affirmed the referee, reasoning that, having accepted the claim, Citizens could not properly deny it without establishing fraud, misrepresentation or other illegal activity by claimant. *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027 (1983). It determined that, because Citizens could not withdraw its acceptance, and SAIF's acceptance of the claim had not been challenged, the case was essentially in the status of a "responsibility" dispute. Apparently reasoning that claimant could not receive benefits from both employers, the Board determined that it needed to decide which of the two entities was "responsible" for the claim.

On the merits, the Board concluded that claimant was Citizens' employee. It found that, when Nugget hired claimant, it was acting as Citizens' agent and that, although Nugget directed claimant's day-to-day work activities, Citizens paid claimant and had the right to control her activities and to terminate her employment.

We affirm the Board's decision that Citizens could not deny the claim after having accepted it, Bauman v. SAIF, supra, and that it acted unreasonably in doing so. Additionally, we conclude that there is substantial evidence to support the Board's findings and that the Board could properly conclude that claimant was Citizens' employee. *See Liberty Northwest v. Church*, 106 Or App 477, ___ P2d ___ (1991).

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[1] ORS 656.029 provides, in part:

"(1) If a person awards a contract involving the performance of labor where such labor is a normal and customary part or process of the person's trade or business, the person awarding the contract is responsible for providing workers' compensation insurance coverage for all individuals, other than those exempt under ORS 656.027, who perform labor under the contract unless the person to whom the contract is awarded provides such coverage for those individuals before labor under the contract commences. If the individual who performs labor under the contract incurs a compensable injury, and no workers' compensation insurance coverage is provided for that individual by the person who is charged with the responsibility for providing such coverage before labor under the contract commences, that person shall be treated as a noncomplying employer and benefits shall be paid to the injured worker in the manner provided in ORS 656.001 to 656.794 for the payment of benefits to the worker of a noncomplying employer.

"(2) If a person to whom the contract is awarded is exempt from coverage under ORS 656.027, and that person engages individuals who are not exempt under ORS 656.027 in the performance of the contract, that person shall provide workers' compensation insurance coverage for all such individuals. If an individual who performs labor under the contract incurs a compensable injury, and no workers' compensation insurance coverage is provided for that individual by the person to whom the contract is awarded, that person shall be treated a a noncomplying employer and benefits shall be paid to the injured worker in the manner provided in ORS 656.001 to 656.794 for the payment of benefits to the worker of a noncomplying employer."

Citizens contends, however, that, because the referee found that Nugget was claimant's employer and Nugget did not contest that determination, the finding is conclusive and precludes the Board from finding that Citizens was claimant's employer. The issue before the referee and the Board concerned which of the two entities was obligated to pay claimant benefits. Although Nugget did not appeal the referee's decision, Citizens did, and it thereby brought to issue all questions related to its obligation to pay benefits, including whether claimant was Nugget's or Citizens' employee.[2] The Board did not err in deciding the issue.

Affirmed.

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[2] In view of our determination affirming the Board'ss holding that claimant is Citizens' employee, Citizens' argument that Nugget engaged claimant in the performance of its contract with Citizens, and is therefore responsible pursuant to the provisions of ORS 656.029(2), is moot.

Cite as 107 Or App 22 (1991) May 1, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Sharon S. Rager, Claimant.

SHARON S. **RAGER**, Petitioner,
v.
EBI COMPANIES and LINCOLN COUNTY SCHOOL DISTRICT, Respondents.
(WCB 85-11532; CA A60485)

Judicial Review from Workers' Compensation Board.
On petitioner's petition for reconsideration filed November 14, 1990. Opinion filed July 18, 1990. 102 Or App 457, 795 P2d 573.
Martin J. McKeown and Martin J. McKeown, P.C., Eugene, for petition.
Before Richardson, Presiding Judge, and Newman and Deits, Judges.
NEWMAN, J.
Reconsideration allowed; opinion modified and adhered to as modified.

Claimant has filed a petition for review ofour decision, 102 Or App 457, 795 P2d 573 (1990), which we treat as a petition for reconsideration. ORAP 9.15(1). In the opinion, we affirmed the Workers' Compensation Board's denial of compensability of a home whirlpool unit. Claimant asserts that the opinion failed to address her assignment of error concerning *former* OAR 436-10-040(7).

We allow reconsideration, withdraw the last two full paragraphs of the opinion, 102 Or App at 462, and replace them with these three paragraphs and a note:

Claimant also assigns as error that the Board relied on *former* OAR 436-10-040(7). She argues that the director exceeded his delegated authority when he promulgated the rule, which elaborated on the definition of 'medical services' in ORS 656.245(1):

> "Furniture is not a medical service. Articles such as beds, hot tubs, chairs, jacuzzis, and gravity traction devices are not compensable unless a need is clearly justified by a report which establishes that the "nature of the injury or the process of recovery requires" that the item be furnished. The report must set forth with particularity why the patient requires an item not usually

considered necessary in the great majority of workers with similar impairments * * *."

Claimant argues that the rule gives "medical services" too narrow an interpretation and is contrary to the statute.

ORS 656.726(3)(a) delegates authority to the director to "[m]ake and declare all rules which are reasonably required in the performance of the director's duties." *Former* OAR 436-10-040(7) does not exclude articles such as home whirlpools from "medical services" under ORS 656.245(1) if the need for them is "clearly justified." That requirement does not conflict with ORS 656.245(1). It does not preclude provision of home whirlpools or other "furniture"; it establishes a reasonable standard for approving them.

Claimant also asserts that the rule's requirement that she show her need for a whirlpool unit with "particularity" impinges on her right, under ORS 656.012, to prompt and complete medical treatment.[1] The particularity requirement does not conflict with ORS 656.012; it is reasonably related to the legislative objective of fair and just administration of the system. The director did not exceed his authority in promulgating the rule.

Reconsideration allowed; opinion modified and adhered to as modified.

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[1] ORS 656.012(2)(a) and (b) describe legislative objectives of the workers' compensation system:

"(a) To provide, regardless of fault, sure, prompt and complete medical treatment for injured workers and fair, adequate and reasonable income benefits to injured workers and their dependents;

"(b) To provide a fair and just administrative system for delivery of medical and financial benefits to injured workers that reduces litigation and eliminates the adversary nature of the compensation proceedings, to the greatest extent practicable * * *."

Cite as 107 Or App 30 (1991) May 1, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Claude E. Over, Claimant.

LIBERTY NORTHWEST INSURANCE CORP. and LAKESIDE INDUSTRIES, Petitioners,
v.
CLAUDE E. **OVER**, Respondent.
(88-06603; CA A63863)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 21, 1990.
Stafford J. Hazelett, Portland, argued the cause and filed the brief for petitioners.
Quintin B. Estell, Salem, argued the cause and filed the brief for respondent.
Before Richardson, Presiding Judge, and Newman and Deits, Judges.
NEWMAN, J.
Affirmed.

Employer seeks review of an order of the Workers' Compensation Board that reversed the referee and allowed claimant's injury claim. We affirm.

The Board made findings of fact:

> "Claimant is a heavy equipment operator for the employer, a paving company. The job requires claimant to work on various construction projects. He travels from his home to each day's project by his private automobile. Claimant carries special tools and safety equipment used on the job in his automobile. Approximately one to two times per week, the crew, including claimant, must leave one job site and travel to a different job site. *The employer does not provide transportation between job sites.* Claimant travels between job sites in his private automobile. The other crew members do the same. The employer pays claimant mileage for travel between job sites. On February 22, 1988, claimant left home in his private automobile to travel to a job site in Tigard. He was involved in a motor vehicle [accident] and was injured." (Emphasis supplied.)

The Board also found as an "ultimate fact" that "the employer implicitly required claimant to supply his automobile as transportation between job sites." It concluded that claimant suffered the injury in the course of his employment.

Employer assigns as error the Board's finding that employer does not provide transportation between job sites. It urges that that finding is not supported by substantial evidence. There is evidence, however, that crew members drove directly from home to work sites to perform their work; that, depending on the size of the project, employees may not have known before leaving home in the morning whether they would change work sites during the day; that at least once each week they would finish work at one site before the workday was over and would be required to move to another site; that the only vehicle of employer that could have transported workers between sites was a pickup truck that could not carry a full crew of at least five; that workers used their own cars to travel between work sites; and that employer reimbursed employees for mileage when they used their own cars to travel between work sites. There was no evidence that the employer's pickup truck was ever used to transport workers between work sites. Substantial evidence exists to support a finding of fact when the record, viewed as a whole, permits a reasonable person to make that finding. ORS 183.482(8)(c); *Garcia v. Boise Cascade*, 309 Or 292, 295, 787 P2d 884 (1990). There is substantial evidence to support the Board's finding that employer does not provide transportation between work sites.

Employer also assigns as error that the Board found that claimant's injuries are compensable. Generally, under the "going and coming" rule, injuries sustained while traveling to and from work are not compensable. *See SAIF v. Reel*, 303 Or 210, 216, 735 P2d 364 (1987); *Gwin v. Liberty Northwest Ins. Corp.*, 105 Or App 171, 173, 803 P2d 1228 (1991). If an employer, however, requires an employee, as part of his job, to bring his own car to work for use during the workday, his trip to and from work is, by that fact alone, within the course of his employment. In *Jenkins v. Tandy Corp.*, 86 Or App 133, 738 P2d 985, rev den 304 Or 279 (1987), the employer required the claimant to have his personal car available at work to make calls to the homes and business places of its customers and to make deliveries, and the employer reimbursed him for use of his car. It did not reimburse him for driving his car to and from work. He was injured as he went from the workplace to his car to drive home at the end of the day. We quoted from *Smith v. Workmen's Comp. App. Bd.*, 69 Cal 2d 814, 824, 73 Cal Rptr 253, 447 P2d 365 (1968):

> "[I]n this day of a highly motorized society we cannot cast the going and coming rule as a protective cloak over the shoulders of the employer who, for his own advantage, demands that the employee furnish the car on the job." 86 Or App at 137.

Here, the Board found that employer required claimant to bring his own car to work for transportation between job sites during the workday.[1] Substantial evidence supports that finding. The Board did not err when it concluded that claimant was injured within the course of his employment and that his injury is compensable.

Affirmed.

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1 In its order, the Board said:

"It is true that the employer did not specifically order claimant to bring his own car. Nevertheless, the requirement was implicit in the way the job was arranged. The unrebutted evidence is that the crew had to move between job sites during the work day approximately one or two times per week. Furthermore, the employer's representative admitted that the employer did not provide sufficient transportation to move all crew members between sites. The fact that the employer reimbursed claimant for mileage and did not provide alternative transportation, indicates that the employer expected claimant to provide transportation between job sites. We conclude that these facts are sufficient to establish an implicit requirement that claimant provide a vehicle for transportation between job sites during the work day. Consequently, we conclude that claimant's injury was within the course and scope of his employment."

Cite as 107 Or App 53 (1991) May 1, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of David R. Abbott, Claimant.

SAIF CORPORATION and OLYMPIC FOREST PRODUCTS, Petitioners,
v.
DAVID R. **ABBOTT**, LIBERTY NORTHWEST INS. and PINKERTONS, INC., Respondents.
(WCB 87-13095, 87-13096, 87-13097; CA A50887)

On SAIF Corporation's and Olympic Forest Products' petition for reconsideration filed November 21, 1990. Opinion filed August 8, 1990. 103 Or App 49, 796 P2d 378 (1990).

Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and David L. Runner, Assistant Attorney General, Salem, for petition.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Reconsideration allowed; remanded for reconsideration of scope of employer's acceptance; otherwise affirmed.

Olympic Forest Products and its workers' compensation carrier (employer) seek reconsideration of our decision. 103 Or App 49, 796 P2d 378 (1990). It contends that our conclusion that it had accepted responsibility for claimant's carpal tunnel syndrome is inconsistent with *Georgia-Pacific v. Piwowar*, 305 Or 494, 753 P2d 948 (1988).

In *Piwowar*, the injury was listed on the claim form as a "sore back." The employer issued a general acceptance. After the claim was accepted, it was determined that the sore back may have been caused by a disease known as ankylosing spondylitis, which was unrelated to claimant's employment. The employer then issued a denial for that condition. The Supreme Court held:

"Read together, *Johnson* and *Bauman* require the employer to compensate the claimant for the specific condition in the notice of acceptance regardless of the cause of that condition. If, for example, Georgia-Pacific accepted a claim for 'lumbosacral strain,' which was one of the original diagnoses of claimant's condition, that acceptance would not include the ankylosing spondylitis, since those are two separate infirmities (*unless of course one is merely a symptom of the other*).

"* * * * *

"Here, Georgia-Pacific accepted a claim for a sore back, which was merely a symptom of an underlying disease, not a separate condition. Therefore, Georgia-Pacific could not deny the compensability of the condition regardless of the cause. Accordingly, we hold that Georgia-Pacific could not properly deny the compensability of the ankylosing spondylitis." 305 Or at 501. (Emphasis supplied.)

Here, claimant submitted a claim for "numbness in hands, arm aches" and "[s]welling and aching every morning to the point of non-sleep. Neck stiff." Employer asserts that, rather than accept the claim as submitted, it issued a specific acceptance for a "right wrist strain" and a "right shoulder strain." It argues that its responsibility is limited to the specific accepted medical conditions.

If those assertions are correct as to the content of the claim and of its acceptance, our opinion was incorrect. The details of the acceptance purportedly are contained in Exhibit 10 in the record before the referee. However, Exhibit 10 in the Board's record is not the pertinent document. The discrepancy is noted in a footnote in employer's petition for reconsideration:

"In preparing this petition for review, SAIF discovered that the record forwarded to the Court of Appeals by the Workers' Compensation Board is incomplete. The exhibits forwarded by the Board were the 21 submitted by Liberty Northwest. The Referee excluded those exhibits and admitted the 31 exhibits introduced by SAIF. (Tr 1-2). If deemed necessary, the Court of Appeals or Supreme Court may require the Board to forward the correct record under ORS 183.482(4) and ORAP 3.05(3). Citations to exhibits in this petition are to those admitted by the Referee, not to those forwarded by the Board."

Employer is correct that the exhibits forwarded to the Court of Appeals by the Board are not the ones admitted by the referee. Also, the exhibits forwarded to the Board by the referee were not the ones admitted by the referee. Therefore, the Board never reviewed the proper record, and the referee's conclusions regarding employer's acceptance could not have been adequately reviewed by the Board.

Reconsideration allowed; remanded for reconsideration of scope of employer's acceptance; otherwise affirmed.

Cite as 107 Or App 73 (1991) May 15, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Ismeal M. Barajas, Claimant.

SAIF CORPORATION and SUMMITT ENTERPRISES, Petitioners,
v.
ISMEAL M. **BARAJAS**, Respondent.
(WCB No. 88-10277; CA A64438)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 7, 1990.
John Reuling, Assistant Attorney General, argued the cause for petitioners. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Roger Ousey, Eugene, argued the cause for respondent. With him on the brief was Bischoff & Strooband, P.C., Eugene.
Before Richardson, Presiding Judge, and Joseph, Chief Judge, and Deits, Judge.
JOSEPH, C.J.
Reversed and remanded for proceedings not inconsistent with this opinion.

Summitt Enterprises, employer, seeks review of aWorkers' Compensation Board order that held that claimant'sinjuries are compensable under ORS 656.005(7)(a).[1] We hold thatthe order is inadequate for review.

Claimant is a tree planter. Sometime before April 4, 1988, employer transported him and other employees from Medford to California. Claimant's home was in Medford. He stayed in California in a motel room paid for by employer, which provided transportation from the motel to the work site and back each day of work.

The Board adopted the findings of the referee, of which these are relevant:

> "(2) * * * Having the employees at the motel benefited the employer.
> "(3) Having the employees congregated at the motel, with no transportation away from it, was contemplated by the employer. The participants would not have been in Orleans, California on April 4, 1988 but for the employer's intervention.
> "(4) The trip from the motel to town and return was for reasons not related to employment. By the credible testimony of claimant, it was to buy shoes. Claimant was not paid for this activity, although transportation was provided by the employer. During the trip, which

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[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."

lasted from 1:00 p.m. to approximately 7:00 p.m., both claimant and Mr. Gomez consumed significant quantities of beer. Verbal exchanges, increasingly vituperative, occurred that afternoon.
"(5) The employer did not prohibit drinking beer after work hours. Although April 4 was a regular work day, the crew was assigned no activity and was not paid for its presence at the motel. The employees were theoretically free to come and go from the motel at will; their conduct was not regulated, either expressly or impliedly, by the employer after working hours.
"(6) Shortly after Mr. Gomez and claimant returned from the shopping/beer drinking trip, Mr. Gomez stabbed claimant, resulting in the need for medical treatment * * *. On June 16, 1988 SAIF denied that the stabbing incident was in the course and scope of employment * * *.
"(7) The reason for the dispute between the two men was work-related: Mr. Gomez was distressed by the fact that he no longer was claimant's supervisor-he had been demoted the week before * * *.
"(8) Mr. Barajas was not the aggressor. Mr. Gomez procured the knife; Mr. Barajas indicated an unwillingness to fight. The blows that were exchanged were in response to the threat of the weapon in Mr. Gomez' hand * * *."

The Board supplemented those findings with findings that "claimant's injury occurred while he was working away from home for the employer and living with coworkers in a motel"; he was "injured after he and his fellow workers returned to their motel from a trip into town, where they became intoxicated"; and he was "stabbed by a coworker after further liquor was consumed at the motel."

The referee concluded that claimant was not a "traveling employee." But *see SAIF v. Reel*, 81 Or App 258, 260, 724 P2d 914 (1986), *aff'd* 303 Or 210, 735 P2d 764 (1987). The Board said that it did "not necessarily agree" with that, but it did not analyze the issue any further. It concluded that an argument between co-workers who are staying at a motel for the employer's convenience is work-related and that claimant's injuries are therefore compensable under the factors identified in *Mellis v. McEwen, Hanna, Gisvold*, 74 Or App 571, 574, 703 P2d 255, *rev den* 300 Or 249 (1985).

We agree with the Board that claimant's injury was incurred in the course of his employment. However, ORS 656.005(7)(a)(A) necessitates a further inquiry, because its criteria relate to *compensability*. If the injury is incurred by an active participant in an assault or combat that is not an actual part of the job, it is not compensable. That exclusion has been referred to, however inexactly, as the "aggressor defense." *See Kessen v. Boise Cascade Corp.*, 71 Or App 545, 548, 693 P2d 52 (1984). Although an aggressor is clearly an active participant, aggressiveness is not the only criterion. The Board adopted the referee's findings that claimant was not the aggressor, that he expressed an unwillingness to fight and that he struck Gomez only as a result of being threatened by the knife. There is substantial evidence to support those findings. However, there are no findings as to how or why claimant became involved in an altercation with Gomez while Gomez was armed with a knife. The referee's conclusion that claimant was a bystander does not logically flow from the findings. Because the findings are insufficient, the Board's order is insufficient for review and must be remanded for further findings respecting the applicability of ORS 656.005(7)(a)(A). *See Teledyne Wah Chang v. Vorderstrasse*, 104 Or App 498, 802 P2d 83 (1990).

In the light of the Board's *de novo* review authority on remand, we need not decide any other issues presented by the petition for review.

Reversed and remanded for proceedings not inconsistent with this opinion.

Cite as 107 Or App 78 (1991) May 15, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Duane L. Jones, Claimant.

DUANE L. **JONES**, Petitioner,
v.
OREGON STATE CORRECTIONAL INSTITUTION and INMATE INJURY FUND, Respondents.
(88-10417; CA A64627)

Judicial Review from Workers' Compensation Board.
Argued and submitted September 28, 1990.
Merrill Schneider, Portland, argued the cause for petitioner. With him on the brief was Merrill Schneider & Associates, Portland.
Thomas E. Ewing, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and Jerome Lidz, Assistant Attorney General, Salem.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

BUTTLER, P.J.
Affirmed.
Rossman, J., dissenting.

Claimant, an injured inmate, seeks review of an order of the Workers' Compensation Board denying his request for insurer-paid attorney fees under ORS 656.386(1) for services rendered before hearing, from the time when the request for hearing was filed to when the Inmate Injury Fund (Fund) withdrew its denial of the claim.

Claimant was injured and filed a claim, which Fund denied. Claimant requested a hearing but, before the case came to hearing, Fund withdrew its denial and accepted the claim. The case then went to hearing only on claimant's request for insurer-paid attorney fees, which the referee denied. The Board affirmed.

The parties agree that ORS 656.386(1) provides the only possible statutory[1] authorization for an award of insurer-paid attorney fees in this case. That statute provides:

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[1] At the relevant time, OAR 438-15-030(1) provided, in part:

> "If an attorney is instrumental in obtaining compensation for a claimant without a hearing before a referee, a reasonable attorney fee may be approved or assessed."

OAR 438-15-005(2) defines an "assessed fee" as "an attorney fee paid to a claimant's attorney by an insurer or self-insured employer in addition to compensation paid to a claimant." The Board concluded that the phrase "in a hearing before a referee" has a precise meaning and leaves no room for interpretation. *Springfield Education Assn. v. School Dist.*, 290 Or 217, 621 P2d 547 (1980). Accordingly, it held that the rule exceeded its statutory authority to award attorney fees and is invalid.

"(1) In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. *In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee.*"

"(2) In all other cases attorney fees shall continue to be paid from the claimant's award of compensation except as otherwise provided in ORS 656.382." (Emphasis supplied.)

The question is whether claimant has prevailed "finally in a hearing" within the meaning of the statute. In Greenslitt v. City of Lake Oswego, 305 Or 530, 754 P2d 570 (1988), the court said:

"There are three prerequisites to the applicability of the attorney fees provision of ORS 656.386(1): (1) the claimant must initiate the hearing process by requesting review from an order or decision denying the claim; (2) the claimant must prevail *finally* on the issue of compensation (before the forum in which the claimant is the initiating party); and (3) the decision of the referee, board or court in which the claimant prevails finally must be from an earlier decision or order denying, rather than allowing, the claim for compensation. *Shoulders v. SAIF*, 300 Or 606, 611-12, 716 P2d 751 (1986). A claimant 'prevails finally' before a forum if that forum holds in the claimant's favor on the issue of the claimant's right to workers' compensation and that determination is not appealed within the time allowed by statute." 305 Or at 533. (Emphasis in original.)

Although the issue in that case was whether the dispute over the amount of fees awarded the claimant by the referee should be resolved by the Board or by the circuit court under ORS 656.388(2),[2] that issue depended on the meaning of ORS 656.386(1). The court's statement, quoted above, follows the plain meaning of the statute: The claimant must prevail finally before the forum in which the claimant is the initiating party. In all other cases, the fees are to be paid out of the award of compensation, except as otherwise provided in ORS 656.382.[3]

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[2] ORS 656.388(2) provides:

"If an attorney and the referee or board cannot agree upon the amount of the fee, each forthwith shall submit a written statement of the services rendered to the presiding judge for the circuit court in the county in which the claimant resides. The judge shall, in a summary manner, without the payment of filing, trial or court fees, determine the amount of such fee. This controversy shall be given precedence over other proceedings."

[3] ORS 656.382(2) provides:

"If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the referee, board or court finds that the compensation awarded to the 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.)

Under ORS 656.382, if the employer is the initiating party, and the forum finds that compensation should not be disallowed or reduced, the employer is required to pay the claimant's attorney fees for services "at *and prior to* the hearing." (Emphasis supplied.) The legislature has distinguished between the two types of cases, allowing the claimant an insurer-paid attorney fee for pre-hearing services in the one and not in the other. There is no ambiguity, and claimant's argument that the word "hearing" is an inexact term under *Springfield Education Assn. v. School Dist.*, *supra* n 1, and so the Board is required to interpret it, is not well-founded.

It is clear, therefore, that an insurer-paid attorney fee is not available under ORS 656.386(1), unless the matter of compensability is resolved by the forum, not by the withdrawal of a denial before the forum has decided the matter. If a referee has not resolved the issue of compensability, then a claimant has not "prevailed finally in a hearing before the referee" for the purpose of ORS 656.386(1).

Because there is no other statutory basis for an award of insurer-paid attorney fees, claimant's fees must be paid out of the award of compensation.[4]

Affirmed.

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[4] The dissent expresses concerns about the "policy implications" of our decision, ___ Or App at ___ n 1. (Slip opinion at 4 n 1.) Although we share some of those concerns, policy decisions are for the legislature. Our function is to apply the law as it reads.

ROSSMAN, J., dissenting

The majority holds that claimant was not entitled to employer-paid attorney fees for services in overcoming the denial of his claim, because he did not prevail finally in a hearing, i.e., in a completed adversarial proceeding where a referee holds in a claimant's favor. Although ORS 656.386(1) provides the only statutory authorization for an award of attorney fees, I cannot agree with the majority's decision that the statute was intended to preclude attorney fees in cases where the claim is settled before the final curtain comes down on a complete hearing. That result is so foreign to consideration of fairness and the efficient administration of justice, within the realm of the Workers' Compensation Law, that I must dissent.

The statute describes, generally, the different levels of review in workers' compensation cases and provides that a claimant who seeks review of a denied claim may recover attorney fees for prevailing finally at any level. It does not state that the claimant must prevail by reason of a decision at the hearing level. Rather, it appears to permit recovery of attorney fees by a claimant who succeeds in establishing finally the compensability of the claim after the employer or insurer has made a decision to deny the claim, whether that be by a determination of the referee or by the employer's ultimate acceptance of the claim at the hearing level.

Greenslitt v. City of Lake Oswego, 305 Or 530, 533, 754 P2d 570 (1988), relied on by the majority, is not inconsistent with my interpretation of the statute. The question in that case was whether, considering ORS 656.386(1) and ORS 656.388(2) together, the Board or the circuit court was the proper forum to review the referee's award of attorney fees. That, in turn, depended on whether the claimant had "finally prevailed" before the referee. The court held that the claimant had not, because the employer had sought Board review of the referee's determination of compensability. *Greenslitt* stands only for the

proposition that a claimant cannot be said to have "finally prevailed" if the issue of compensability remains ultimately unresolved. It does not preclude an award of attorney fees if the issue of compensability is resolved in the claimant's favor after a hearing has been requested but before the referee has reached a decision. The court was not faced with that issue and had no occasion to consider it.

Employer, having denied the claim, forced claimant to request a hearing, thereby bringing the case to the hearing level of review. The efforts of claimant's attorney were presumably responsible for the Fund's ultimate withdrawal of the denial and acceptance of the claim. A claimant incurs attorney fees throughout the entire process and should be fully compensated when a claim is accepted. The proper focus in determining whether claimant is entitled to attorney fees is on whether he finally prevailed on the issue of compensation, not when he prevailed or in what setting. Claimant did prevail, no matter how one looks at it, and he should be awarded attorney fees.

In view of the legislature's apparent policy, as expressed in ORS 656.386, that the employer, not the claimant, bear the cost of a claimant's legal representation when a claim is erroneously rejected and it proceeds to the hearing level, the Board's interpretation of the statute is erroneous as a matter of law. For more than 20 years, the Board interpreted the statute to permit attorney fees for services provided after a request for a hearing had been filed but before the hearing. See *former* OAR 438-15-030(1). The legislature did nothing to change that interpretation, and I see no reason suddenly to move the goalposts now.

Accordingly, I dissent.[1]

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[1] I am also very much concerned about the policy implications of the majority's holding. It is likely to discourage claimants from seeking prehearing rescission of claim denials, because attorney fees, if any, will be deducted from the award. Obtaining relief effectively exposes a claimant to a penalty. There are also negative consequences on the employers' side: The majority's result will eliminate an important incentive for employers to investigate and accept meritorious claims promptly and carefully and forces claimants to incur unnecessary expenses that the responsible employers will not be required to reimburse. Beginning with this case, other than the penalties imposed for unreasonable denials, there no longer is a risk of incurring attorney fees for denying valid claims. I believe that that unfairly places the financial burden of error on claimants.

Cite as 107 Or App 103 (1991) May 15, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Daniel S. O'Leary, Claimant.

DANIEL S. **O'LEARY**, Petitioner,
v.
VALLEY VIEW CUTTING and SAIF CORPORATION, Respondents.
(88-21172; CA A65401)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 27, 1991.
James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Dale C. Johnson and Malagon,Moore & Johnson, Eugene.
Ann F. Kelley, Assistant Attorney General, Salem, argued the cause for respondents. With her on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
WARREN, P.J.
Affirmed.

The facts in this workers' compensation case are undisputed. Before claimant filed a request for a hearing, he sent SAIF a request to provide him the claim documents. SAIF sent the documents 22 days later. Claimant sought a penalty and attorney fees for failure to provide discovery within 15 days, as required by *former* OAR 438-07-015(2). The referee denied his request, and the Board affirmed. Claimant seeks review, and we affirm.

Former OAR 438-07-015(2) provided:

> "Documents pertaining to claims are obtained by mailing a copy of the Request for Hearing, or a written demand accompanied by an attorney retention agreement or medical information release, to the insurer. Within fifteen (15) days of said mailing the insurer shall furnish the claimant and other insurers, without cost, originals or legible copies of all medical and vocational reports, records of compensation paid, and all other documents pertaining to the claim(s). Upon specific demand by the claimant, payroll records shall be obtained by the insurer from the employer and provided in the same manner as other documents. Failure to comply with this section shall be considered delay or refusal under ORS 656.262(10) and may be grounds for exclusion of documents upon motion of the adverse party."

ORS 656.262(10) provides:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

The Board concluded that *former* OAR 438-07-015(2) does not apply until a claimant files a request for a hearing. Chapter 438 containing the Board's rules of practice and procedure for contested cases. OAR 438-05-010 states:

> "*These rules* are effective January 1, 1988 and shall *apply to all cases pending before the Hearings Division* under the provisions of ORS 656.283, 656.291, 656.307 and 656.740 and before the Board under the provisions of ORS 656.295, 656.307 and 656.576 to 656.595 on and after that date. With respect to matters before the Board on its own motion under ORS 656.278, these rules shall apply only to cases in which claim reopening is ordered by the Board on or after January 1, 1988." (Emphasis supplied.)

The Board reasoned that, because claimant had not yet requested a hearing when he sought the documents, the case was not "pending before the Hearings Division." It held that the applicable rule was *former* OAR 436-10-030(10) (since renumbered as OAR 436-10-030(15)), promulgated by the director of the Department of Insurance and Finance. It stated, in part:

> "Injured workers, or their representatives, are entitled to copies of all relevant medical information. This information should ordinarily be available from the insurers, but may be obtained from physicians upon the payment of an appropriate charge for copies."

The rule does not establish a specific time in which the material must be provided. The Board concluded that the test for penalties and attorney fees is simply whether the insurer "unreasonably delay[ed]," as stated in ORS 656.262(10), and held that 22 days was not unreasonable under the circumstances.

We defer to the Board's interpretation of its own rules, so long as the interpretation is not inconsistent with the rules and the statutory. *Mershon v. Oregonian Publishing*, 96 Or App 223, 772 P2d 440, *rev den* 308 Or 315 (1989). The board's interpretation is not inconsistent with the rule or with the policy expressed in the statutes. ORS 656.298(6); ORS 183.482(8).

Affirmed.

Cite as 107 Or App 107 (1991) May 15, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Richard F. Taylor, Claimant.

RICHARD F. **TAYLOR**, Petitioner,
v.
LIBERTY NORTHWEST INSURANCE CORPORATION and MULTNOMAH COUNTY SCHOOL DISTRICT,
Respondents.
(WCB 88-03008, WCB 88-03007; CA A64275)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 28, 1990.
James L. Edmunson, Eugene, argued the cause and filed the brief for petitioner.
Stafford J. Hazelett, Portland, argued the cause and filed the brief for respondents.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
WARREN, P.J.
Affirmed.

Claimant seeks review of an order of the Workers' Compensation Board that reversed a referee's order that Liberty Northwest Insurance Corporation (Liberty) pay a penalty and attorney fees. We affirm.

Claimant injured his lower back in December, 1978, while working for an employer insured by SAIF. He had surgery and received a permanent disability award. In 1985, he reinjured his back while working for Multnomah County School District, insured by Liberty. Liberty accepted the claim, which was closed by a determination order in March, 1986. Claimant then returned to work and continued working until February, 1987, when he left because of increased pain. Liberty denied claimant's request to reopen his claim as an aggravation, and SAIF also denied responsibility. Claimant requested a hearing on both denials; the requests were consolidated and heard on October 6, 1987.

The referee held Liberty responsible for claimant's condition after February, 1987, and absolved SAIF of responsibility. The referee did not send a copy of the order to SAIF. Liberty requested reconsideration of the order and pointed out that a copy had not been sent to SAIF. The referee then issued an Order of Abatement. Again, a copy was not sent to SAIF. On January 28, 1988, the referee issued an Order on Reconsideration that republished the original order. A copy of the republished order was not sent to SAIF.

Liberty appealed the republished order to the Board. On April, 25, 1988, the Board dismissed the request for review, because the referee's January 28 order on reconsideration had not been mailed to all parties and therefore was not reviewable as a final order. The Board remanded the case to a different referee. On June 8, 1988, the second referee republished the January 28, 1988, order and mailed it to all of the parties.

Claimant then requested a hearing, asserting that Liberty had unreasonably delayed payment of compensation and had not timely provided requested claims data, in violation of *former* OAR 438-07-015. The referee found that Liberty had failed to provide the requested information timely and that it had unreasonably delayed paying claimant temporary total disability (TTD) until February 19, 1988, 22 days after the January 28 order. Former OAR 436-60-150(3) provided, in part:

> "Timely payment of temporary disability benefits means payment has been made no later than the 14th day after:
> "* * * * *
> "(e) The date of any determination or litigation order which orders payment of temporary disability * * *."[1]

The referee directed Liberty to pay penalties and attorney fees on both grounds. Liberty appealed, and the Board reversed, holding that, because the January 28 order had not been served on SAIF, it was not sufficient to require Liberty to begin paying TTD.

Claimant contends that the Board erred in its interpretation of *former* OAR 436-60-150(3)(e). He argues that, once Liberty had received notice of its responsibility, it was obligated to begin payment within 14 days and that the fact that SAIF did not receive a copy of the January 28 order in no way affected Liberty's obligation.[2]

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[1] That rule has been renumbered as OAR 436-60-150(4), and subsection (e) provides for an automatic stay of the award if the insurer appeals. Neither party contends that the current version of the rule is applicable in this case.

[2] Even though the referee awarded a penalty and attorney fees both for delay in providing discovery and for unreasonable delay in paying TTD, claimant raises only the latter delay here.

We will reverse the Board's decision only if its interpretation of "litigation order" is inconsistent with a statute, rule, officially stated agency position or prior agency practice. See ORS 656.298(6); ORS 183.482(8)(b)(B); *Mershon v. Oregonian Publishing*, 96 Or App 223, 226, 772 P2d 440, *rev den* 308 Or 315 (1989). In reaching the conclusion that the January 28 order was not a "litigation order," the Board relied on ORS 656.289, which requires a referee to make an order within 30 days after the conclusion of the hearing, ORS 656.289(1), and to send a copy of the order to the director and "all parties in interest," ORS 656.289(2), and sets the time from which to request review as the date when the order is mailed to all parties. ORS 656.289(3). The Board concluded that a referee's decision does not become a litigation order until a notice has been sent to all parties, as required by that statute.

We affirm the Board's decision, because its interpretation of *former* OAR 436-60-150(3) is consistent with both the wording of the rule and ORS 656.289. *Mershon v. Oregonian Publishing, supra*, 96 Or App at 226. Contrary to claimant's argument, ORS 656.262(4) does not apply to this case. That subsection requires that the first installment of compensation be paid within 14 days after the employer has notice of the claim. It applies to payments of so-called interim compensation after a claim is first filed, not to when an employer must begin paying compensation after being ordered to do so by a referee.

Claimant does not identify any applicable statute with which the Board's interpretation of the rule is inconsistent. Although we might have made a different interpretation than the Board did, we may not substitute our judgment for that of the Board.

Affirmed.

Cite as 107 Or App 133 (1991) May 15, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Amparo Cordero, Claimant.

AMPARO **CORDERO**, Petitioner,
v.
MOLLER'S NURSERY and EBI COMPANIES, Respondents.
(WCB 88-07044; CA A64062)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 15, 1991.
James L. Francesconi, Portland, argued the cause for petitioner. With him on the brief was Francesconi & Associates, P.C., Portland.
Jerald Keene, Portland, argued the cause for respondents. With him on the brief was Leah Sideras and Roberts, Reinisch, et al, Portland.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
ROSSMAN, J.
Reversed and remanded for reconsideration.

Claimant seeks review of a decision of the Workers' Compensation Board reducing the referee's award from permanent total disability to 100 percent permanent partial disability.

Claimant suffered a compensable back injury, which severely limits her activity. She was 36 years of age at the time of the hearing and had a third

grade education in Mexico. She understands simple spoken English. At the time of the hearing, she was working for employer part-time, pruning, watering and potting small plants. She had a special chair that enabled her to work while seated.

Claimant's first contention is that her work at employer was not "regular," as required by ORS 656.206(1)(a), because her duties were modified to accommodate her back condition and her part-time employment was possible "only because of her extraordinary efforts and [employer's] sympathy and willingness to provide special working conditions." Claimant argues that the evidence supports only the conclusion that she was not employable in a hypothetically normal labor market. *Harris v. SAIF*, 292 Or 683, 642 P2d 1147 (1982). We agree with employer that the record supports the Board's finding that claimant is gainfully employed.

We also affirm the Board's ruling that a remand to the referee is not warranted for consideration of a letter containing a statement of claimant's attorney that, after receipt of the referee's order determining that claimant is permanently and totally disabled, employer terminated claimant. We agree with the Board that the letter is not material to a determination of claimant's disability as it existed at the time of the hearing.

The only remaining issue concerns the extent of claimant's disability. As the Board correctly noted, the criterion for rating unscheduled permanent partial disability is the 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." The Board held:

> "Given claimant's relatively young age, limited education, moderately severe permanent physical impairment, prior work experience, and limited transferable skills, we conclude that an award of 100 percent permanent disability appropriately compensates her for her loss of earning capacity due to the compensable injury."

Given the Board's determination that claimant is 100 percent disabled, it must have found that she has lost 100 percent of her ability to hold gainful employment. ORS 656.214(5). As claimant argues, that would appear to be inconsistent with the Board's determination that claimant is gainfully employed for purposes of permanent and total disability. We remand to the Board for it to resolve that apparent inconsistency.

Reversed and remanded for reconsideration.

Cite as 107 Or App 158 (1991) May 15, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON

Barbara E. **PERKINS**, Appellant
v.
Mark G. **GEHLAR**, Trustee for the Mark G. Gehlar Trust, Respondent
(88C-11322; CA A63279)

Appeal from Circuit Court, Marion County.
Rodney W. Miller, Judge.
Argued and submitted September 17, 1990.
Frank J. Susak, Portland, argued the cause and filed the briefs for appellant.
Mildred J. Carmack, Portland, argued the cause for respondent. With her on the brief were Joyce A. Hyne and Schwabe, Williamson & Wyatt, Portland.
Before Deits, Presiding Judge, and Newman and De Muniz, Judges.
NEWMAN, J.

Reversed and remanded.
Deits, P.J., dissenting.

Appellant brought this action for personal injuries sustained on property that that had been leased to Oregon Fruit Products Company. She appeals a summary judgment against her. ORCP 47. We reverse and remand.

These facts are undisputed. Mark G. Gehlar (Gehlar) co-founded Oregon Fruit Products in 1935. It has remained in the same location, and it includes a main office building and separate buildings for fruit processing and canning. In the late 1960's, Gehlar incorporated Oregon Fruit Products Company (the company) and transferred the business to it. He retained ownership of the real property and leased it to the company.

In 1978, Gehlar created the Mark G. Gehlar Trust, with himself as trustee. In 1980, he conveyed the real property by a bargain and sale deed "to MARK G. GEHLAR, Trustee, as Grantee." In 1985, Gehlar, as trustee, executed a written lease of the real property to the company. The lease recited that it was

> "by and between MARK G. GEHLAR, Trustee, as 'Landlord,' and OREGON FRUIT PRODUCTS CO., an Oregon corporation, as 'Tenant'."

It provided:

> "REPRESENTATIVE CAPACITY OF LANDLORD. Landlord is executing this lease solely as Trustee under a written Trust Agreement, as amended, between Mark G. Gehlar, as Trustee, and Mark G. Gehlar, as Trustor, and solely in such representative capacity and not in his separate individual capacity, and the liability of Landlord and all events under this lease shall be limited to the assets and property constituting the trust estate of said trust while in the hands of the Trustee."[1]

After 1985, Gehlar continued to act as a director of the company and to work for it as a part-time employee.

In 1987, appellant worked for the company in a building on the property known as the cannery. At the time of the accident, she was washing fruit containers in a sink and placing them on a nearby table. The area in which she worked often had standing water on the wooden floor. As she walked from the sink to the table, she fell through the wooden floor and injured her shoulder, back and legs. She received workers' compensation benefits from the company. She then sued the trustee (defendant) for negligence, asserting that it is liable for her injuries. ORS 656.154. [2]

Defendant moved for summary judgment, arguing that it is a co-employee of plaintiff and is exempt from liability under ORS 656.018(3). It also asserted

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1 There is no written trust instrument in the record. Gehlar stated in an affidavit that he "entered into a Revocable Living Trust by which I created the Mark G. Gehlar Trust, of which I am both trustor and trustee."

2 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 * * * may elect to seek a remedy against such third person."

that, even if it is not exempt under ORS 656.018(3), it is not liable under the terms of the lease for her injuries. The court granted a summary judgment and made what it described as "findings":

> "1. As to the issues raised in defendant's Motion for Summary Judgment, there are no genuine issues as to any material facts.
> "2. The Workers' Compensation exemption in ORS 656.10893) extends to defendant/trustee.
> "3. Under the terms of the lease between defendant and tenant Oregon Fruit Products Company, the tenant has the responsibility for repairs and maintenance."

The issue is whether defendant established that no genuine issues of material fact exist and that it is entitled to summary judgment as a matter of law. We review the record in the light most favorable to plaintiff. *Stanfield v. Laccoarce*, 288 Or 659, 665, 607P2d 177 (1980); *Uilein v. Albertsons, Inc.*, 282 Or 631, 634, 580 P2d 1014 (1978). Plaintiff contends that defendant is not exempt from liability under ORS 656.018(3), which provides:

> "The exemption from liability given an employer under this section is also extended to * * * the * * * employees * * * and directors of the employer * * * ."

She asserts that defendant is not her co-employee, even Gehlar, as an individual, is. Defendant responds that it is exempt because

> "[t]he Mark Gehlar who is plaintiff's coemployee is the same Mark Gehlar who is the trustee of the Mark G. Gehlar trust and is the very person from whom plaintiff seeks recovery in this case."

The court erred as a matter of law when it held that defendant is exempt under ORS 656.018(3). We reject defendant's argument that, because Gehlar, the individual, is also the trustee, the trustee and the individual are the same entity and that the trustee is, therefore, plaintiff's co-employee. In 1980, Gehlar conveyed the real property to defendant, "Mark G. Gehlar, Trustee," who then owned it. Defendant, as landlord, leased the property to the company as "tenant." The lease recites that Gehlar executed it "solely as Trustee under a written Trust Agreement * * * between Mark G. Gehlar, as Trustee, and Mark G. Gehlar, as Trustor, and solely in such representative capacity and not in his separate individual capacity" and that defendant's liability would be "limited to the assets and property constituting the trust." In his deposition, Gehlar denied that he owned the property; he testified that it is owned by "Mark G. Gehlar, Trustee." Defendant may not assert now that it and Gehlar are the same. The only evidence in the record is that the company employed Gehlar, not defendant. There is no showing whatsoever that defendant is an employee of the company and, therefore, a co-employee of plaintiff.

Plaintiff also assigns as error that the court ruled that defendant, as landlord, is not liable for her injuries on the ground that the company, as tenant, had the responsibility to maintain and repair the floor of the cannery. Plaintiff responds that, on that question, the lease is ambiguous and that, in any event, it does not bear on her right to recover from defendant.

In *Bellikka v. Green*, 306 Or 630, 762 P2d 997 (1988), the court said that a landlord is not liable for injuries to someone other than a tenant caused by a defect on leased property when

> " 'the nature of the defect might be such that the landlord would reasonably expect that the tenant would take steps to remedy the

> defect or otherwise to safeguard persons entering them at his invitation.' " 306 Or at 647 (quoting *Jensen v. Meyers*, 250 Or 360, 364 & n5, 441 P2d 604 (1968.)

Defendant has not shown that there are no genuine issues of material fact as to whether defendant could reasonably expect that the company would remedy any defect in the cannery floor or otherwise safeguard plaintiff from it.

> The lease provides:
> "(6) REPAIRS AND CONDITIONS OF PREMISES.
> "(a) Tenant has examined the premises and knows their condition and accepts them as they now are. No representations nor warranties as to the condition of the premises have been made by Landlord, unless herein stated.
> "(b) Repairs. Tenant shall keep the land and all buildings and improvements thereon and all sidewalks and ways adjacent thereto in a condition that meets the requirements of local laws and ordinances. Except for the main office building, Tenant shall have no further duty of repair and maintenance with respect to improvements existing on the property as of May 1, 1985. With respect to the main office building and all improvements which Tenant places on the property after May 1, 1985, Tenant shall maintain such improvements in good condition, reasonable wear and tear excepted. Landlord shall have no obligation to keep any present or future buildings on the property in tenantable condition or to repair or to restore any such buildings under any circumstances. Subject to the provisions of paragraph (14)(b) below [which concern destruction of buildings by casualty], no damage to or destruction of any such buildings shall relieve Tenant from Tenant's obligations hereunder. It is the intent of the parties that Tenant shall pay all charges and burdens connected in any way with such property during this lease, and that Landlord shall pay none of them, except as specifically provided in this lease."

Defendant has not shown that the condition of the cannery floor did not meet requirements of any local laws or ordinances. The cannery is not the main office building, and defendant has not shown that the cannery is an improvement that did not exist on the property before May 1, 1985. Consequently, the lease does not place the responsibility for repair and maintenance of the cannery floor on the company. It also does not place that responsibility on defendant. The lease is silent as to whether defendant or the company has that responsibility. On this record, the court erred in "finding" that, under the terms of the lease, the company had that responsibility.

Moreover, Gehlar stated in a deposition that the "floors on the [cannery] premises were replaced with concrete and cement slabs as rapidly as [was] necessary," because forklifts had broken through them.[3] Defendant did not show, however, the times that those events occurred, who had the time and the opportunity to repair the defect in the cannery floor that caused plaintiff's injury, whether that defect was an undisclosed dangerous condition known to defendant or to the company and whether defendant retained any control of the premises. *See Bellikka v. Green, supra*, 306 Or at 647. Accordingly, there are genuine issues of material fact as to whether defendant could reasonably expect that the company would maintain and repair the cannery floor or safeguard plaintiff from a defect in it. The court erred when it granted summary judgment to defendant.

Reversed and remanded.

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[3] Only three pages of Gehlar's deposition are in the record.

DEITS, P.J., dissenting.

The majority begins and ends its analysis of the co-employee immunity issue with the truism that a trustee is legally different from the individual who serves in that capacity. However, the majority fails to offer any meaningful explanation of why that truism results in the conclusion that Gehlar is not immune under ORS 656.108(3).

Plaintiff acknowledges that Gehlar, the individual, is her fellow employee. She also appears to acknowledge that he would be immune under ORS 656.018(3) for injuries that she sustained in the building that he owns if he had held title to it in his individual capacity. That is true, even though his status as owner of the building in any capacity is legally distinct from his status as an employee of the company and a co-employee of plaintiff. The majority ignores those concessions and concludes that, technically, "defendant [Gehlar, as trustee] is an entity distinct from Gehlar [as individual]"[1] and therefore, as trustee, he is not entitled to immunity. The majority reaches that conclusion without any explanation of why the additional fact that Gehlar owns the building as a trustee rather than individually divests him of immunity. Further, the majority does not consider the purpose of the immunity statute, nor does it discuss the existing authority on the issue.

The most pertinent case that the parties cite or that I find is Kimball v. Millet, 52 Wash App 512, 762 P2d 10 (1988), rev den 111 Wash 2d 1036 (1989), where the court construed the Washington equivalent of ORS 656.018(3), in an action by an employee against two co-employees who also owned the property on which the plaintiff was injured and who leased it to their mutual employer. The court said that the plaintiff

> "attempts to [avoid the immunity statute] by characterizing the Millets not as employers or coemployees, but as landowners, thereby invoking the 'dual persona' doctrine, recognized but not applied in *Carr v. Willamette Indus., Inc.*, 105 Wash. 2d 217, 220-21, 713 P.2d 92 (1986). Under this doctrine, an employer (and presumably a co-employee) may fall within the third person exception to immunity if, but only if, possessing a second persona so completely independent from and unrelated to the status of employer (or coemployee) that, by established standards, the law recognizes the second persona as a separate legal person.
>
> "The immunities conferred by the Act are not easy to avoid, * * * and Kimball cannot avoid them in this case. Our statute has always been construed stringently in eliminating claims against employers. * * * Theories that attempt to circumvent statutory immunities should be examined with the same stringency.
>
> "Although in this field the courts of this state are seldom persuaded by decisions from other states, * * * it is nevertheless appropriate to consider how those courts have dealt with problems that are new to us. Having considered cases from other jurisdictions dealing with this issue, we are persuaded, by the reasoning of the New York Court of Appeals, that where the facts supporting a third party/'dual persona' claim are those under which a coemployee

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[1] The issue cannot be avoided simply by calling Gehlar the trustee "defendant" and Gehlar the individual "Gehlar", as the majority does. Indeed, it is plaintiff's attempt to make that distinction that gives rise to the issue.

> would be immune from suit under the Act, the putative defendant cannot be said to have a second persona so *completely separate* as to be recognized by law as a separate person for purposes of third-party liability for an on-the-job injury. *Heritage v. Van Patten*, 59 N.W. 2d 1017, 466 N.Y.S. 2d 958, 453 N.E. 2d 1247 (1983) * * *." 52 Wash App at 513 (Emphasis in original; footnote and some citations omitted.)

Applying the Washington court's analysis, in order for Gehlar to lose his immunity, his status as a trustee must have some bearing on the parties' relationship that alters the reason for the immunity of co-employees. That is not the case. Gehlar, individually, is plaintiff's co-employee. The fact that he also owns the building as a trustee has nothing to do with plaintiff, nothing to do with her relationship to the work premises that he owns and nothing to do with her work relationship with him.

Plaintiff and the majority reason that Gehlar the trustee is "legally distinct" from Gehlar the individual; therefore, because only the latter is a co-employee and only the former is the named defendant, there can be no immunity under ORS 656.018(3). However, the sharp line that plaintiff and the majority would draw between the two "entities" has no foundation in authority. In the first place, it would be more accurate to say that the *trust*, not the *trustee*, is the legal entity and that the trustee stands in a defined relationship and has responsibilities attendant to that entity. Plaintiff's theory is not that the trust is liable, but that the trustee is personally liable to her by reason of his negligence in connection with the maintenance of the business premises.

Plaintiff relies on Restatement (Second) Trusts, Section 264 (1959):

> "The trustee is subject to personal liability to third persons for torts committed in the course of the administration of the trust *to the same extent that he would be liable if he held the property free of trust*." (Emphasis supplied.)

Rather than supporting plaintiff, the *Restatement* illustrates the circularity of her argument. If Gehlar held the property free of trust, he would be immune. His personal liability as trustee under the quoted provision can be no greater.

In sum, plaintiff's argument, and the majority's acceptance of it, make co-employee immunity contingent on the absence of any status or relationship between the parties other than that of fellow employees. The policy underlying ORS 656.018(3) is strong. I cannot agree that the legislature intended that the immunity could be circumvented by meaningless distinctions of the kind on which plaintiff's case depends.

I would affirm and, therefore, I respectfully dissent.

Cite as 107 Or App 198 (1991) May 15, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Lou D. Bales, Claimant.

SAIF CORPORATION and AUMSVILLE RURAL FIRE DEPT., Petitioners,
v.
LOU D. **BALES**, Respondent.
(WCB 88-05665; CA A65158)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 25, 1991.
Thomas E. Ewing, Assistant Attorney General, Salem, argued the cause for petitioners. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
J. Michael Alexander, Salem, argued the cause for respondent. With him on the brief was Burt, Swanson, Lathen, Alexander & McCann, Salem.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
EDMONDS, J.
Reversed and remanded for reconsideration.

Employer seeks review of a Workers' Compensation Board order that set aside its denial of claimant's claim for chronic obstructive pulmonary disease (COPD). We reverse.

Claimant, who has been a fire fighter for more than 20 years, is the fire chief of the Aumsville Fire Department. In March, 1983, he saw Dr. Foster, his family doctor, for a fever, sore throat, cough and congestion. The doctor examined his eyes, ears, nose and throat, listened to his lungs with a stethoscope and took his temperature. The examination revealed that his lungs were clear. Foster's notes regarding that examination state, in part:

> "I think he has a viral [upper respiratory tract] infection which is epidemic in the community. Also states that he hasn't had a physical in 30 years and is concerned about this. I think that at the present time the only thing that needs to be done is a colon cancer screening and he is given hemocults times 3 which he will return to us."

In March, 1987, claimant began complaining to Foster regarding shortness of breath. In October, 1987, the doctor ordered pulmonary function studies, which revealed that claimant had significant obstructive lung disease. Claimant filed a workers' compensation claim. Employer denied the claim; claimant requested a hearing. The referee concluded that claimant's 1983 examination qualified as a "physical examination" under the "fire fighters' presumption"[1] in ORS 656.802(3). On review, the Board agreed.

ORS 656.802(3) provides:

> "Death, disability or impairment of health of fire fighters of any political division who have completed five or more years of employment as fire fighters, caused by any disease of the lungs or respiratory tract, hypertension or cardiovascular-renal disease, and re-

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[1] When these proceedings were initiated, the "fire fighters' presumption" was codified in ORS 656.802(1)(b) and (2). Those provisions have been renumbered since as ORS 656.802(3). Or Laws 1987, ch 713, 4. For convenience, we will refer to ORS656.802(3).

> sulting from their employment as fire fighters is an 'occupational disease.' Any condition or impairment of health arising under this subsection shall be presumed to result from a fire fighter's employment. *However, any such fire fighter must have taken a physical examination upon becoming a fire fighter, or subsequently thereto, which failed to reveal any evidence of such condition or impairment of health which preexisted employment.* Denial of a claim for any condition or impairment of health arising under this subsection must be on the basis of clear and convincing medical evidence that the cause of the condition or impairment is unrelated to the fire fighter's employment." (Emphasis supplied.)

Employer argues that ORS 656.802(3) requires a more comprehensive physical examination than was conducted by Foster in 1983.[2] Claimant argues that, because the examination failed to reveal any evidence of COPD, it satisfied the requirements of the statute.

We review for substantial evidence and errors of law. ORS 656.298(6). The dispute in this case concerns the Board's interpretation of the statutory term "physical examination." The scope of our inquiry depends on whether "physical examination" is an exact, inexact or delegative statutory term. *Springfield Education Assn. v. School Dist.*, 290 Or 217, 621 P2d 547 (1980). As used in ORS 656.802(3), it is an inexact term, because it is a complete expression of legislative intention but imports less than a precise meaning. Accordingly, we review to determine whether the Board's interpretation of the term in the context of this case is consistent with the purpose of ORS 656.802(3). 290 Or at 223-228.

ORS 656.802(3) creates a presumption of work-relatedness in favor of fire fighters, if they have undergone the required physical examination. An employer can overcome that presumption only by offering clear and convincing evidence to the contrary. *See, e.g., Johnson v. City of Roseburg*, 86 Or App 344, 739 P2d 602 (1982). Our review of the legislative history indicates that the legislature intended as a predicate to the presumption that a physical examination under ORS 656.802(3) must be of the type that would reveal any evidence of "any disease of the lungs or respiratory tract, hypertension or cardiovascular-renal disease" for which a claimant later seeks compensation.[3]

We cannot tell from the Board's opinion what interpretation of "physical examination" it applied. The Board said:

> "The Referee found that claimant was examined by his treating physician in 1983 and several times subsequently, that claimant's lungs were clear, and that there was no evidence of COPD. We agree with the Referee that this examination satisfied that statutory requirement [of ORS 656.802(3)] and that therefore the presumption applies." (Emphasis supplied.)

Whether there was "no evidence" of COPD does not relate to the adequacy of the examination to reveal evidence of the disease.

Reversed and remanded for reconsideration.

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[2] Employer argues that an upper respiratory tract viral infection is not a "disease of the lungs or respiratory tract," as that phrase is used in ORS 656.802(3). Employer is wrong. See ORS 656.802(1)(a).

[3] The legislative history suggests that, when the legislature used the term "physical examination" in ORS 656.802(3), it contemplated that the

examination would be at least as "rigid" or "competent" as that required by certain exhibits. One of the bill's sponsors told the Senate Labor and Industries Committee that fire fighters go through a "rigid examination" before entering the service. Minutes, Senate Labor and Industries Committee 2 (Mar. 8, 1961 -- statement of Senator Grenfell). Further, the January 24, 1961, minutes of the House Labor and Industries Committee say, in part:

> "Rep. Rogers thought that there was some question whether some of the conditions leading to impairment of health of the fire fighter would be determined by a physical examination. Mr. Noble [, secretary of the Oregon State Fire Fighters' Council,] agreed that this was true, but that a *competent examination* on entering into service will show up any heart disease, lung disease, etc." Minutes, House Labor and Industries Committee 1 (Jan. 24, 1961). (Emphasis supplied.)

Also, the exhibits before the Senate Labor and Industries Committee included the Oregon City Civil Service Commission's medical standards for fire fighters and police officers. The Commission's standards provided, in part:

> "8. Chest and Lungs: (a) Chest Mobility - There must be a chest expansion of at least 2 1/2 inches. Measurements may be made at the ninth rib or at the nipple, or both may be considered together. (b) Respiration - must be full, easy, and regular; the respiratory murmur must be clear and distinct over both lungs, and no disease of the respiratory organs present. Lungs will be X-rayed."

Cite as 107 Or App 207 (1991) May 15, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Paulette D. Lehman, Claimant.

Paulette D. **LEHMAN**, Petitioner
v.
SAIF CORPORATION and Club Pioneer, Respondents.
(88-04124; CA A64276)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 28, 1991.
James F. Larson, Prineville, argued the cause for petitioner. With him on the brief was Minturn, Van Voorhees, Larson & Dixon, Prineville.
David L. Runner, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

EDMONDS, J.
Affirmed.

Claimant seeks review of an order of the Workers' Compensation Board finding that she is no longer permanently and totally disabled and awarding her 65% unscheduled permanent partial disability (PPD). We affirm.

Claimant compensably injured her head, neck and back in a car accident in 1972 and was awarded permanent total disability (PTD) in 1976. In May, 1987, she opened and worked in a women's clothing store. Pursuant to ORS 656.206(5)[1]

and ORS 656.325(3),[2] SAIF submitted documentation to the Department of Insurance and Finance, requesting reexamination of claimant's PTD award. The Department determined that her disability remained unchanged. SAIF requested a hearing, and claimant moved to dismiss for lack of jurisdiction. After denying the motion, the referee concluded that claimant was no longer permanently totally disabled and issued an order awarding her 65% PPD. The Board adopted the referee's order.

Claimant argues that the referee did not have jurisdiction to review the order because, under ORS 656.206(5), only the director of the Department (director) has discretion to reexamine PTD awards. She relies on OAR 436-30-065(6), Farmers Ins. v. Hopson, 53 Or App 109, 631 P2d 342 (1981), and Bentley v. SAIF, 38 Or App 473, 590 P2d 746 (1979). SAIF argues that its request for hearing was authorized by ORS 656.325(3), ORS 656.325(6)[3] and ORS 656.268(6)[4].

Before 1979, periodic examinations of PTD awards were conducted by the Evaluation Division, which, under its rule, prepared the record and made a recommendation to the Board for its decision. Or Laws 1977, ch 430, Section 1; Or Laws 1977, ch 804, Section 30; Or Laws 1965, ch 285, Sections 31 and 41b. Those provisions were codified as ORS 656.325 and 656.268, which provided for the right to request a hearing under ORS 656.283(1)[5]. In 1979, the responsibility for reexamination of PTD awards under ORS 656.206 was transferred from the Board to the director. Or Laws 1979, ch 839, Sections 20 and 25. However, ORS 656.325(6), ORS 656.268(6) and ORS 656.283 remained in effect. There is nothing in the 1979 legislative history or the amendments to suggest that the legislature intended to end the Board's power to review what before had been a recommendation but was now a determination order. To the contrary, the power to review expressly continued under ORS 656.325 and ORS 656.268.

Claimant contends that SAIF had no right to seek Board review, because OAR 436-30-065(6)[6] provides that only a worker may request a hearing if a PTD award is reduced. The rule is silent as to an insurer's right to a hearing regarding a reexamination determination. However, the rule does not and cannot defeat an insurer's statutory right to a hearing under ORS 656.325 and ORS 656.268 See OSEA v. Workers' Compensation Dept., 51 Or App 55, 65, 624 P2d 1078, rev den 291 Or 9 (1981).

Claimant's reliance on *Farmers Ins. v. Hopson, supra*, and *Bentley v. SAIF, supra*, is misplaced. The issue in Hopson was whether an insurer could challenge the initial determination order that awarded PTD to the claimant, when the insurer had also requested reexamination of the award pursuant to ORS 656.206(5)

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[1] ORS 656.206(5) provides:

> "Each insurer shall reexamine periodically each permanent total disability claim for which the insurer has current payment responsibility to determine whether the worker is currently permanently incapacitated from regularly performing work at a gainful and suitable occupation. Reexamination shall be conducted every two years or at such other more frequest interval as the director may prescribe. Reexamination shall include such medical examinations, reports and other records as the insurer considers necessary or the director may require. The insurer shall forward to the director the results of each reexamination."

Throughout this opinion we refer to the statutes by their current citations and in their current form, unless otherwise noted.

and the Board had issued an order continuing the award. Although the issue was not before us, we commented that, under former OAR 438-24-030(3), "an insurer has no right to appeal to this court from a reconsideration order which continues claimant's status * * *." 53 Or App at 116. Similarly, in *Bentley v. SAIF, supra*, we did not decide whether an insurer has a right to request a hearing on a determination order that continues a claimant's PTD award. The issue was whether the proper procedure for initiating a reexamination of a final PTD award is a request for a redetermination under ORS 656.325(3) and ORS 656.268 or a request for a hearing under ORS 656.283. Here, the issue is squarely before us, and we conclude that, under ORS 656.325 and ORS 656.268(6), SAIF can seek review of an order reexamining a PTD award.

Finally, claimant argues that the Board erred in reducing her PTD award when there was no change in her medical condition or in any of the other factors affecting disability. Claimant is not entitled to benefits for PTD if she presently is able to perform a gainful occupation, even if her physical condition remains essentially unchanged. *Harris v. SAIF*, 292 Or 683, 696, 642 P2d 1147 (1982); *Kytola v. Boise Cascade Corp.*, 78 Or App 108, 112, 714 P2d 1083, *rev den* 301 Or 765 (1986).

Affirmed.

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[2] ORS 656.325(3) provides:

"A worker who has received an award for unscheduled permanent total or unscheduled partial disability should be encouraged to make a reasonable effort to reduce the disability; and the award shall be subject to periodic examination and adjustment in conformity with ORS 656.268."

[3] ORS 656.325(6) provides:

"Any party may request a hearing on any dispute under this section pursuant to ORS 656.283."

[4] ORS 656.268(6) provides:

"The Department of Insurance and Finance shall mail a copy of the determination to all interested parties. Any such party may request a hearing under ORS 656.283 on the determination made under subsection (4) of this section within 180 days after copies of the determination are mailed."

[5] ORS 656.283(1) provides:

"Subject to subsection (2) of this section and ORS 656.319, any party or the director may at any time request a hearing on any question concerning a claim."

[6] OAR 436-30-065(6) provides:

""The worker may request a hearing if the permanent total disability award is reduced:

"(a) Requests for hearing must be made in writing to the Workers' Compensation Board.

"(b) Requests for hearing must be made within 180 days after the mailing date of the order reducing the award."

Cite as 107 Or App 218 (1991) May 15, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Pablo G. Cortes, Claimant.

PABLO G. **CORTES**, Petitioner,
v.
BONNIE **WYLAND**, dba HILLY ACRES, and SAIF CORPORATION, Respondents.
(88-17078, 88-19802; CA A66024)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 25, 1991.
Robert Wollheim, Portland, argued the cause for petitioner. With him on the brief was Welch, Bruun & Green,Portland.
Steven Schwindt, Canby, argued the cause for respondent Bonnie Wyland, dba Hilly Acres. With him on the brief was Reif & Reif, Canby.
Thomas E. Ewing, Assistant Attorney General, Salem, waived appearance for respondent SAIF Corporation.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
EDMONDS, J.
Affirmed.

Claimant seeks review of a Workers' Compensation Board order that held that he is not entitled to compensation because he was a nonsubject worker under ORS 656.027(3).[1] We affirm.

The Board adopted the referee's findings:

"Hilly Acres is a 148 acre farm located near Molalla, Oregon. Approximately 65 acres of the land is in pasture and the remainder is forest. Hilly Acres usually has between 30 and 35 head of cattle. In approximately October of each year cattle are sold. In 1987 Hilly Acres sold cattle that resulted in total proceeds of $8,885. In 1988 Hilly Acres sold 28 calves, four cows and one bull for total proceeds of approximately $9,000. In 1986 and 1987 the farm operation resulted in a net loss for income tax purposes.

"The real property is owned by Bonnie V. Wyland. George Wyland is Bonnie Wyland's son. Except for his military service, George Wyland has lived in his mother's home since 1968. He does not pay rent and does not contribute to the purchase of food. If he did not live with his mother, he would incur living expenses of more than $500 per month. Until her retirement in late 1987, Bonnie

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[1] ORS 656.027(3) provides:
"All workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections:
"* * * * *
"(3)(a) A worker whose employment is casual and either:
"(A) The employment is not in the course of the trade, business or profession of the employer; or
"(B) The employment is in the course of the trade, business or profession of a nonsubject employer.
"(b) For the purpose of this subsection, 'casual' refers only to employments where the work in any 30 day period, without regard to the number of workers employed, involves a total labor cost of less than $200."

Wyland was employed full time away from her home and farm. George Wyland has been employed full time away from the home and farm for the past 13 years. Since his father died in 1968, George Wyland has performed the necessary physical labor for the maintenance and operation of the farm. Bonnie Wyland does not do any physical labor on the farm. George and Bonnie Wyland do not have any written agreement as to what each is supposed to do in connection with the operation of the farm. One piece of farm equipment, a tractor, is owned in George Wyland's name. In addition to performing maintenance, George Wyland uses his own funds to purchase and pay for necessary goods and services to run the farm. Once each year he turns his receipts over to Bonnie Wyland. He receives a portion of the proceeds from the sale of cattle, after other expenses are covered. For the year 1987 he received exactly $4,000. He expects to receive a portion of the proceeds of the 1988 cattle sale, but did not know how much he would receive as of the hearing. He does not always receive funds after the sale of cattle.

"Each summer the 65 acres of pasture are harvested as hay. The usual practice is for George Wyland to hire teenage neighbors to put up the hay. In July 1988 no neighbors were available. George Wyland recruited claimant and five other persons to put up the hay. The contract of hire was that each worker would be paid $4 per hour and would be transported by George Wyland from Woodburn, Oregon to the farm and returned to Woodburn after the work was completed each day.

"On July 18, 1987 all six persons worked and, in the aggregate, earned a total of $171. On July 19, 1987 George Wyland picked up claimant and two other persons in Woodburn to complete the haying. George Wyland anticipated that it would take approximately 6 man hours to complete the haying. On the way from Woodburn to Molalla the vehicle driven by George Wyland was involved in a motor vehicle accident in which claimant received a compression fracture of T6. Neither claimant nor any of the other workers did any more work and George Wyland finished putting up the hay himself. Claimant made a claim for workers' compensation benefits, which was denied by the SAIF Corporation on the ground that claimant was not a subject worker." (Citations omitted.)

The Board concluded that claimant's work was casual under ORS 656.027(3)(b), that he was working for Hilly Acres and that the work was in the course of its business. It also concluded that the Wylands are partners and, accordingly, are not subject workers of Hilly Acres under ORS 656.027(8).[2] Lastly, it concluded that, because neither George nor Bonnie is a subject

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[2] ORS 656.027 provides:

"All workers are subject to ORS 656.001 to 656.894 except those nonsubject workers described in the following subsections:
"* * * * *
"(8) Partners who are not engaged in work performed in direct connection with the construction, alteration, repair, improvement, moving or demolition of an improvement on real property or appurtenances thereto. When labor or services are performed under contract, the partnership must qualify as an independent contractor."

worker, Hilly Acres is not a subject employer. Therefore, ORS 656.027(3)(a)(B), claimant is not entitled to benefits.

In claimant's first assignment of error, he asserts that the Board erred in holding that Hilly Acres is not a subject employer. He argues that George Wyland was a subject worker of Hilly Acres, because he did most of the physical labor and hired other employees as needed; he received consideration in excess of $200 per month; and Bonnie Wyland had the right to direct and control his work activities. The Board disagreed, because George's share of the proceeds of the cattle sales and the room and board that he received did not bear any relationship to the amount of work that he performed. It also found insufficient evidence that Bonnie had the right to direct and control George's operation of the farm. Based on those findings, we agree with the Board's conclusion that George and Bonnie were partners and that neither was a subject employee of Hilly Acres. It follows that Hilly Acres was not a subject employer. ORS 656.023.

Claimant also asserts that the Board erred as a matter of law in holding that he is not a subject worker; he relies on *Hunnicutt v. Dollarhyde*, 95 Or App 375, 768 P2d 444 (1989), for the proposition that ORS 656.027(3) is inapplicable "where the employment is in the course of the trade, business or profession of the employer." *Hunnicutt* is inapposite. The parties there agreed that Dollarhyde was an employer, contrary to what the referee had found. We remanded for a determination of whether the claimant was involved in casual employment under ORS 656.027(3)(b), which is not the issue here. Moreover, ORS 656.027(3)(a)(B) applies to casual employment in the course of the business of a nonsubject employer. The Board did not err.

In his second assignment of error, claimant asserts that the Board erred in holding that Hilly Acres is a partnership, because that issue was neither raised nor argued. Employer responds:

> "This issue is properly before the [Board] because [claimant], in fact, raised it when he attempted to claim that George Wyland was a subject employee. This is not an attempt to introduce a new issue. Rather, it is an explanation of the issue raised by [claimant]."

We agree with employer that, when claimant raised the issue of whether Hilly Acres is a subject employer, that necessarily required the referee to determine if any of the exceptions in ORS 656.027 apply. We hold that the issue was properly before the Board.

Affirmed.

Cite as 107 Or App 224 (1991) May 15, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Anthony B. Beardslee, Claimant.

ANTHONY B. **BEARDSLEE**, Petitioner,
v.
DIAMOND WOOD PRODUCTS and LIBERTY NORTHWEST INSURANCE CORPORATION,
Respondents.
(WCB No. 88-10474; CA A64794)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 1, 1991.
James L. Edmunson, Eugene, argued the cause and filed the brief for petitioner.

Jerald P. Keene, Portland, argued the cause for respondents. With him on the brief was Roberts, Reinisch, Mackenzie, Healey & Wilson, P.C., Portland.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

DE MUNIZ, J.

Affirmed.

Rossman, J., dissenting.

Claimant seeks review of a decision of the Workers' Compensation Board reversing the referee and holding that his injury, sustained in a car accident while on the way to an independent medical exam (IME), is not compensable.

Claimant had filed claims for on-the-job injuries to his back and arm. Employer deferred acceptance or denial of the claims until after an IME, which was scheduled for January 20, 1988, at 3:30 p.m. Between 12:30 and 1:30 a.m., January 20, while on his way to Portland from Lebanon for the IME, claimant fell asleep at the wheel and drove his car into a ditch, sustaining the injury at issue. His mother eventually drove him to the IME in Portland. A referee later held that the claims for the back and arm were not compensable. Claimant did not appeal that determination. He contends, however, that he is entitled to benefits for the injury sustained in the car accident.

Claimant attempts to analogize this case to those in which we and the Supreme Court have held, under various circumstances, that, when the injury or need for treatment is a consequence of the compensable injury, it is compensable. In *Williams v. Gates, McDonald & Co.*, 300 Or 278, 709 P2d 712 (1985), the Supreme Court held compensable surgery that was necessary in order to treat the claimant's compensable condition. In *Fenton v. SAIF*, 87 Or App 78, 741 P2d 517, *rev den* 304 Or 311 (1987), we held that injuries sustained en route to a physician's office for treatment of a compensable injury were a direct and natural consequence of the injury and were compensable. In *Wood v. SAIF*, 30 Or App 1103, 569 P2d 648 (1977), *rev den* 282 Or 189 (1978), we held compensable an injury sustained in the course of vocational training necessitated by a work injury. This case is not like those. Claimant's injury was not a consequence of a compensable injury, but a consequence of an attempt to obtain compensation for a condition that was ultimately determined not to be compensable. The analogy does not work, and those cases do not support a determination of compensability.

Claimant contends, in any event, that the condition is compensable, because it occurred as a result of his employment:

> "The trip to participate in the IME was itself in the course and scope of claimant's employment because he was required to attend the IME as a consequence of his employment relationship. The employer, by and through its agent, the insurer, directed claimant to travel to Portland for the benefit of the employer and as a consequence of claimant's status as an employee. * * * Even if the circumstances of injury in [the] underlying claim fell outside the employment relationship, the IME itself was part of the employment duties claimant owed to his employer."

Contrary to claimant's contention, a worker's attendance at an IME is not a fulfillment of the obligations of his employment, but a condition of entitlement to workers' compensation. A worker who refuses to attend an IME risks the loss or suspension of benefits, *see* ORS 656.325, but does not risk the loss of his job. The IME itself bears no relation to the employment, unless the condition for which it is sought is ultimately determined to be compensable. Here, it was not.

Affirmed.

ROSSMAN, J., dissenting.

Although I agree that, by definition, claimant's injury cannot fit within the "consequence of a compensable injury" doctrine, I cannot agree that the employer-mandated attendance at an Independent Medical Exam (IME) "bears no relation to the unemployment unless the condition for which it is sought is ultimately determined to be compensable." 107 Or App at 227. Accordingly, I dissent.

I can find, and the majority cites, no authority for the unnecessarily broad determination that IME attendance can never be considered within the scope of employment unless the employee's underlying injury is compensable. Further, the opinion fails to examine whether claimant's IME-related injury arose out of his employment.

As the author of today's majority opinion so eloquently pointed out in his dissent in *Gwin v. Liberty Northwest Ins. Corp.*, 105 Or App 171, 175, 803 P2d 1228 (1991), several factors *must be considered* when determining whether a claimant's injury is work related:

(1) *Was the activity for the benefit of the employer?* Here, it was. Attendance at the IME allowed employer to determine whether the claimed injury was valid. *See* ORS 656.325. For claimant, it was simply one more hoop to jump through the claims process.

(2) *Was the activity contemplated by the employer and employee at the time of hiring or later?* We must presume that, at the time of hiring, parties are aware of the possibility that, by statute, attendance at an IME may be required at some point during the employment.

(3) *Was the activity an ordinary risk of, and incidental to, the employment?* Yes; employer directed claimant to visit a particular doctor in a particular city. An employee is required to attend, if requested to by the employer or insurer. ORS 656.325(1)(a). Claimant was simply responding to employer's directions.

(4) *Was the employee paid for the activity?* No.

(5) *Was the activity on the employer's premises?* No.

(6) *Was the activity directed by or acquiesced in by the employer?* Absolutely; but for the specific directions of employer, claimant would not have been there.

(7) *Was the employee on a personal mission of his own?* Although the journey to Portland was a personal mission to the extent that claimant was trying to secure compensation for what he believed was a work-related injury, it was primarily an employment-related mission, because claimant was on the road to Portland at the request of employer.

In the light of those questions and answers, I would hold that the relationship between claimant's injury and his employment is sufficiently close to render the injury compensable. Given employer's specific directive--a directive that was simply being carried out by claimant--the connection is too strong to ignore. Nonetheless, I would remand for the Board to determine whether claimant, in leaving for Portland late at night and stopping by a friend's house, turned his journey into such a personal mission as to break the causal link to his employment.

Cite as 107 Or App 254 (1991) May 22, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Arnold G. Wheeler, Claimant.

SAIF CORPORATION, Petitioner,
v.
ARNOLD G. **WHEELER**, Respondent.
(WCB No. 87-0276M; CA A64163)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 7, 1990.
David L. Runner, Assistant Attorney General, Salem, argued the cause for petitioner. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
No appearance for respondent.
Before Richardson, Presiding Judge, and Joseph, Chief Judge,and Deits, Judge.
JOSEPH, C.J.
Reversed and remanded for reconsideration.

SAIF Corporation (SAIF) seeks review of the Workers' Compensation Board's Own Motion Order on Reconsideration and a remand for further proceedings.

SAIF requested the Board to consider terminating claimant's permanent total disability award for injuries predating 1966. The Board held that it lacked jurisdiction to reevaluate the award under ORS 656.278.[1] It reasoned that ORS 656.278(1)(b) expressly permits it only to authorize payment of medical benefits for pre-1966 injuries, in addition to temporary disability

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[1] ORS 656.278 provides, in part:

"(1) Except as provided in subsection (5) of this section, the power and jurisdiction of the board shall be continuing, and it may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified in those cases in which:

"(a)There is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, the board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the board; or

"(b) The date of injury is earlier than January 1, 1966. In such cases, in addition to the payment of temporary disability compensation, the board may authorize payment of medical benefits."

Subsection (1) was amended by Or Laws 1987, ch 884, 37. Previously, the subsection provided:

"Except as provided in subsection (5) of this Section, the power and jurisdiction of the Board shall be continuing, and it may, upon its own motion, from time to time, modify, change or terminate former findings, orders or awardsif in its opinion such action is justified."

compensation provided for in subsection (1)(a). The Board found no express language or legislative intent apparent in the statute to authorize it to decrease or terminate permanent disability awards.

SAIF would interpret ORS 656.278(1)(b) differently. It argues that, on its face, the statute authorizes the Board to terminate a former award in all cases where "[t]he date of injury is earlier than January 1, 1966." The second sentence of the subsection, SAIF contends, does not limit the meaning of the first sentence; it merely authorizes the Board to grant medical benefits and temporary disability awards under the limited conditions specified in subsection (1)(a). SAIF points to the language in ORS 656.278(3)[2] that allows a claimant "to appeal" an own motion order that reduces or terminates a former award and argues that subsection (3) would be meaningless under the Board's interpretation of subsection (1). SAIF also contends that nothing in the legislative history of the amendment evidences any intent to eliminate the Board's authority to reduce permanent disability awards.

We have interpreted ORS 656.278(1), as it now reads, to abolish the Board's authority to award permanent disability benefits on its own motion. *See State ex rel Borisoff v. Workers' Comp. Board*, 104 Or App 603, 606, 802 P2d 98 (1990); *Independent Paper Stock v. Wincer*, 100 Or App 625, 628, 788 P2d 466, *rev den* 310 Or 195 (1990). The question in this case is whether, under ORS 656.278(1), the Board may on its own motion *reduce or terminate* a permanent disability award for injuries pre-dating 1966.[3]

ORS 656.278(1) unambiguously provides that the Board can "from time to time modify, change or *terminate* former * * * awards" in cases where the injury occurred "earlier than January 1, 1966." (Emphasis supplied.) ORS 656.278(3) evidences the legislature's intent to continue the Board's authority to reduce awards but only as limited by subsection (1). Our interpretation is consistent with the policy that claimants should be encouraged to attempt to reduce their disabilities and become self-sufficient to the greatest extent practicable. *See* ORS 656.012(2)(c); ORS 656.206(5); ORS 656.325(3).

Reversed and remanded for reconsideration.

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[2] ORS 656.278(3) provides:

"The claimant has no right to appeal any order or award made by the board on its own motion, except when the order diminishes or terminates a former award. The employer may appeal from an order which increases the award."

[3] Before ORS 656.278(1) was amended in 1987, the Board exercised its own motion jurisdiction to reduce pre-1966 permanent disability awards when they were otherwise unreviewable under ORS 656.325(3). *See Thornsberry v. SAIF*, 57 Or App 413, 418 n 2, 644 P2d 661 (1982); *McDowell v. SAIF*, 13 Or App 389, 395, 510 P2d 587 (1973); *see also Elgin E. Amidon*, 37 Van Natta 612 (1985).

Cite as 107 Or App 276 (1991) May 22, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Rami M. Shureh, Claimant.

RAMI M. **SHUREH**, Petitioner,
v.
UNITED PARCEL SERVICE and LIBERTY NORTHWEST INSURANCE CORP., Respondents.
(89-00381; CA A66071)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 13, 1991.
Gerald C. Doblie, Portland, argued the cause for petitioner. With him on the brief was Doblie & Associates, Portland.
Deborah L. Sather, Portland, argued the cause for respondents. With her on the brief was Cooney, Moscato & Crew, Portland.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
BUTTLER, P.J.
Affirmed.

Claimant seeks review of an order of the Workers' Compensation Board holding that employer acted reasonably and had authority to suspend claimant's benefits for failing to attend a scheduled independent medical examination (IME).

The facts found by the Board are supported by substantial evidence. Claimant suffered a compensable injury when he fell from a trailer. He was treated initially for a low back problem. Because of dizziness and related symptoms thought to be related to his industrial accident, evaluation of that condition was undertaken. His treating physician recommended that he undergo an IME by a physician in Seattle.

At that time ORS 656.325(1)(a) provided:

> "Any worker entitled to receive compensation under ORS 656.001 to 656.794 is required, if requested by the director, the insurer, or self-insured employer, to submit to a medical examination at a time and place and from time to time at a place reasonably convenient for the worker and as may be provided by the rules of the director. However, no more than three examinations may be requested except after notification to and authorization by the director. If the worker refuses to submit to any such examination, or obstructs the same, the rights of the worker to compensation shall be suspended with the consent of the director until the examination has taken place, and no compensation shall be payable during or for account of such period."

Claimant contends that he was not obligated to attend the IME, because it would have been his fourth one.

On April 8, 1987, at employer's request, claimant saw two doctors, Dr. Hodgson, an otolaryngologist, and Dr. Ferguson, an orthopedist. The Board found that

> "[t]he purpose of the examination was to provide an independent medical assessment of claimant's ear condition and back condition. Because of the medical complexity of the conditions to be examined, a panel, consisting of two appropriate medical specialities, conducted

the examination. Additionally, due to the need to utilize special equipment, the inner ear examination was held in Dr. Hogsdon's office. Although the two examinations were conducted in different locations and at different times, they were held on the same day, in sequential chronological order, for the same claim, and carried out under the auspices of the Western Medical Consultants. Under these facts, we find there was one multi-discipline independent medical examination conducted on April 8, 1987."

Substantial evidence supports the Board's finding that the examination by two specialists in different fields of medicine under the auspices of Western Medical Consultants was one IME for purposes of ORS 656.325(1)(a). Claimant does not contest the Board's determination that he had had only one other IME before the Seattle IME. Accordingly, the Seattle examination would have been his third IME, and claimant was obligated to attend it, unless it was unreasonable to require him to go to Seattle.

Claimant's treating physician recommended to employer that it obtain an analysis of claimant's inner ear condition from one of four qualified specialists, all of whom resided outside Oregon; the Seattle doctor was the closest. Substantial evidence supports the Board's findings that it was reasonable for employer to request that claimant attend the IME in Seattle and that claimant did not have a valid reason for not attending it.

Claimant argues, nevertheless, that employer acted unreasonably in requesting the suspension of benefits after he had requested a hearing on the issue of whether he should be required to attend the out-of-state IME. Although claimant was entitled to request a hearing on that issue, his doing so did not prevent employer from seeking a remedy under the procedures provided by ORS 656.325(1)(a).

Affirmed.

Cite as 107 Or App 287 (1991) May 22, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Timothy E. Dooley, Claimant.

SAIF CORPORATION, Petitioner,
v.
TIMOTHY E. **DOOLEY**, Respondent.
(TP-89026; CA A63380)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 29, 1990.
Katherine H. Waldo, Assistant Attorney General, Salem, argued the cause for petitioner. With her on the brief were Dave Frohnmayer, Attorney General, and Virginia Linder, Solicitor General, Salem.
Gary K. Jenson, Eugene, argued the cause and filed the brief for respondent.
Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.
Reversed and remanded.

SAIF petitioned the Workers' Compensation Board for a third-party distribution order, ORS 656.593(1)(d), that it was entitled to $5,481.43 of the

proceeds from claimant's settlement of an action against a third party. ORS 656.593(3).[1] The Board denied the petition, and SAIF seeks review. We reverse.

There is no challenge to the Board's findings of fact. We review for errors of law. In June, 1986, claimant suffered a back injury at work, which caused pain in his low back, left hip and neck. SAIF accepted the claim and paid him benefits for medical costs and time loss. In May, 1987, as he was nearing medically stationary status, and while he was still receiving temporary total disability benefits, he was involved in an automobile accident unrelated to his employment. The accident resulted in new injuries and worsened his compensable condition. His physician was able to distinguish both the medical costs and the time loss attributable to the automobile accident from those attributable to the original injury. SAIF did not pay the medical costs of the accident. It paid him, however, $5,481.43 for four months of additional temporary total disability benefits for his worsened condition. Later, he sued the other driver and, with SAIF's approval, entered into a settlement for $24,593.75. ORS 656.593(3). SAIF then asserted that, as the paying agent, it should receive, as its just and proper share, $5,481.43 of the settlement proceeds. ORS 656.593(3).

The Board held that claimant did not suffer a "compensable injury" in the accident. It also held that the accident was not the consequence of a compensable injury. It concluded, therefore, that SAIF was not entitled to a share of the settlement proceeds. SAIF asserts that the Board erred and that it may share in the proceeds that claimant recovered from the third person that are attributable to the injury for which SAIF paid benefits.

ORS 656.578 provides:

> "[I]f a worker receives a compensable injury due to the negligence or wrong of a third person * * *, entitling the worker under ORS 656.154 to seek a remedy against such third person, such worker * * * shall elect whether to recover damages from such employer or third person."

The Board erred as a matter of law when it ruled that claimant did not sustain "a compensable injury due to the * * * wrong of a third person." In *Grable v. Weyerhauser Company*, 291 Or 387, 631 P2d 768 (1981), the claimant suffered a compensable back injury at work and later suffered an injury at home that worsened his condition. The court said:

> "If the claimant establishes that the compensable injury is a 'material contributing cause' of his worsened condition, he has thereby necessarily established that the worsened condition is not the result of an 'independent, intervening' non-industrial cause. We hold that an employer is required to pay workers' compensation benefits for worsening of a worker's condition where the worsening is the result of both a compensable on-the-job back injury and a

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[1] ORS 656.593(3) provides:

> "A claimant may settle any third party case with the approval of the paying agency, in which event the paying agency is authorized to accept such a share of the proceeds as may be just and proper * * *. Any conflict as to what may be a just and proper distribution shall be resolved by the board."

> subsequent off-the-job injury to the same part of the body if the worker establishes that the on-the-job injury is a material contributing cause of the worsened condition." 291 Or at 401.

An off-the-job injury that aggravates a compensable condition is a "compensable injury" within the meaning of ORS 656.578.

In *SAIF v. Meredith*, 104 Or App 570, 802 P2d 95 (1990), SAIF brought an action as the assignee of an injured worker's third party tort action stemming from an automobile accident injury that worsened the symptoms of her compensable condition and prolonged her recovery. We said that her

> "condition following the accident was a compensable aggravation for which SAIF was responsible. * * * 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 [the worker] 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." 104 Or App at 574.

Here, as in *Meredith*, claimant could and did bring an action against the driver who caused the injury that aggravated his condition. SAIF was required to pay compensation for that aggravation. ORS 656.578; *Grable v. Weyerhauser Company, supra*, 291 Or at 401. Claimant sued the third party, and he settled the action with SAIF's approval. SAIF was entitled to receive its just and proper share of the settlement proceeds. ORS 656.593(3).

Reversed and remanded.

Cite as 107 Or App 304 (1991) May 22, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Jacqueline D. Hanes, Claimant.

JACQUELINE D. **HANES**, Petitioner,
v.
WASHINGTON COUNTY COMMUNITY ACTION and SAIF CORPORATION, Respondents.
(88-11146; CA A64484)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 18, 1990.
Ronald A. Fontana, Portland, argued the cause and filed the brief for petitioner.
David L. Runner, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General and Virginia L. Linder, Solicitor General, Salem.
Before Richardson, Presiding Judge, and Newman and Deits, Judges.
DEITS, J.
Affirmed.

Claimant seeks review of a Workers' Compensation Board order holding that her compensable injuries are nondisabling. In an earlier, unappealed order, a referee stated that her injuries were "compensable and disabling." Claimant argues that the Board was precluded from later deciding that she is not disabled. She also contends that there was not substantial evidence to support the Board's decision that she was not disabled. We affirm.

Claimant was employed by Washington County Community Action Agency from 1978 until 1986. She started as a secretary and eventually was promoted to program director. Because she had difficulty dealing with her increased responsibilities, she voluntarily took a demotion to the position of lead counselor in August, 1985. She continued to have difficulties on the job and with her supervisor. She was terminated in January, 1986, and obtained unemployment benefits. Describing her reaction to the termination, she testified:

> "I was more scared than anything, and I think I was really in a state of shock, and--I don't know. I didn't think about whether I could work or not work. I--you know--I'm a single parent, and I have children, and I know they needed to be taken care of and I was--you know--panicky."

From April, 1985, through 1987, claimant obtained counseling from her ministers, one of whom had a master's degree in counseling psychology. They encouraged her to consult other mental health practitioners, but she did not do so. In early 1986, she sought medical treatment for skin rash, bloody stools, diarrhea, gastrointestinal upset and spasm, chest and extremity pain and numbness. Her doctor diagnosed reflux esophagitis and depression and concluded that stress could have exacerbated her physical conditions. Claimant testified that her physical symptoms were continuing at the time of the hearings. After her termination by employer, she had applied for about 200 jobs. She obtained a position at a restitution center in mid-1986 but was fired after one month. She was hired to work 32 hours per week at a senior center in February, 1988, and resigned seven months later. She also worked cleaning houses.

Claimant filed this occupational disease claim on June 19, 1987. SAIF denied the claim, and she appealed. At SAIF's request, she was given an independent psychiatric exam by Dr. Turco, whose report diagnosed her as having "adjustment reaction, with what appears to be elements of fatigue." In a deposition that was made part of the record, he stated that claimant had suffered from emotional distress in 1985 and 1986, that it may have been disabling and that some of her distress related to her working conditions. In an order issued on April 20, 1988, the referee set aside SAIF's denial:

> "Claimant has met her burden of proving that she suffered from a mental disorder which was disabling, that there were stressful conditions on her job and that those stressful job conditions and events were the major contributing cause of her mental disorder."

SAIF did not appeal that order; instead, it accepted the claim as compensable and nondisabling. It then requested a determination order, which was issued on June 13, 1988, and awarded no temporary or permanent disability. Claimant had a hearing on the determination order, and the referee set it aside. He concluded that claimant was disabled and awarded her temporary total disability and temporary partial disability benefits. SAIF appealed that order. The Board held that claimant was not disabled and reinstated the determination order. Claimant seeks review of the Board's decision.

Claimant contends that the referee's finding of disability in the first order precludes the Board from deciding now that her condition was nondisabling. We hold that employer was not precluded from seeking a determination on the extent of disability after the first referee's order.

Issue preclusion is defined in *Drews v. EBI Companies*, 310 Or 134, 139, 795 P2d 531 (1990):

> "The issue preclusion branch of preclusion by former adjudication, formerly called collateral estoppel, precludes future litigation on a subject issue only if the issue was 'actually litigated and determined' in a setting where 'its determination was essential to' the final decision reached. *North Clackamas School Dist. v. White*, 305 Or 48, 53, 750 P2d 485, *modified* 305 Or 468, 752 P2d 1210 (1988); Restatement (Second) of Judgments 17(3) (1982); *see also id.* at 27."

The purpose of the first referee's finding of disability was to support the initial determination that the condition was compensable. The extent of disability, if any, had not yet been fully litigated. To determine whether claimant's mental disorder was compensable, the referee needed to determine whether it arose out of and in the course of her employment and whether it had required medical services or was disabling. ORS 656.802(1). Because employer had denied the claim as noncompensable, it had not yet had an opportunity to assert whether the condition, if found to be compensable, was disabling[1] or to litigate the extent of disability. The first referee's order simply set aside the initial denial of compensability and remanded the case for processing, which would include the determination of the extent of disability.

Claimant also contends that the Board's finding that she is not disabled is not supported by substantial evidence. She points to Turco's testimony as sufficient evidence that she was disabled. However, the issue on review is whether a reasonable person could conclude that claimant's condition was not disabling. See Armstrong v. Asten-Hill Co., 90 Or App 200, 206, 752 P2d 312 (1988). Although Turco testified that he believed that she was disabled, the record includes other evidence that supports the Board's conclusion that her compensable condition is not disabling. The Board found:

> "No time loss was authorized by any physician. Claimant's family physician, Dr. Glasser, did not treat claimant for her employment related stress and authorized no time loss. Furthermore, the only psychiatric evidence in the record is that of Dr. Turco. Dr. Turco concluded that claimant was psychiatrically stationary and capable of working on a regular full-time basis. Dr. Turco found that while claimant could have possibly been disabled from her job with SAIF's insured he could not determine when she would have been capable of returning to regular work. His suggestion that claimant was disabled from work at the time she was terminated is primarily based on information obtained through claimant's statements that she could not perform the job when terminated and for some time thereafter. The remainder of this record, which includes other employments as well as receipt of unemployment benefits, does not support claimant's statements that she was continuously disabled during this period of time even on a partial basis."

We conclude that there is substantial evidence in the record to support the Board's findings.

Affirmed.

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[1] ORS 656.262(6)(a) requires an employer to provide written notice of acceptance or denial within 60 days after it has notice or knowledge of a claim and, if the claim is accepted, to give notice of whether the injury is considered disabling or nondisabling. If a claim is denied, the employer is not required to advise the claimant whether it considers the claim to be for a disabling or nondisabling injury.

Cite as 107 Or App 316 (1991) May 22, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of E. Earlene J. Little, Claimant.

SAFEWAY STORES, INC., Petitioner,
v.
E. EARLENE J. **LITTLE**, Respondent.
(87-19635; CA A66555)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 15, 1991.
Kenneth L. Kleinsmith, Portland, argued the cause for petitioner. With him on the brief was Meyers & Radler, Portland.
Dale C. Johnson, Eugene, argued the cause for respondent. With him on the brief was Malagon, Moore & Johnson, Eugene.
Before Richardson, Presiding Judge, and Deits and Edmonds, Judges.
EDMONDS, J.
Affirmed.

Employer seeks review of a Workers' Compensation Board order that held that it had prematurely terminated claimant's temporary total disability (TTD) benefits in violation of OAR 436-60-030(5) and that, therefore, she is entitled to a penalty and attorney fees. We affirm.

In May, 1987, claimant sustained a compensable back injury, for which she received TTD compensation. She saw Dr. Womack, a chiropractor, Dr. Hendricks, an orthopedist, and Dr. Marier, her "regular" physician, for that injury and several unrelated conditions. She also saw Dr. Baker, another orthopedist, at the request of employer. On December 2, 1987, Marier notified claimant by letter that he had approved her return to light work. The letter stated, in part:

> "I have been contacted by the Central Office at Safeway Stores, Inc. They have informed me that they are willing to offer you any sort of limited duty employment that you can tolerate.
>
> "Thusly, I am approving you for limited duty to return to work."

Employer terminated claimant's benefits the same day.[1]

On December 11, 1987, Baker released claimant to return to light work, and employer sent her an offer of employment that incorporated his statement. Claimant refused to accept the offered job on December 18, 1987, saying that Baker had told her that she could not return to work until she had had back therapy. Thereafter, she sought reinstatement of her benefits as of December 2, a penalty and attorney fees. The referee found that Baker was claimant's treating physician, held that the requirements of OAR 436-60-030(5) were met as of December 11 and awarded TTD benefits up to that date.

Claimant sought Board review. The Board first found that Baker was not claimant's attending physician. Then, it said:

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[1] The record does not indicate why employer chose to terminate claimant's TTD benefits on that date.

"In this case, it is extremely difficult to determine whether Dr. Hendricks, Dr. Marier or Dr. Womack is the attending physician. However, resolution of that factual issue is not necessary to determine whether claimant's temporary total disability compensation was improperly unilaterally terminated. The employer had the responsibility under the rule to resubmit the job offer to claimant after the treating doctor approved the job offer, especially in light of her response to the earlier job offer. Accordingly, whether the treating physician was Dr. Hendricks, Dr. Marier or Dr. Womack, the employer failed to comply with the procedural requirements of OAR 436-60-030(5).

"Since the triggering event is the worker's refusal of a job offer, and the employer terminated claimant's benefits prior to her refusal of a job offer based on Baker's authorization, we conclude that the employer unilaterally ceased payment in violation of the rule. Furthermore, because in this case it was incumbent on the employer to resubmit the job offer to claimant after the treating doctor's agreement not [sic] to the duties, the termination was not permissible even after claimant's refusal."

OAR 436-60-020(5), provides:

"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 conditions*:

"(a) the attending physician *has been notified* by the employer or the 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 workers' 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." (Emphasis supplied.)

Employer argues that there is not substantial evidence to support the Board's finding that Baker was not claimant's "attending physician."[2] Instead, it asserts that either Baker or Marier was. Accordingly, because either or both of them agreed to release claimant to the light duty job that employer ultimately offered her, employer argues that it complied with the rule. It also asserts that the Board erred when it stated that resubmission of the offer was required under the rule. Claimant relies on the facts that employer terminated her benefits before it received her refusal and that, notwithstanding that refusal, it failed to submit to her a job offer that complied with the rule.

There is substantial evidence to support the Board's finding that Baker

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[2] ORS 656.005(12) provides, in part:
"'Attending physician' means a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury."

was not claimant's attending physician. He examined claimant at employer's request, and claimant was then seeing other doctors for her back condition. Substantial compliance with the procedural requirements of OAR 436-60-020(5) is insufficient to authorize an employer to terminate TTD benefits. *Eastman v. Georgia Pacific Corp.*, 79 Or App 610, 719 P2d 1310 (1986). Employer did not comply with the requirements of the rule when it terminated benefits *before* claimant had either received or refused its written offer of employment. Further, even if Marier was claimant's attending physician, the improper termination was not rectified by claimant's refusal of the offer, because the offer did not contain a statement that he had said that the offered employment was within her capabilities. The Board was correct when it held that, in the light of the initial invalid offer, employer was required to submit an offer to claimant that complied with the rule before it could terminate her benefits.

Employer also asserts that, because claimant did not personally appear at the hearing, the Board erred when it refused to dismiss the request for hearing. Employer is wrong. See *Williams v. SAIF*, 99 Or App 367, 781 P2d 1269, *aff'd* 310 Or 320, 797 P2d 1036 (1990).

Last, employer asserts that, under ORS 656.262(10) and ORS 656.382(1), the Board erred in assessing a penalty and attorney fees for employer's unreasonable refusal to pay compensation. Under the facts, the Board did not err.

Affirmed.

Cite as 107 Or App 321 (1991) May 22, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON

COBRA CONSTRUCTION, Petitioner,

v.

The filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE** and SAIF CORPORATION, Respondents.

(89-12-32; CA A65233)

Judicial Review from Department of Insurance and Finance, Insurance Division.

Argued and submitted March 15, 1991.

Bruce D. Smith, Medford, argued the cause for petitioner. With him on the brief was Smith and Smith, Medford.

David 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 by respondent National Council on Compensation Insurance.

Before Richardson, Presiding Judge, and Deits and Edmonds, Judges.

EDMONDS, J.

Affirmed.

Employer seeks review of an order of the Department of Insurance and Finance (Department) that dismissed its appeal, because it had not been timely filed. ORS 737.505(4). We affirm.

After receiving SAIF's final premium audit billing on October 16, 1989, employer mailed a request for appeal to Department. Department did not receive the request until December 18, 1989. The appeal was dismissed pursuant to ORS 737.505(4):

"Appeals to the director pursuant to ORS 737.318 with regard to a final premium audit billing must be *made* within 60 days after receipt of the billing." (Emphasis supplied.)

Employer argues that its mailing complied with the time requirement for making an appeal.[1] SAIF argues that "made" means "filed" and that filing did not occur until Department received the request. The issue is what the legislature intended by the word "made" in ORS 737.505(4).

Subsection 4 was added to ORS 737.505 in 1987. Or Laws 1987, ch 884, 6; *see also* ORS 737.318. Testimony in support of the bill indicated that the appeal procedure in subsection 4 of ORS 737.505 was to be patterned after the procedure for contested case hearings in ORS chapter 183. Minutes, Senate Committee on Labor, May 21, 1987, Tape 164, Side B; Minutes, Senate Committee on Labor, June 2, 1987, Tape 187, Side A. In a contested case, the petition for review must be "filed" within 60 days after the order has been served. ORS 183.482(1). That suggests that "made" in ORS 737.505(4) is synonymous with "filed." In other contexts, it has been held that "filed" means received by the person or tribunal with which filing is required. *See In re Wagner's Estate*, 182 Or 340, 342, 187 P2d 669 (1947); *Barr v. EBI Companies*, 88 Or App 132, 744 P2d 582 (1987); *Hoffman v. City of Portland*, 57 Or App 688, 691, 646 P2d 49, *rev'd on other grounds*, 294 Or 150, 654 P2d 1106 (1982); *Bergeron v. Ontario Rendering Co.*, 34 Or App 1025, 580 P2d 216, *rev den* 284 Or 80 (1978); *Williams v. Cody*, 24 Or App 433, 545 P2d 905 (1976).

In the absence of any contrary expression of legislative intent, we agree with Department that the legislature intended that merely mailing a request for appeal did not constitute making an appeal under ORS 737.505(4). *See Springfield Education Assn. v. School Dist.*, 290 Or 217, 621 P2d 547 (1980).

Affirmed.

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[1] Employer relies in part on OAR 836-43-110 (since amended), which provided that an insurer, when adjusting a premium for an employer after a premium audit, had to notify the employer of the right to appeal by this notice:

"You may appeal this billing to the Director of the Department of Insurance and Finance, State of Oregon, by applying in writing to the Director within 60 days after receiving this premium audit billing. Your completed appeal must state your grounds for questioning the billing, and must include your contentions of error by your insurer and your request for correction and relief.

"The appeal must be sent to the following address:

"Director
Department of Insurance and Finance
21 Labor and Industries Bldg.
Salem, OR 97310

"You may send a copy of your appeal to your insurer. This will give you and your insurer an opportunity to resolve the dispute prior to a hearing."

The rule tells an employer that an appeal must be in writing and not oral, but it is unrelated to the issue of what the legislature intended by the word "made." The rule does not assist employer's argument. Although it does not pertain to this case, we note that the rule was amended in 1990 to require receipt of an appeal within the 60-day period.

Cite as 107 Or App 358 (1991) May 22, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of M. Glenn Wardell, Claimant.

M. GLENN **WARDELL**, Petitioner,
v.
SMURFIT NEWSPRINT and HARTFORD INSURANCE, Respondents.
(WCB Nos. 88-17934, 89-02546 and 89-03291; CA A66221)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 13, 1991.
David L. Johnstone, Portland, argued the cause for petitioner. With him on the brief was Bennett & Durham, Portland.
Deborah L. Sather, Portland, argued the cause for respondent Smurfit Newsprint. With her on the brief were Frank Moscato and Cooney, Moscato & Crew, P.C., Portland.
Robert E. L. Bonaparte, Portland, argued the cause for respondent Hartford Insurance. On the brief were Stephen R. Frank, Matthew K. Rossman and Tooze Shenker Holloway & Duden, Portland.
Before Buttler, Presiding Judge, and Edmonds and De Muniz, Judges.
DE MUNIZ, J.
Affirmed.

Claimant seeks review of an order of the Workers' Compensation Board affirming the referee and holding that he is not entitled to additional benefits for compensable hearing loss.

In September, 1982, claimant filed a claim for hearing loss. Employer accepted the claim, and claimant received an award for 16.91% binaural hearing loss, resulting from 16.75% hearing loss in the right ear and 18% hearing loss in the left ear. In July, 1988, claimant filed a second claim for hearing loss, contending that his hearing had worsened since the first award. Employer denied the claim. The Board found that claimant's work environment had not changed over the years and that his off-the-job exposure to noise was insignificant.

Claimant had an audiogram in October, 1988, which showed that hearing loss in his right ear has increased to 22.25%. Nevertheless, taking into account normal hearing loss due to age, claimant's *compensable* binaural hearing loss was only 16.78%, which is less than it was in 1982. On that basis, the Board concluded that claimant is not entitled to additional compensation. Claimant does not dispute that there is substantial evidence showing an improvement in his binaural hearing. He contends, however, that he is entitled to additional compensation on the basis of the worsening of hearing in his right ear alone.

Claimant did not argue the case in that manner to the referee. He did present the issue to the Board, and the parties have adequately briefed it here. Thus, we consider the question of whether a worker who has received an award for a binaural hearing loss is entitled to an award for a worsening of his hearing in one ear, although his compensable binaural hearing loss is slightly improved.

The method for calculating disability due to hearing loss is described in ORS 656.214(2):

> "(f) For partial or complete loss of hearing in one ear, that percentage of 60 degrees which the loss bears to normal monaural hearing.

"(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. For the purpose of this paragraph, combined binaural hearing loss shall be calculated by taking seven times the hearing loss in the less damaged ear plus the hearing loss in the more damaged ear and dividing that amount by eight. *In the case of individuals with compensable hearing loss involving both ears, either the method of calculation for monaural hearing loss or that for combined binaural hearing loss shall be used, depending upon which allows the greater award of disability.*" (Emphasis supplied.)

Claimant contends that, because his hearing has become worse in one ear, only that ear should be considered for the purpose of determining whether he has experienced an aggravation; that is, his claim should be treated as a claim for hearing loss in one ear, without regard to any hearing loss in the other ear. We conclude, however, that having once been compensated for hearing loss in both ears, claimant's hearing loss must be evaluated on the basis of both ears. The statute requires that claimant's total hearing disability be calculated under both the monaural method and the binaural method and that he be compensated according to the method that yields the greater award. As at the time of the original claim, the binaural formula produces the higher award but, under that formula, claimant's disability now is less than it was at the time of the original claim. He is not entitled to additional compensation.

Affirmed.

Cite as 107 Or App 376 (1991) May 22, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Hubert W. Barker, Claimant.

HUBERT W. **BARKER**, Petitioner,
v.
FARMERS PACKING COMPANY and SAIF CORPORATION, Respondents.
(87-00261; CA A64922)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 12, 1991.
James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Christopher D. Moore and Malagon, Moore & Johnson, Eugene.
Thomas E. Ewing, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
PER CURIAM
Reversed and remanded for reconsideration not inconsistent with this opinion.

Claimant seeks review of an order of the Workers' Compensation Board reversing the referee and holding that he is not entitled to benefits for permanent total disability.

Claimant contends that the Board erred in concluding that he had not established a willingness to work, because the "sanitor" job that was offered to him and that he refused was not available on a regular basis in a hypothetically normal job market. There is substantial evidence to support the Board's determination that the offered job was available, that it was within claimant's

physical ability and that he refused it. The same evidence is sufficient to support the Board's finding that claimant did not make a reasonable effort to find work, and that finding, in turn, requires the conclusion that claimant is not entitled to benefits for permanent total disability.[1]

Claimant also contends, and employer concedes, that there is no substantial evidence to support the Board's statement that claimant has a "documented history of functional overlay." Given the Board's possible reliance on that factor in its determination that claimant is not totally disabled from a physical standpoint, we cannot say that the error did not influence the Board's decision. Accordingly, we remand to the Board for reconsideration.

Reversed and remanded for reconsideration not inconsistent with this opinion.

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[1] Claimant also states, apparently in the alternative, that the Board erred in failing to address his willingness to seek work. In view of the Board's finding that claimant had not made a reasonable effort to seek work, a finding regarding his willingness to work was unecessary.

Cite as 107 Or App 395 (1991) May 29, 1991

In the Court of Appeals of the State of Oregon
In the Matter of the Compensation of Randy R. Westfall, Claimant

Randy R. **WESTFALL**, Petitioner,
v.
RUST INTERNATIONAL and Underwriters Adjusting Company, Respondents.
(WCB 88-01147; CA A62442)

Judicial Review from Workers' Compensation Board.
On Petitioner's petition for reconsideration filed March 6, 1991. Opinion awarding sanctions filed October 17, 1990, 104 Or App 132, 798 P2d 1124. Order for sanctions filed January 30, 1991.
David Force, Salem, and Vick & Gutzler, Salem, for petition.
Bradley R. Scheminske, Portland, and Scheminske & Lyons, Portland, contra.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
WARREN, P.J.
Reconsideration allowed; opinion adhered to. Respondent's motion for sanctions on reconsideration denied.

Claimant's attorney petitions for review of our decision imposing sanctions on him pursuant to ORS 656.390. 104 Or App 132, 798 P2d 1124 (1990). We treat the petition as one for reconsideration, ORAP 9.15, allow it and adhere to our decision.

ORS 656.390 provides:

"Notwithstanding ORS 656.236, if either party appeals for review of the claim to the Court of Appeals or to the Supreme Court, or files a motion for reconsideration of the decision of the Court of Appeals or the Supreme Court, and the court finds that the appeal or motion for reconsideration was frivolous or was filed in bad faith or for the purpose of harassment, the court may impose an appropriate sanction upon the attorney who filed the appeal or motion. The sanction may include an order to pay to the other party the amount of the 78

> reasonable expenses incurred by reason of the appeal or motion, including a reasonable attorney fee."

The attorney argues that he cannot be sanctioned under the statute, because it provides for sanctions only against "the attorney who filed the appeal * * *." He contends that "filed the appeal" means "filed the notice of appeal." Because he did not sign the notice of appeal,1 but only filed the brief and argued the cause, he argues that he cannot be sanctioned. Although the statute could be read in the way that the attorney asserts, its language is also susceptible of a broader meaning, which is supported by the Legislative history and purpose.

The statute authorizes sanctions not only for frivolous appeals in this court, but also for frivolous Supreme Court "appeals for review." Supreme Court review of a decision by this court is initiated by the filing of a petition for review, not by the filing of a notice of appeal. *See* ORAP 9.05(1). Under the attorney's interpretation, sanctions could never be authorized for a frivolous petition for Supreme Court review, because the notice of appeal relates only to Court of Appeals review.

Legislative history supports a broader reading of the phrase. The chairman of the Senate Labor Committee told the committee that the proposed statute was based on FRCP 11 and that similar sanctions were already available in the trial court, but needed to be extended to the appellate courts. Tape recording, Senate Labor Committee, June 10, 1987, Tape 211, Side B at 187. The committee members were concerned about how to force the courts to impose sanctions. Tape recording, Senate Labor Committee, May 27, 1989, Tape 178, Side B at 34. FRCP 11 by its terms applies to "[e]very pleading, motion, or other paper" signed by an attorney. The rule requires that sanctions be imposed for violation of the rule that the attorney's signature constitutes a certificate that the attorney

> "has read the pleading, motion, or other paper; that to the best of [the attorney's] knowledge, information, and belief formed after reasonable inquiry it is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and that it is not interposed for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation."

Given FRCP 11's application to all papers signed by an attorney, not just the initial pleading, the legislature's use of FRCP 11 as a model for ORS 656.390 and the committee's concern about how to force appellate courts to apply the sanctions rule in appropriate circumstances, ORS 656.390 must be read to encompass more than just the filing of the notice of appeal.

We conclude that ORS 656.390 allows this court to impose sanctions on an attorney who files documents relating to prosecution of an appeal, including the notice of appeal and briefs. The legislature wanted to deter frivolous appeals. Allowing an attorney who crafts and submits frivolous arguments to escape sanctions merely because another attorney signed the notice of appeal would be contrary to legislative intent.

The attorney in this case signed and filed a brief that was wholly devoid of merit. He orally argued that position to this court. Accordingly, he is subject to sanctions under ORS 656.390.

Respondent has asked that we impose sanctions for the attorney's having petitioned for review. We decline to do that.

Reconsideration allowed; opinion adhered to. Respondent's motion for sanctions on reconsideration denied.

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1 "Notice of appeal" includes a petition for judicial review. ORS 656. 298(3).

Cite as 107 Or App 400 (1991) May 29, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON

LITTLE DONKEY ENTERPRISES, INC., Petitioner
v.
STATE ACCIDENT INSURANCE FUND, Respondent
(88-11-01; CA A63546)

Judicial Review from Department of Insurance and Finance.
Argued and submitted January 7, 1991.
Montgomery W. Cobb, Portland, argued the cause for petitioner. With him on the brief were David R. Simon and Tooze, Shenker, Holloway & Duden, Portland.
John T. Bagg, 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 Warren, Presiding Judge, and Riggs and Edmonds, Judges.
RIGGS, J.
Reversed and remanded for reconsideration of whether owner-operators are exempt as non-subject workers; otherwise affirmed.

Petitioner seeks review of the final order of the Department of Insurance and Finance that ordered petitioner to pay workers' compensation premiums assessed by SAIF. We review for substantial evidence and errors of law, ORS 183.480; ORS 183.482, and conclude that substantial evidence supports the department's factual findings and that it did not err in determining that the workers in question are employees rather than independent contractors. However, the department failed to consider whether those employees are exempt as non-subject workers under ORS 656.027.

Petitioner argues that the department erred in finding that the testimony of petitioner's witnesses lacked credibility; in finding that OAR 836-43-110(3) does not apply to the audit; in finding that the workers are petitioner's employees rather than independent contractors; and in failing to consider whether the workers are exempt under ORS 656.027. Only the last contention merits discussion.

Petitioner characterizes itself as a transportation management company. It enters into contracts with persons who own and operate trucks (owner-operators) and arranges loads for them to transport. It collects payments from the shippers for the transportation provided and pays the owner-operators a percentage of that amount. It also handles the accounting for the owner-operators.

SAIF provided petitioner workers' compensation coverage from November 11, 1986, through December 31, 1987. After an audit, SAIF adjusted the premiums for that period, because it considered the owner-operators under written contract with petitioner to be employees subject to the Workers' Compensation Law. Petitioner was assessed additional premiums of $43,000.

Petitioner requested review of the assessment. At the hearing, the department found that petitioner's relationships with the owner-operators involved three types of operations: common-carrier, broker-carrier and trip-leasing. The department found that, under the contract for common-carrier operations, petitioner retains the right to control the owner-operators' duties and responsibilities and that, therefore, they are petitioner's employees.

The department did not address petitioner's contention that the owner-operators are exempt under ORS 656.027. SAIF argues tht the department was not

obliged to discuss the statutory exemptions because, to be exempt under the current version of ORS 656.027(7), a sole proprietor must qualify as an independent contractor and the department had already determined that the owner-operators do not qualify. The language on which SAIF relies, that "the sole proprietor must qualify as an independent contractor," was added in 1989. Or Laws 1989, ch 762, Section 41. The same language was also added to the exemptions for partners and corporate officers in ORS 656.027(8) and (9). At the time of the audit, the statute read:

"All workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections:

"* * * * *

"(7) Sole proprietors."

Under the statute, sole proprietors were exempt, even if they did not qualify as independent contractors. [1] The same was true for partners and corporate officers under ORS 656.027(8) and (9). The department should have considered whether the owner-operators are exempt as non-subject workers under the pre-amendment version of ORS 656.027. Therefore, we remand for reconsideration.

Reversed and remanded for reconsideration of whether owner-operators are exempt as non-subject workers; otherwise affirmed.

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1 In *Bernards v. Wright*, 93 Or App 192, 760 P2d 1388 (1988), the claimant was found to be an employee, rather than an independent contractor, but was not exempt as a sole proprietor under ORS 656.027(7), because the employer did not prove that the claimant was a sole proprietor. The clear implication of that case is that, if the employer had proved that the claimant was a sole proprietor, the exemption would have applied. See also *Lockard v. The Murphy Company*, 49 Or App 101, 109n6, 619 P2d 283 (1980), *rev den* 290 Or 519 (1981).

Cite as 107 Or App 404 (1991) May 29, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Edward K. McGuire, Claimant

ROSE CITY VAN & STORAGE and Liberty Northwest Insurance Corporation, Petitioners

v.

Edward K. **McGUIRE**, Chipman Moving & Storage, Lile International/Liberty Northwest Insurance Corporation, Eastside Van & Storage, Bekins Moving, SAIF Corporation, Safeco Insurance Company and Oregon Insurance Guaranty Association, Respondents.

(WCB 87-07348, 87-07480, 87-07481, 87-10318, 87-12554; CA A64531)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 28, 1991.

Paul L. Roess, Portland, argued the cause for petitioners. With him on the brief was Acker, Underwood, Norwood & Hiefield, Portland.

Craig A. Staples, Portland, argued the cause for respondents Lile International and Liberty Northwest Insurance Corporation. With him on the brief was Roberts, Reinisch, MacKenzie, Healey & Wilson, Portland.

Richard A. Sly, Portland, waived appearance for respondent Edward K. McGuire.

Thomas E. Ewing, Assistant Attorney General, Salem, waived appearance for respondents SAIF Corporation and Chipman Moving & Storage.

Ridgway K. Foley, Jr., Portland, waived appearance for respondents Eastside Van & Storage and Safeco Insurance Company.

Jay W. Beattie, Portland, waived appearance for respondents Bekins Moving & Storage and Oregon Insurance Guaranty Association.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.

Reversed and remanded for reconsideration of responsibility between Rose City and Lile International; otherwise affirmed.

The issue in this case is which employer is responsible for claimant's condition. Rose City Van and Storage (Rose City) petitions for review of a Workers' Compensation Board order on reconsideration that assigned it responsibility, because it was the last "potentially causal" employer. We reverse and remand.

In 1985, claimant suffered a compensable injury while working as a furniture mover for Corporate Relocation. He returned to his regular work without any restrictions in April, 1986. Claimant worked as an "on call" furniture mover for six different employers between April and August, 1986. Eastside Van and Storage Company (Eastside), Rose City and Lile International (Lile) were three of the employers.[1] Shortly after returning to work, claimant's symptoms returned and his underlying condition gradually worsened. No new injury or specific incident occurred, and the work at each employment was equally strenuous. On August 12, 1986, claimant saw Dr. Crumpacker, who took him off work. Claimant filed an aggravation claim with Corporate Relocation, which denied it. A referee affirmed the denial, concluding that claimant's subsequent employment with other movers independently contributed to the worsening of the underlying condition resulting from the 1985 injury.[2]

Claimant filed claims against each of the other employers; all of them denied compensability and responsibility. In March, 1988, in response to a request by Eastside, Drs. Crumpacker and Walsh each responded affirmatively to these statements:

> "2. Claimant's right-sided complaints of *late June and early July 1986* are an aggravation of the underlying condition that [claimant's] work exposure *in late June and early July 1986* was the major contributing cause to the onset and need for medical care and treatment; and
>
> "3. Any medical care and treatment subsequent to July 1986 would be symptoms of the aggravated condition *of late June or early July 1986*." (Emphasis supplied.)

Another referee held a hearing in March, 1988, on the denials of Rose City, Lile and the other employers. On the basis of the responses of Crumpacker and Walsh, he concluded that claimant's underlying condition "did worsen in June and July due to his work as a furniture mover." Relying on Boise Cascade Corp. v. Starbuck, 296 Or 238, 675 P2d 1044 (1984), he applied the last injurious exposure rule and assigned responsibility to Lile as the last employer whose

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[1] Claimant worked for Eastside on April 30, May 1 and August 13, 1986. He worked for Rose City on May 4, June 1,2,3,4,27 and July 11, 1986. He also worked for Rose City for one day in the period between July 26 and August 8, 1986. He worked for Lile on July 2,10,11,12,18 and 19, 1986.

[2] The other moving companies were not parties to that proceeding.

conditions of employment could have caused the disability. The Board adopted the referee's findings and affirmed as to compensability and the assignment of responsibility to Lile, because it held that the last "potentially causal employment" was with Lile on July 19, 1986. On reconsideration, the Board reversed itself and assigned responsibility to Rose City, because of evidence that claimant had worked for Rose City for one day sometime between July 26 and August 8, 1986. The exact date is unknown. The Board concluded that Rose City is responsible, because it was claimant's last potentially causal employment before the onset of disability on August 12, 1986.[3]

Rose City argues that the Board erred in applying the last injurious exposure rule to assign responsibility to it, because, in this case, compensability was premised on medical evidence of causation occurring in the period from late June to early July. Under the circumstances, Rose City contends that "that employment must, as a matter of law, represent the last 'potentially causal employment' for the purposes of assigning responsibility."

We agree. Under the last injurious exposure rule of liability, responsibility is assigned to the last employer before the onset of disability where work conditions could have caused claimant's injury. *Bracke v. Baza'r, Inc.*, 293 Or 239, 248, 646 P2d 1330 (1982). In this case, the medical evidence, on which the Board relied to find the claim compensable, is that claimant's underlying condition worsened during a discrete period, *late June to early July*.[4] In that situation, responsibility for the claim is properly assigned to the last potentially causal employer *within that period*.

Although the Board said that it was persuaded by the opinions of Crumpacker and Walsh and that it would defer to them, its order refers to the critical period as "June and July" rather than late June and early July, as stated in their opinions. On the basis of that incorrect rephrasing, the Board then concluded that Rose City is responsible, because its work exposure for one day some time between July 26 and August 8 was the last "potentially causal" employment. We conclude that the Board erred in assigning responsibility to Rose City on the basis of employment in late July or early August, because that employment was not in the discrete period during which the compensable claim arose. We remand for the Board to determine for which employer claimant worked between "late June and early July" is responsible for the claim. That may be Rose City, where claimant worked on June 27 and July 11, or it may be Lile, where claimant worked on July 2,10,11,12,18 and 19, 1986.

Reversed and remanded for reconsideration of responsibility between Rose City and Lile International; otherwise affirmed.

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[3] The only issues raised here relate to responsibility between Lile and Rose City.

[4] Both doctors agreed that any work activity after that time merely contributed to claimant's symptoms.

Cite as 107 Or App 429 (1991) May 29, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of John A. Tallant, Claimant

TROJAN CONCRETE, Petitioner,
v.
John A. **TALLANT**, SAIF Corporation, Green Holdings, Wausau Insurance Company and Department of Insurance and Finance, Respondents
(86-08967, 86-02121; CA A65108)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 20, 1991.
Adam T. Stamper, Medford, argued the cause for petitioner. On the brief were H. Scott Plouse and Cowling & Heysell, Medford.
Robert Chapman, Medford, argued the cause for respondent John Tallant. With him on the brief was Black, Chapman & Webber, Medford.
John Reuling, Assistant Attorney General, Salem, argued the cause for respondents SAIF Corporation and Department of Insurance and Finance. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
David Horne, Beaverton, waived appearance for respondents Wausau Insurance Company and Green Holdings.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

EDMONDS, J.
Affirmed.

Employer seeks review of an order of the Workers' Compensation Board invalidating a disputed claim settlement between claimant and employer because SAIF was not a party to the agreement. We affirm.[1]

The Board found that claimant had experienced low back pain while working for employer. On the date of the injury, employer had no workers' compensation insurance. Claimant filed a claim and requested a hearing on the compensability of his injury. The Department of Insurance and Finance (Department) declared employer a noncomplying employer and referred the claim to SAIF for processing. SAIF accepted the claim and notified employer of the acceptance. Employer requested a hearing to contest compensability. SAIF and Department elected not to appear at the hearing. Although no hearing was convened, employer and claimant entered into a disputed claim settlement agreement that provided, in part:

> "The parties stipulate as follows:
>
> "(1) That on or about November [26], 1985, claimant filed a Form 801 Report of Occupational Injury or Disease alleging that on November 18, 1985, he injured himself during the course of his employment. The Employer, Trojan Concrete, has denied that Claimant suffered an injury during the course and scope of his employment.
>
> "* * * * *

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[1] Claimant also entered into a disputed claim settlement with Green Holdings that was affirmed by the Board and is not challenged in this petition for review.

"(3) That it appears to the parties that a bona fide dispute exists as to the compensability of Claimant's claim and that the matter should be settled by a lump sum payment of $2,500.00 to Claimant under the provisions of ORS 656.289(4).

"(4) That Claimant fully understands the terms and stipulations of this settlement including the fact that his claim is determined to be noncompensable. That he is represented by an attorney, has consulted with the attorney regarding these matters, and does not require a hearing with regard to the denial of his claim provided that it is approved by a Referee of the Workers' Compensation Board.

"(5) Claimant's Request for Hearing shall be dismissed with prejudice as to all issues raised or that could have been raised and the Employer's denial of Claimant's claim as being compensable shall be affirmed."

At the time of the settlement, SAIF had paid approximately $10,000 in claim costs. Neither SAIF nor Department was a party to the agreement. The referee approved the agreement, dismissed claimant's request for hearing and affirmed employer's denial. SAIF and Department requested review of the order. Employer moved to dismiss the request for review on the ground that neither SAIF nor Department had standing to request review. The Board denied employer's motion, invalidated the agreement and held that the claim was compensable.

Employer argues that SAIF and Department have no standing to challenge the disputed claim settlement. SAIF and Department contend that SAIF has standing, because it has the statutory obligation to process the claim. They argue that Department has standing because, under ORS 656.283(1),[2] the director "may at any time request a hearing on any question concerning a claim."

Whether "standing" exists depends on a legislative recognition that a particular interest ought to be represented in the statutory proceeding at issue. *People for Ethical Treatment v. Inst. Animal Care*, 102 Or App 276, 280, 794 P2d 1224, *rev allowed* 310 Or 612 (1990). ORS 656.054 [3] places the responsibility on SAIF to process a claim made by a worker employed by a noncomplying employer. Department reimburses SAIF for its expenditures from the Industrial Accident Fund. Under ORS 656.054(3), all costs of processing a claim, including compensation awarded to the claimant, are a liability of the noncomplying employer. ORS 656.262(7) requires SAIF to send notice of acceptance or denial of the claim to the noncomplying employer. Those responsibilities and the Department's pecuniary interest show that the legislature has recognized that SAIF and Department have standing to seek review of the disputed claim settlement to which they were not parties.[4]

Employer contends that SAIF and Department waived their right to challenge the settlement by failing to appear at the hearing. A waiver is the intentional relinquishment of a known right. *Drews v. EBI Companies*, 310 Or 134, 150, 795 P2d 531 (1990). SAIF had previously accepted the claim. Although SAIF and Department waived the right to appear at the hearing requested by employer, there was no hearing convened and SAIF and Department were not informed that the

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[2] ORS 656.283(1) provides:

"Subject to subsection (2) of this section and ORS 656.319, any party or the director may at any time request a hearing on any question concerning a claim."

parties intended to negotiate a settlement. We hold that SAIF and Department did not waive their party status under these circumstances.

Employer next argues that the Board erred in holding that it did not have authority to enter into a disputed claim settlement with claimant. SAIF and Department acknowledge that employer, as a noncomplying employer, was entitled to request a hearing on the issue of compensability after SAIF had accepted the claim. *Clark v. Linn*, 98 Or App 393, 779 P2d 203 (1989). SAIF and Department contend, however, that a noncomplying employer's right to have the question of compensability determined does not include the right to settle a disputed claim without SAIF's consent.

ORS 656.289(4) provides, in part:

> "[I]n any case where there is a bona fide dispute over compensability of a claim, the parties may, with the approval of a referee, the board or the court, by agreement make such disposition of the claim as is considered reasonable."

Under ORS 656.005(19), employer was a party to the workers' compensation proceeding and had a right, under ORS 656.283(1), to request a hearing to contest compensability. However, because employer is a noncomplying employer, the primary responsibility for processing and payment of the claim lies with SAIF and Department, who are therefore also parties to the proceeding. No settlement can be binding under ORS 656.289(4) without all parties agreeing to it. Employer is not an agent for SAIF and Department and, therefore, had no authority to bind them. The Board did not err in holding the agreement void.

Finally, employer contends that the Board exceeded its statutory authority under ORS 656.295 by deciding the matter of compensability, instead of remanding it to the referee for a determination, and that the Board erred in finding the claim compensable. Employer does not dispute the Board's finding that the record was sufficient to allow it to address the issue of compensability. Under ORS 656.295(6), the Board may "supplement the order of the referee and make such disposition of the case as it determines to be appropriate."

There is substantial evidence to support the Board's holding that the claim was compensable.

Affirmed.

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[3] ORS 656.054 now provides:

> "(1) A compensable injury to a subject worker while in the employ of a noncomplying employer is compensable to the same extent as if the employer had complied with ORS 656.001 to 656.794. The director shall refer the claim for such an injury to the State Accident Insurance Fund Corporation within 60 days of the date the director has notice of the claim. A claim for compensation made by such a worker shall be processed by the State Accident Insurance Fund Corporation in the same manner as a claim made by a worker employed by a carrier-insured employer, except that the time within which the first instalment of compensation is to be paid, pursuant to ORS 656.262(4), shall not begin to run until the director has referred the claim to the State Accident Insurance Fund Corporation.

"(2) Whenever a subject worker suffers a compensable injury while in the employ of a noncomplying employer, the director shall, after an order closing the claim has become final, serve upon the employer a notice of proposed penalty to be assessed pursuant to ORS 656.735(3).

"(3) In addition to, and not in lieu of, any civil penalties assessed pursuant to ORS 656.735, all costs to the Industrial Accident Fund of a claim processed under subsection (1) of this section shall be a liability of the noncomplying employer. Such costs include compensation, reasonable administrative costs and any attorney fees awarded to the claimant, but do not include assessments for reserves in the Insurance and Finance Fund. The director shall recover such costs from the employer. The director shall provide by regulation for the Insurance and Finance Fund to reimburse, on a periodic basis, the Industrial Accident Fund for any costs it incurs under this section. When the director prevails in any action brought pursuant to this subsection, the director is entitled to recover from the noncomplying employer court costs and attorney fees entitled by the director."

There have been amendments to the statute since the disputed claim settlement, but none pertains to this case.

[4] We note, after the date of the settlement, the Board amended OAR 438-05-040(10) to provide:

" 'Party' means a claimant, an employer, including a noncomplying employer, the SAIF corporation as processing agent in cases under ORS 656.054, and an insurer."

IN THE COURT OF APPEALS OF THE STATE OF OREGON

JEFFREY **BENZINGER**, Respondent,
and
SHARON **BYERS**, SANDRA COLLINS, RICHARD FRIEND, TEDDY MOUNTON and BLAIN YOUNG,
Plaintiffs,
v.
OREGON DEPARTMENT OF INSURANCE AND FINANCE, acting through the WORKERS' COMPENSATION DIVISION APPELLATE UNIT, agencies of the STATE OF OREGON,Appellant.
(9102-01201; CA A69059)

Appeal from Circuit Court, Multnomah County.
Harl H. Haas, Judge.
Argued and submitted May 6, 1991.
Kendall M. Barnes, Assistant Attorney General, Salem, argued the cause for appellant. With him on the brief were Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General and Michael D. Reynolds, Assistant Attorney General, Salem.
Robert K. Udziela, Portland, argued the cause for respondent. With him on the brief were Dan O'Leary and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.
Before Richardson, Presiding Judge, and Newman and Deits, Judges.
RICHARDSON, P.J.
Affirmed.

Benzinger (plaintiff),[1] a workers' compensation claimant, brought this proceeding under ORS 183.490, to compel defendant Workers' Compensation Division to process his request for reconsideration of a claim closure within 15 days from the date of request therefor," pursuant to ORS 656.268(6)(a), as amended by Oregon Laws 1990, chapter 2, section 16.[2] Plaintiff contends that defendant's failure to complete reconsideration within 15 days violated the statute. Defendant contends that the 15-day limit is not mandatory. The trial court agreed with plaintiff and concluded "that the statute is clear on it[s] face." Defendant appeals, and we affirm.

Defendant's first assignment is, in essence, that the court erred in concluding that the 15-day limit in ORS 656.268(6)(a) is mandatory. It first argues that the word "shall" is not always mandatory and does not compel the trial court's conclusion. Although we do not disagree with that abstract proposition, the word is facially mandatory when used in a statute that prescribes a time limit for performing an act. As defendant all but concedes, the principal Oregon authority that it found to support the contrary conclusion was implicitly overruled in *Anaconda Company v. Dept. of Rev.*, 278 Or 723, 736, 65 P2d 1084 (1977) (Howell, J., dissenting). In any event, although "authority" can be found to support just about any proposition, the *general* rule, stated in *Stanley, Adm. v. Mueller*, 211 Or 198, 208, 315 P2d 125 (1957), is that "[i]t is elementary that 'shall' connotes the imperative." We conclude that the word is mandatory as used in ORS 656.268(6)(a).

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[1] The other plaintiffs' actions are being held in the trial court pending disposition of this case. The trial court entered a final judgment under ORCP 67B.

[2] The 1990 amendments have not been published in the Oregon Revised Statutes as of the date of this opinion.

Defendant's more fervently urged contention is that, functionally and in the light of the requirements of other statutes, it is impossible for it to comply with a 15-day requirement for the completion of every request for reconsideration to which the statute applies. Hence, defendant maintains, the legislature could not have intended it to be a mandatory requirement and, to avoid an absurd result, we should not give effect to the literal words of the statute. We recently reiterated in *Southwood Homeowners v. City Council of Philomath*, 106 Or App 21, 806 P2d 162 (1991):

> "We noted in Dennehy v. City of Portland, [87 Or App 33, 40-41, 740 P2d 806 (1987)], that the 'absurd results' doctrine should be used sparingly, because it entails the risk of judicial displacement of legislative policy on the basis of judicial speculation that the legislature could not have meant what it unmistakably said. In this instance, there is nothing that we can say is absurd in the literal reading of the statute." 106 Or App at 24.

See also Anaconda Company v. Dept. of Rev., supra, 278 Or at 729.

Similarly, here, there is nothing even arguably absurd in a literal reading of the statute. Defendant's references to such factors as its caseload and the need for more extensive consideration than can be achieved within 15 days may demonstrate that compliance with the statute is difficult and would require the sacrifice of competing equities and even that the statute may be ill-advised. However, it is hard to imagine a clearer case for the admonition that the argument must be addressed to the legislature. We agree with plaintiff and the trial court that the statute means what it says.

Defendant's second assignment assails the trial court's exclusion of certain evidence that defendant characterizes as legislative history and that would suggest that the 15-day limit was unintended or "was a mistake in the drafting process." Because the language of the statute has a clear meaning, the evidence could have had no effect on the decision of the case.

Defendant makes three other assignments that require no discussion.

Affirmed.

Cite as 107 Or App 468 (1991) June 5, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of William T. Shields, Claimant.

TRI-MET, INC., Petitioner,
v.
WILLIAM T. **SHIELDS**, Respondent.
(89-02938, 89-02937; CA A66363)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 13, 1991.
Scott H. Terrall, Portland, argued the cause for petitioner. On the brief were Eric R. Miller and Terrall & Miller, Portland.
Steven T. Fagenstrom, Portland, argued the cause for respondent. With him on the brief were Charles D. Colett and Galton, Scott & Colett, Portland.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
BUTTLER, P.J.
Reversed.

Employer petitions for review of an order of the Workers' Compensation Board awarding claimant employer-paid attorney fees.

Claimant suffered compensable injuries to his right knee in August, 1984, and February, 1986. The 1986 claim was closed with a determination order on August 1, 1986, with no award of permanent partial disability (PPD). On August 26, 1986, a determination order closed the 1984 claim with an award of 15 percent PPD.

Claimant requested a hearing on the extent of his disability. At the hearing, employer argued that the permanent disability award should have been made for the 1986 claim, rather than for the 1984 claim. The referee agreed and amended the August 26, 1986, determination order to eliminate the PPD award and amended the August 1, 1986, determination order to award 15 percent PPD. The referee stated that, "[b]ecause the employer has already paid claimant on the 1984 claim, that award may be treated as an advance against the 15 percent award ordered on the 1986 claim, resulting in no net payment to claimant." Claimant was not awarded attorney fees, because there had been no increase in his disability award.

Claimant sought review of the referee's order and, on January 5, 1989, the Board affirmed the referee on the merits but held that, although no additional compensation was to be paid to claimant, claimant's attorney was entitled to a fee paid out of the increased award for the 1986 injury. Claimant did not seek review of the Board's order, which became final.

Later, claimant requested a hearing, contending that employer had failed to pay his attorney fees as required by the Board's order. The referee held that employer had no obligation to pay claimant's attorney fees and that they must be paid by claimant out of the award of compensation previously paid to claimant. The Board reversed the referee and, relying on OAR 438-15-090, held that the fees should be paid by employer.

OAR 438-15-090(2) provides:

> "An attorney fee which has been authorized under these rules to be paid out of increased compensation awarded by a referee, the Board or a court shall not be subject to any offset based upon prior overpayment of compensation to the claimant."

The rule is a limitation on an employer's right to offset an award of compensation. If a claimant receives an increased award of compensation, out of which an award of attorney fees is payable, but payment of the award is offset by a prior overpayment, that portion of the award that would have been paid to the claimant's attorney as attorney fees is not subject to an offset.

The Board held that its earlier decision to give employer a "credit" on the award for the 1986 claim because of an "overpayment" on the 1984 injury was the procedural equivalent of an offset. Because that offset was not available under OAR 438-15-090(2) with respect to the amount that would have been paid to claimant's attorney out of the increased award, it ordered that employer pay that amount to claimant's attorney.

Even assuming that the administrative rule did not authorize the Board to allow the offset, its January 5, 1989, order authorized an offset of the full award and became final when claimant failed to seek review of that determination. It is not subject to collateral attack. There is no other basis for an award of employer-paid attorney fees.

Reversed.

Cite as 107 Or App 485 (1991) June 5, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Ralph J. Davis, Claimant.

FRERES LUMBER CO., Petitioner,
v.
RALPH J. **DAVIS**, YOUNG & MORGAN and LIBERTY NORTHWEST INSURANCE, Respondents.
(WCB 88-16048 and 88-20680; CA A66812)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 19, 1991.
Jerry K. Brown, McMinnville, argued the cause for petitioner. With him on the brief was Cummins, Brown, Goodman, Fish & Peterson, P.C., McMinnville.
Willard E. Fox, Salem, argued the cause for respondent Davis. With him on the brief was Allen, Stortz, Fox, Susee & Olson, Salem.
Stafford Hazelett, Portland, argued the cause for respondents Young & Morgan and Liberty Northwest Insurance Corporation. With him on the brief was Davis and Bostwick, Portland.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
ROSSMAN, J.
Affirmed.

Freres Lumber Co. (Freres) seeks review of an order of the Workers' Compensation Board reversing the referee and holding that it, and not Young & Morgan (Y & M), is responsible for claimant's low back condition.

Claimant injured his low back in February, 1984, while working for Freres as a heavy equipment mechanic. He had a preexisting degenerative disc disease. Dr. Melgard, a neurologist, confirmed that his low back problems were due to the injury. Claimant lost two weeks of work and then returned to modified work for about five weeks, when he was terminated. He began to work for Y & M in September, 1984, as a heavy equipment mechanic. The claim against Freres was accepted and closed by a determination order in November, 1984.

Claimant has not been pain free since the 1984 injury. The pain has gradually spread from his low back to his hips. He has missed time from work as a result. X-rays taken in November, 1987, showed, in the doctor's words, "no significant changes" since 1984. In July, 1988, Melgard requested an MRI, which showed "bulging disks at L2 through S1 without significant neural impingement." Claimant filed an aggravation claim with Freres and a new claim with Y & M. Both denied compensability and responsibility. The referee and the Board found that claimant's condition was compensable by Freres as an aggravation of the 1984 injury.

Freres contends, first, that the Board's finding is not supported by substantial evidence. There is substantial evidence to support the Board's conclusion that claimant's employment with Y & M did not independently contribute to his back condition. The opinions of Melgard and Western Medical Consultants support the view that, although claimant's symptoms have become disabling, they do not represent a change in the underlying condition.

Freres also argues that the Board applied an incorrect standard of proof. In support of its conclusion that Freres did not establish that the employment at Y & M independently contributed to his condition, the Board said:

> "Although we note that claimant has bulging discs at L2 through S1, we do not find such changes significant. X-rays and CAT scans

were done by Salem Hospital in April 1984 and November 1987. The November 1987 report stated that appearances had not changed significantly since April 1984. Also, the Western Medical Consultants compared x-rays dated March 6, 1984, June 22, 1988 and December 7, 1988 and found that they all showed similar findings. The only MRI was done in June 1988. It showed bulging discs at L2 through S1 without significant neural impingement. Thus, taking the diagnostic tests as a whole, we do not find that claimant's bulging discs represent a pathological worsening of claimant's condition by [the employment at Y & M]."

Freres contends that that shows that the Board improperly applied a "significant" change standard of proof, when all that had to be shown was any change in the underlying condition.

The argument is not well taken. It is clear from the Board's opinion that it applied the correct test. In the quoted paragraph, the Board simply discusses medical reports that show that the changes in claimant's condition are not clinically significant. It was proper for the Board to rely on that evidence to support its conclusion that Freres had not established that the employment at Y & M had independently contributed to a worsening of his condition.

Affirmed.

Cite as 107 Or App 494 (1991) June 5, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Donna E. Aschbacher, Claimant.

AETNA CASUALTY CO. and ST. VINCENT HOSPITAL, Petitioners,
v.
DONNA E. **ASCHBACHER**, Respondent.
WCB 88-07257; CA A61687)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 20, 1990.
Thaddeus J. Hettle, Portland, argued the cause for petitioners. With him on the brief was Scheminske & Lyons, Portland.
J. Michael Casey, Portland, argued the cause for respondent. With him on the brief was Doblie & Associates, Portland.
Before Richardson, Presiding Judge, and Newman and Deits, Judges.
DEITS, J.
Reversed and remanded for reconsideration.

Employer seeks review of an order of the Workers' Compensation Board that reversed the referee and held that claimant's low back condition is compensable. The Board decided that, under ORS 656.802(1), claimant could receive benefits for worsened symptoms without establishing that her underlying disease had worsened, if she proved that her work was a material contributing cause of the worsened symptoms. Employer contends that the Board erred in its interpretation of the 1987 [1] amendments to ORS 656.802(1), both with respect to its conclusion that the material contributing cause standard applies to this type of occupational disease claim and in its conclusion that it was not necessary to prove a

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[1] The 1987 amendments to ORS 656.802 became effective January 1, 1988. Or Laws 1987, ch 713, 4.

worsening of claimant's underlying condition. We agree and reverse.

The facts are undisputed. At the time of the hearing, claimant was a 52-year-old phlebotomist who collected blood samples from hospital patients. She had worked full-time for twenty years before she left work in 1980. She returned to her job in 1984 and worked an average of two to three days per week. She stood or walked most of her shift. In December, 1987, she began to have pain in the calf of her lower right leg about four hours after beginning work. By March, 1988, the pain had worsened and was beginning earlier in her workday. Her physician referred her to Dr. Waller, a neurosurgeon, who diagnosed a degenerative spinal disc and a narrowing of the foramen lumbosacral disc space with foraminal stenosis on the right side. He said that the pain in the calf was a symptom of a preexisting low back condition that was caused by "normal degenerative changes with aging." Waller prescribed conservative therapy. However, claimant's pain continued, and she missed work. She filed a workers' compensation claim on March 4, 1988, for her low back condition. She left work on April 4, 1988, and, as of the time of the hearing, she had not returned to work. She continued to have pain in her right leg when she was on her feet for more than three hours at a time.

After a hearing on compensability, the referee decided that claimant had not proved a compensable occupational disease under ORS 656.802(1)(c). The Board reversed. It held that, under the 1987 amendments to ORS 656.802(1), a claimant no longer needs to prove that work was *the major* contributing cause of a condition, as had been required under *Dethlefs v. Hyster Co.*, 295 Or 298, 310, 667 P2d 487 (1983). Instead, it determined that a claimant only has to prove that the work was a material contributing cause of the condition. The Board also decided that, under the amended statute, claimant did not need to prove that her underlying disease had worsened, as had been required under *Weller v. Union Carbide*, 288 Or 27, 602 P2d 259 (1979). Instead, it concluded that a claim is compensable even if the claimant has only worsened symptoms, if they are disabling and require medical services. It then held that, even though claimant's underlying disease had not worsened, her claim is compensable because her work materially contributed to worsened symptoms that are disabling and require medical services.

Employer first argues that the Board erred in concluding that the 1987 amendments to the occupational disease statute require claimant only to prove that her employment was a material contributing cause of her condition, rather than the major contributing cause. Before the 1987 amendments, "occupational disease" was defined in ORS 656.802(1)(a) as

> "[a]ny disease or infection arising out of and in the scope of employment, and to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein."

In 1987, the definition of "occupational disease" was amended to read:

> "(a) *Any disease or infection* arising out of and in the course of employment caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gasses, radiation or other conditions or substances *to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein*, and which requires medical services or results in physical or mental disability or death.
>
> "(b) Any mental disorder arising out of and in the course of employment and which requires medical services or results in physical or mental disability or death.

"(c) Any series of traumatic events or occurrences arising out of and in the course of employment which requires medical services or results in physical disability or death." (Emphasis supplied.)

The Board concluded that the language in ORS 656.802(1)(a), "to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment," had been the foundation for the court's conclusion in *Dethlefs v. Hyster Co., supra*, 295 Or at 307, that occupational disease claims must be considered under the major contributing cause standard. The Board reasoned that, because the 1987 legislature included the same phrase in subsection (a), which governs exposure to substances, but did not use it in subsections (b) and (c), which relate to claims for mental disorders and "a series of traumatic events," occupational disease claims under subsections (b) and (c) need only be considered under the material contributing cause standard. It then went on to conclude that, because in its view the language of the statute was clear, it was unnecessary to consider the legislative history of the amendment.

Although the court in *Dethlefs* did refer to the quoted phrase, it concluded that "[t]he text of the statute does not provide a clear answer as to compensability." *Dethlefs v. Hyster Co., supra*, 295 Or at 309. (Emphasis in original.) In its analysis of the statute, the court first rejected the view that the "proper test is whether the disease was caused solely by the work environment." It also rejected the suggestions of *amicus curiae* that a claimant only needs to prove that on-the-job exposure was a material contributing cause. On the basis of its understanding of legislative history and the purpose of the statute, the court held that, for an occupational disease to be compensable, the work environment had to be its *major* cause. Accordingly, we do not think that *Dethlefs* compels the conclusion that omission of the quoted phrase from subsections (b) and (c) means that the standard of proof for occupational disease claims is *material* contributing cause. The subsections, in fact, say nothing about what the standard is. We conclude that the language of ORS 656.802(1)(b) and (c) is ambiguous and that, therefore, it is necessary for us to interpret it.

In interpreting a statute, the intention of the legislature is to be followed if possible. ORS 174.020; *Fifth Avenue Corporation v. Washington County*, 282 Or 591, 581 P2d 50 (1978). The legislative history of the 1987 amendments was well summarized in this case in the dissenting opinion of board member Ferris:

"The amendments to ORS 656.802 were part of the 1987 House Bill 2271. The impetus for HB 2271, and a number of other bills introduced during the 1987 legislative session, was the 'Oregon Comeback' plan initiated by Governor Neil Goldschmidt. One of the primary goals of this plan was to streamline and otherwise reduce the cost of the workers' compensation system in Oregon in order to attract or retain business for the state. In accordance with this general purpose, one of the major objectives of HB 2271 was to restrict the compensability of mental stress claims. Tape Recording, Senate Committee on Labor, April 23, 1987, Tape 120, Side A at 164-66 (statement of Representative Shiprack, Chairman of the House Committee on Labor).

"When HB 2271 was originally introduced, none of the paragraphs of the revised definition of an occupational disease contained the *Dethlefs* language or any other language expressing a quantum of contribution applicable to claims under the section. During public hearings conducted on the bill by the House Committee on Labor, some of the witnesses pointed out that the absence of such language created an ambiguity. Tape Recording, House Committee on Labor, March 6, 1987, Tape 49, Side A at 446-85 (testimony of Mr.

> Francesconi); Id., Tape 48, side B at 27-52 (testimony of Mr. Snarskis). One of these witnesses noted that if this ambiguity was construed to mean 'material contributing cause,' it would be much easier for claimants to establish the compensability of all occupational diseases, including stress-related mental disorders, and that this would be contrary to one of the major purposes of HB 2271."

After that, the legislature retained the previous and now disputed language in ORS 656.802(1)(a); however, it did not include it in the new subsections (b) and (c).

We find no guidance as to why the legislature used the language in subsection (a), but not in subsections (b) and (c). However, after reviewing the legislative history, we conclude that the legislature did not intend to change the standard of proof for the latter kinds of occupational disease claims. We hold that the standard of proof for proving all types of occupational disease claims under ORS 656.802(1), as amended in 1987, remains the major contributing cause.

As discussed above, the purpose of the 1987 legislation was to reduce the costs of workers' compensation and, specifically, to restrict the compensability of stress claims. The Board's interpretation of ORS 656.802(1) would do just the opposite. There is no indication in the legislative record that the legislature intended that result. Not only would the Board's interpretation of the statute result in a significant change in the standard of proof for occupational disease claims, it would create different levels of proof for different types of occupational disease claims. Claims based on exposure to toxic fumes under subsection (a) would have to be proven under the major contributing cause standard, but claims based on mental disorders or "a series of traumatic events" would only need to be proven under a material contributing cause standard. There is no rationale for that distinction, and there is no indication in the legislative history that that result was intended.

Our conclusion is also supported by the subsequent legislative history. As stated in *1000 Friends of Oregon v. Wasco County Court*, 299 Or 344, 358 n 15, 703 P2d 297 (1985):

> "Amendments to an act may be resorted to for the discovery of the legislative intent in the enactment amended, *Kaiser Cement v. Tax Com.*, 250 Or 374, 378, 443 P2d 233, 235 (1968), and if the amendment 'follows immediately and after controversies have arisen as to the true construction of the prior law it is entitled to great weight' in interpreting the amended statute. *Kaiser Cement [v. Tax Com., supra,]* 250 Or at 378, 443 P2d at 235, *quoting Holman Tfr. SPPLE Co. v. Portland*, 196 Or 551, 566, 249 P2d 175, 182, 250 P2d 929 (1952)."

After the 1987 amendments were adopted, they became the subject of controversy. In May, 1990, the special session of the legislature again amended the statute. It is apparent from the record of the 1990 amendments that the legislature never intended to change the standard of proof for occupational disease claims in 1987. The 1990 Report from the Governor's Workers' Compensation Labor-Management Advisory Committee to the Legislature said:

> "The Committee's proposed language is intended to allow such claims where the worker is able to show the work activity was the *major contributing cause* of the disease or its worsening. This expressly states the law as it had been interpreted by the courts prior to a 1988 Workers Compensation Board opinion which interpreted a statutory ambiguity to apply the material contributing cause test. The Committee's proposal is intended to do nothing more than restore

> what had been well settled case law in Oregon for many years." Minutes, Interim Special Workers' Compensation Committee, May 3, 1990, Ex B.

The "opinion which interpreted a statutory ambiguity," referred to in the report, is the Board's opinion in this case.

During the 1990 Interim Special Committee hearing, a representative of the American Federation of State, County and Municipal Employees on the Governor's Advisory Committee testified:

> "There was a decision handed down that moved the standard to material contributing factor * * *. So we felt that was absolutely not the intent of the parties long term in the Worker's Comp system and needed to be changed. We needed to reinstate the previous standard that had existed for many years and was not a subject of major challenge * * *." Tape Recording, Interim Special Workers Compensation Committee, May 3, 1990, Tape 7, Side A at 390.

It is clear that the legislature believed that the "major contributing cause" standard for occupational diseases remained the law, until the Board decided this case. Representative Shiprack stated:

> "I wrote that statute back in 1987 * * *. We're moving the law back in this to about a year ago, prior to a decision that I disagreed with at the Worker's Comp Board called the Aschbacher decision that's on its way to the Court of Appeals. I expect it will be overturned at that level. I'm going to support in any way I can that the decision be overturned and we're simply putting the law back to what it was as much as one year ago in the case of occupational disease." Tape Recording, Interim Special Workers Compensation Committee, May 3, 1990, Tape 7, Side A at 010.

The 1990 legislative history shows that it was never the legislature's intent to change the kind of proof required for occupational disease claims. The proof in this case should have been of a major contributing cause.

The Board also reversed the referee and concluded that a claimant may prove an occupational disease claim under ORS 656.802(1)(c) by showing a worsening of symptoms of a preexisting disease without also proving a worsening of the underlying disease. The Board held that claimant's condition was compensable, because it was shown that her work activities resulted in increased symptoms of her underlying low back condition, i.e., leg pain. That holding is directly contrary to *Weller v. Union Carbide, supra*, at 288 Or 36, in which the Supreme Court held that proving a worsening of symptoms of a preexisting disease without establishing a worsening of the underlying disease does not establish a compensable occupational disease. The Board recognized the holding in Weller but concluded that it is inapplicable to occupational disease claims based on ORS 656.802(1)(c), enacted in 1987.

We conclude that the 1987 amendments did not affect the applicability of *Weller* and that claimant was still required to prove a worsening of her underlying condition. As discussed above, before the 1987 amendments an "occupational disease" was defined as

> "[a]ny disease or infection arising out of and in the scope of employment, and to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein."

After the 1987 amendments, subsection (a), relating to occupational disease claims based on exposure to substances, still included the language "any disease or infection." However, the new subsection (c) did not include that language. The Board concluded that the legislature's failure to use the term "any disease or infection" and its use of "series of traumatic events or occurrences" means that an occupational disease claim under subsection (c) may be established by proving increased symptoms of a preexisting disease without proving a worsening of the underlying condition.

As the Board recognized, the language of ORS 656.802(1)(c) does not directly address the question of whether a worsening of the disease must be proven. Therefore, it is again necessary to examine the legislative history of the change in the language of the statute. It appears from the legislative history that the purpose of the language "any series of traumatic events or occurrences" was to make it clear that workers' compensation claims involving physical overuse of a body part are to be treated as occupational diseases rather than as injuries.

In testimony before the Senate Labor Committee, a representative of the Oregon Trial Lawyers' Association was askedabout the purpose of subsection (c). He replied:

> "That is the overuse syndrome-type cases [sic] where there's not exposure to anything toxic or anything harmful but simply the overuse of a body part, a hip, an elbow and wrist, something of that nature, may --may become an occupational disease. And we deal with that now within the existing definition, but the House attempted to make a special definition so there would be no question that that was an occupational disease.
>
> "Primarily, Madam Administrator, I believe that history shows there was a concern that a series of traumatic events should be considered an injury and not a disease because it is actually a series of -- let's use the wrist, a series of traumatic events. A traumatic event is generally considered an injury but injury laws are considerably easier to prove than disease law, *and the House felt that those sorts of conditions should be under the more strict occupational disease standard. I argued for an injury standard, but it's here as an occupational disease. I hope I answered your question.*" Tape Recording, Senate Committee on Labor, April 30, 1987, Tape 133, Side A at 070-086. (Emphasis supplied.)

There is no indication in the legislative record of any intent to change the applicability of *Weller* to this type of occupational disease claim. It is unlikely that the legislature would make such a significant change in the law without making a record of it.

The Board relied on the court's reasoning in *Wright v. SAIF*, 289 Or 323, 613 P2d 755 (1980). However, *Wright* involved the interpretation of a different statutory scheme, and the court's reasoning does not support the Board's conclusion here. *Wright* involved a claim under *former* ORS 656.802(1)(b), which related to occupational disease claims by fire fighters and defined "occupational disease" as

> "[d]eath, disability or impairment of health of fire fighters * * *, caused by any disease of the lungs or respiratory tract, hypertension or cardiovascular-renal disease, and resulting from their employment as fire fighters."

Under the fire fighter provisions of the Worker's Compensation Law, any "condition or impairment of health" is presumed to result from a fire fighter's employment. *Former* ORS 656.802(2). It was argued in *Wright* that, under *Weller*, a fire fighter claimant must prove a worsening of an underlying disease in order for increased symptoms to be compensable. The court held that Weller is not applicable:

> "ORS 656.802(1)(b) provides that an 'occupational disease' means 'death, disability or *impairment of health* of firemen * * *.' The language of ORS 656.802(2) provides that 'any condition or impairment of health,' arising under 656.802(1)(b) is presumed to result from a fireman's employment. This language is markedly different from the terms 'injury, disease, or infection,' and includes in the presumption of compensability a worsening of symptoms as well as a worsening of the underlying disease. To read the words 'impairment of health' to exclude symptomatology would ignore the all-inclusive phrase chosen by the legislature." 289 Or at 335. (Emphasis in original.)

Here, the Board concluded that the language "any series of traumatic events or occurrences" is comparable to the term "impairment of health" in the fire fighter statute. We disagree. As the court held in *Wright*, "impairment of health" is an extremely broad term and is markedly different from "injury, disease, or infection," which was analyzed in *Weller*. However, here, the pertinent language is not markedly different from the terms discussed in Weller. The word "traumatic" means injurious. *Webster's Ninth New Collegiate Dictionary* 1256 (1990). The language of the new subsection (c) was not all inclusive, as is "impairment of health." It is limited to occupational disease claims based on a series of injuries. We conclude that the 1987 enactment of subsection (c) did not make *Weller* inapplicable and that claimant had to prove a worsening of her preexisting disease.

Reversed and remanded for reconsideration.

Cite as 107 Or App 510 (1991) June 5, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Karen J. Maroon, Claimant.

KAREN J. **MAROON**, Petitioner,
v.
GREAT WESTERN CONSTRUCTION and STATE ACCIDENT INSURANCE FUND, Respondents.
(WCB No. 89-13721; CA A66206)

Judicial Review from Workers Compensation Board.
Argued and submitted April 12, 1991.
Margaret H. Leek Leiberan, Portland, argued the cause for petitioner. With her on the brief were Dennis Henninger and Leiberan & Gazeley, Portland.
David L. Runner, Assistant Attorney General, Salem, argued the cause for respondent SAIF. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
No appearance for respondent Great Western Construction.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
DE MUNIZ, J.
Reversed and remanded for proceedings not inconsistent with this opinion.

Claimant seeks review of a Workers' Compensation Board order affirming the referee's denial of her claim on the ground that she was a sole proprietor and had not elected coverage for herself pursuant to ORS 656.128.[1]

In 1986, claimant began working as a bookkeeper for Mike Maroon, who was doing business as Great Western Construction Company (Great Western). In 1987, she married Maroon and continued working. In August, 1988, she filed an application with SAIF for workers' compensation insurance for Great Western, listing herself as its president and sole proprietor. The application stated that SAIF "does not provide coverage for a sole proprietor." In fact, under ORS 656.027, a sole proprietor is not considered to be a subject worker for purposes of workers' compensation. If there is to be coverage, the sole proprietor must elect it, pursuant to ORS 656.128. Claimant did not elect coverage. In August, 1988, SAIF issued a policy in the name of claimant, as president, doing business as Great Western.

In processing the application, SAIF learned that Great Western was registered as an assumed business name of Mike Maroon and that claimant did not have the right to use the name. It notified claimant that it could not show Great Western as an assumed business name for claimant under the policy, because the name was registered to another individual. It advised claimant to contact the Corporation Division to correct the registration. SAIF received no response from claimant. The letter also stated that an individual proprietor of a business is personally covered only if the proprietor's name appears on the "sole proprietor endorsement." Because claimant had not elected coverage for herself, her name did not appear on the endorsement.

Great Western subcontracted roofing work. In April, 1989, one of its roofers quit, and claimant replaced the worker as an apprentice roofer. On May

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[1] ORS 656.128 provides:

"(1) Any person who is a sole proprietor, or a member of a partnership, may make written application to an insurer to become entitled as a subject worker to compensation benefits. Thereupon, the insurer may accept such application and fix a classification and an assumed monthly wage at which such person shall be carried on the payroll as a worker for purposes of computations under this chapter.

"(2) When the application is accepted, such person thereupon is subject to the provisions and entitled to the benefits of this chapter. The person shall promptly notify the insurer whenever the status of the person as an employer of subject workers changes. Any subject worker employed by such a person after the effective date of the election of the person shall, upon being employed, be considered covered automatically by the same guaranty contract that covers such person.

"(3) No claim shall be allowed or paid under this section, except upon corroborative evidence in addition to the evidence of the claimant.

"(4) Any person subject to this chapter as a worker as provided in this section may cancel such election by giving written notice to the insurer. The cancellation shall become effective at 12 midnight ending the day of filing the notice with the insurer."

4, she fell through a hole in a roof and sustained massive head, neck and shoulder injuries and a ruptured spleen. SAIF denied her claim for benefits on the ground that it did not insure Great Western.

The referee upheld SAIF's denial. She reasoned, first, that the policy that claimant had obtained, which was for a sole proprietorship, did not cover the employees of Great Western, because that name was registered to Mike Maroon, not to claimant, and the registration had never been changed. Additionally, she held that the policy did not provide coverage for claimant personally, because she had not elected coverage under ORS 656.128(1). The Board affirmed those determinations, and we agree that they are correct.

The Board also "[a]greed with the Referee that claimant was a sole proprietor." We note, initially, that the referee and the Board did not expressly find, as SAIF suggests, that claimant was the sole proprietor of *Great Western*. In fact, the Board stated that "claimant was not insured as an individual doing business as" Great Western. The Board's determination that claimant was not covered personally appears to have been based only on the conclusion that, under her policy as a sole proprietor, she had not elected to be covered personally.

Despite that, the Board held that, "because we find that claimant was a sole proprietor and that she had not elected coverage, we do not reach the merits of claimant's argument that she was a subject employee at the time of her injury." The Board's decision appears to have been based on the assumption that claimant could not be both a sole proprietor and an employee of the same business, in the absence of an election. That is a correct assumption.

However, as the Board found, claimant was not insured as the sole proprietor of Great Western. Additionally, we conclude that, if the Board's opinion is read to contain the finding that claimant was, in fact, the sole proprietor of Great Western, substantial evidence does not support it. The only evidence to support the finding is that claimant represented herself to be the sole proprietor of Great Western in the application for workers' compensation insurance and in other documents submitted to SAIF. All the other evidence weighs so heavily against a finding that Great Western was claimant's business that the Board could not reasonably have found that claimant was its sole proprietor.[2] *Younger v. City of Portland*, 305 Or 346, 356, 752 P2d 262 (1988).

Because claimant was not, in fact, the sole proprietor of Great Western, and was not insured as such, she could be covered under the Workers' Compensation Law as a subject worker of Great Western. The referee found that claimant was not a subject worker of Great Western, because she was not paid for her services. The Board did not decide the issue because of its mistaken belief that claimant could not be a subject worker. Accordingly, we remand the case for the Board to consider whether claimant was a subject worker of Great Western.

Reversed and remanded for proceedings not inconsistent with this opinion.

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[2] For example, the referee found:

"Mike Maroon was the sole manager of the business. He hired and fired, obtained business, purchased materials, estimated jobs, trained and supervised. Claimant was the bookkeeper and office worker. She shared in the profits and losses to the extent any family member naturally would. She in no way had any control over the profits or jobs undertaken, exercised minimal, if any, supervision, and was not personally responsible for making up any of the business losses."

Cite as 107 Or App 545 (1991) June 12, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Millie M. Crockett, Claimant.

BAKER INDUSTRIES and CNA INSURANCE COMPANIES, Petitioners,
v.
MILLIE M. **CROCKETT**, Respondent.
(WCB 89-03462; CA A66108)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 22, 1991.
Jerald P. Keene, Portland, argued the cause for petitioners. With him on the brief was Roberts, Reinisch, MacKenzie, Wilson & Healey, Portland.
Brent Wells, Eugene, argued the cause for respondent. With him on the brief was Malagon, Moore & Johnson, Eugene.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
RIGGS, J.
Affirmed.

Employer seeks review of an order of the Workers' Compensation Board affirming and adopting the referee's order requiring payment of compensation for food necessary for claimant's weight loss program. We affirm.

The parties submitted the case to the referee on these stipulated facts:

> "Claimant sustained an industrial injury on May 29, 1987. The claim was accepted and is currently in open status. Claimant is obese and a weight reduction program has been recommended. She wishes to participate in the Nutri-Systems weight loss program. The insurer has approved claimant's participation in the program and agrees to pay the necessary enrollment fees.
>
> "In addition to the cost of the Nutri-Systems program itself is the separate weekly cost for food used in the program. The food is produced exclusively by Nutri-Systems and can only be purchased by participants in the program. Participants order food from Nutri-Systems and the orders are filled by program personnel.
>
> "The anticipated cost of Nutri-Systems food for claimant is approximately $55.00 per week. This includes three meals per day. Claimant has already paid for seven weeks of food at a cost of $385.00.
>
> "It is not possible to participate in the Nutri-Systems program without the purchase and use of Nutri-Systems food."

Employer contends that the Board erred in awarding claimant compensation for food associated with the weight loss program, because claimant was simultaneously receiving temporary total disability (TTD) benefits. It argues that, because TTD benefits are intended to provide an injured worker's maintenance during recovery, awarding separate payments for food amounts to double compensation.

Claimant argues that employer has agreed that the weight loss program is compensable. The Nutri-Systems food is an integral part of that program, and claimant cannot participate without it. She contends that, because the food is a reasonable and necessary component of the approved program, employer should pay for the cost of the entire program, including the food.

We agree. Employer approved claimant's participation in the Nutri-Systems weight reduction program. Claimant cannot participate in the program unless she buys the Nutri-Systems food. Not only is the food a reasonable and necessary aspect of the total program, employer agreed to pay for the program. The Board did not err in awarding compensation for the Nutri-Systems food.

Affirmed.

Cite as 107 Or App 565 (1991) June 12, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Dorothy J. Hayes, Claimant.

DOROTHY J. **HAYES**, Petitioner,
v.
COOS CURRY MANPOWER, SAIF CORPORATION and SAFEWAY STORES, INC., Respondents.
(WCB 88-06310, 88-08392; CA A65602)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 20, 1991.
Eveleen Henry, Eugene, argued the cause for petitioner. With her on the brief was Rasmussen & Henry, Eugene.
John A. Reuling, Jr., Assistant Attorney General, Salem, argued the cause for respondents Coos Curry Manpowerand SAIF Corp. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Kenneth Kleinsmith, Portland, argued the cause for respondent Safeway Stores, Inc. With him on the brief was Meyers & Radler, Portland.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
PER CURIAM
Affirmed.

Claimant seeks review of a Workers' Compensation Board order denying her attorney fees under ORS 656.386(1). We affirm.

Claimant has a form of asthma, for which SAIF's insured, Coos Curry Manpower (Coos), accepted responsibility in 1980. She began experiencing increased symptoms in 1987, after she began working for Safeway. She filed an aggravation claim against Coos, for which SAIF denied responsibility. Claimant sought a hearing and moved to join Safeway, a self-insured employer. Safeway denied both compensability and responsibility. After the hearing, but before the decision, the parties stipulated that Coos would accept the aggravation claim and that Safeway's denial would be affirmed. The parties reserved the issue of attorney fees for the referee to decide. The referee entered an order dismissing with prejudice claimant's request for a hearing, except on the issue of attorney fees, and ordered Safeway to pay $4650 in fees. The Board reversed that award, reasoning that claimant had not finally prevailed against Safeway, because its denial was affirmed.

Claimant contends that she is entitled to attorney fees from either Coos or Safeway under ORS 656.386(1). She is not. *Jones v. OSCI*, 107 Or App 78, ___ P2d ___ (1991).

Affirmed.

Cite as 107 Or App 594 (1991) June 19, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Richard J. Peters, Claimant.

RICHARD J. **PETERS**, Petitioner,
v.
DOUBLE DD TRUCKING and LIBERTY NORTHWEST INSURANCE CORPORATION, Respondents.
WCB 86-01810; CA A64056)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 21, 1990.
J. Michael Alexander, Salem, argued the cause for petitioner. With him on the brief was Burt, Swanson, Lathen, Alexander & McCann, Salem.
Stafford J. Hazelett, Portland, argued the cause and filed the brief for respondents.
Before Richardson, Presiding Judge, and Newman and Deits, Judges.
RICHARDSON, P.J.
Affirmed.

In this workers' compensation case, claimant seeks review of the Board's denial of compensation. The sole issue is whether claimant is a "subject worker" under ORS 656.027. We affirm.

Claimant requested a hearing on employer's denial of his claim to recover for injuries sustained in a 1985 trucking accident. The primary issue was whether claimant was a "subject worker" of Double DD Trucking (employer) or whether he was an independent contractor. The referee found that employer had the right to control claimant and that, therefore, he was a subject worker and entitled to workers' compensation benefits. Employer appealed to the Board, which reversed the referee's opinion, concluding that claimant was an independent contractor. The Board found:

> "Claimant was 56 years old at the time of hearing. In February, 1985, claimant and Mr. Ganoe agreed to be truck driving partners. At that time, Ganoe had an agreement with Double DD Trucking Lines Inc. (the insured in this case) to drive a truck and deliver loads for them. That agreement included that Ganoe would be paid by the load; that no taxes would be taken from the load settlement; that the amount of the load settlement would be a percent of the load; that Ganoe would pay for all of his expenses (i.e., gas, oil, food, lodging, etc.) in hauling the load; that Ganoe would call the main office to receive new assignments upon completing a load; that Ganoe could refuse assignments; that the requirement of successfully completing an assignment was to timely deliver the load to the required location in good condition; that failure to successfully complete assignments could result in Ganoe not being given any more assignments; and that hours and route were up to Ganoe.
>
> "Ganoe and claimant had an agreement that when Double DD would make out a settlement check to Ganoe, he would pay claimant a straight 50 percent of whatever that load brought in. The checks were made out to Mr. Ganoe, who in turn would cash the check, and pay claimant after all of their expenses (i.e., gas, oil, food, lodging, etc.) were deducted. Claimant and Ganoe split all the expenses equally.
>
> "Before claimant could operate the truck Ganoe was using, he had to pass a written examination, and a road test. These tests are

part of state licensing requirements for all persons operating trucks. Both of these examinations were administered by Mr. Diede, the owner of the insured.

"Mr. Kuhlman owned the truck driven by claimant and Ganoe. Kuhlman leased the vehicle to Double DD. He provided no direction or control over claimant's employment activities. Double DD had an arrangement with Ganoe regarding the lease and use of the truck.

"Ganoe and claimant exercised all the rights of Ganoe's agreement with the insured.

"Claimant was injured in a truck accident on March 22, 1985. Claimant received treatment for a laceration of the instep and toes of his right foot."

We review for substantial evidence to support the findings and for whether the reasoning from those findings supports the conclusions and for errors of law. ORS 183.482(8)(a) and (c); *see Weyerhaeuser Co. v. Fillmore*, 98 Or App 567, 570, 779 P2d 1102, rev den 308 Or 608 (1989). Claimant makes no specific challenge to the Board's findings of fact or to the application or interpretation of the legal principles that it applied to reach its conclusion. The findings are supported by substantial evidence in the record, and the law was correctly applied by the Board.

Claimant's argument boils down to a dispute about the weight to be assigned to various factors that went into the decision that claimant was an independent contractor, but that is not a reviewable issue in this case. The Board's reasoning supports its conclusion that claimant was not a "subject worker" at the time of his injury.

Claimant argues in the alternative that ORS 656.029(1)[1] is applicable and makes him a "subject worker." However, that issue was never raised or litigated before the referee or the Board. As employer points out, even if that statute is applicable, there are factual predicates that need to be determined. Because the issue was not raised and litigated, we decline to address it.

Affirmed.

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[1] ORS 656.029(1) provides:

"If a person awards a contract involving the performance of labor where such labor is a normal and customary part or process of the person's trade or business, the person awarding the contract is responsible for providing workers' compensation insurance coverage for all individuals, other than those exempt under ORS 656.027, who perform labor under the contract unless the person to whom the contract is awarded provides such coverage for those individuals before labor under the contract commences. If an individual who performs labor under the contract incurs a compensable injury, and no workers' compensation insurance coverage is provided for that individual by the person who is charged with the responsibility for providing such coverage before labor under the contract commences, that person shall be treated as a noncomplying employer and benefits shall be paid to the injured worker in the manner provided in ORS 656.001 to 656.794 for the payment of benefits to the worker of a noncomplying employer."

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Laurina A. Randall, Claimant.

LAURINA A. **RANDALL**, Petitioner,
v.
LIBERTY NORTHWEST INSURANCE CORPORATION and POINT ADAMS PACKING, Respondents.
(WCB 87-19076; CA A64057)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 29, 1990.
Martin L. Alvey, Astoria, argued the cause for petitioner. With him on the brief was Patrick Lavis, P.C., Astoria.
Stafford J. Hazelett, Portland, argued the cause and filed the brief for respondents.
Before Richardson, Presiding Judge, and Newman and Deits, Judges.
RICHARDSON, P.J.
Affirmed.

Claimant seeks review of a Workers' Compensation Board order that upheld the denial of her aggravation claim and refused to award her attorney fees. We affirm.

The Board found these facts:

> "In 1983, claimant was working in the employer's fish processing plant when she slipped and injured her wrist as it struck the metal edge of a table. She finished her shift and sought treatment for her wrist the following day. Approximately one month after her injury, claimant received treatment in a Seattle hospital for continuing pain in her wrist.
>
> "Six weeks after receiving treatment in Seattle, claimant left for Alaska to work for a second employer. Eight to ten days after beginning work as a fish processor, claimant noticed a lump on her left wrist. In 1985, claimant returned from Alaska to work for her previous employer. * * * In March 1986, she began to experience tingling and numbness in her arm and fingers.
>
> "Claimant commenced treatment with Dr. Swanson on May 14, 1987."

Claimant's first assignment is that the "Board err[ed] when it accorded greater weight to the opinions of the consulting physicians in this case." The substance of her argument is that the reason given by the Board for discounting her treating doctor's opinion was "unreasonable and is therefore not supported by substantial evidence." The Board explained:

> "Claimant treated with several physicians immediately after her initial injury. She did not seek treatment from [the treating physician], however, until nearly four years after she first noticed the lump. Where a treating physician has not had an opportunity to personally observe claimant's condition near the time of the critical event and then make his comparison based on firsthand knowledge, we may accord more weight to other medical opinions."

As we said in *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988), when there are medical opinions on both sides of the case, there will in

all probability be substantial evidence to support the decision. The Board rationally explained why it had accepted the opinions of the consulting physicians rather than claimant's treating doctor. There was substantial evidentiary support for the decision on compensability.

The second assignment is that the Board erred by not awarding claimant attorney fees for unreasonable delay in denying the claim. Under ORS 656.262(6), an employer or its insurer has 60 days in which to deny or accept a claim for aggravation. Claimant filed her claim in May or June, 1987, and it was denied on December 9, 1987, well after the 60-day period. The Board held that, "because we have decided that there is no compensable aggravation, the delay in accepting or denying the aggravation claim did not delay any compensation and is, therefore, not an unreasonable resistance to the payment of compensation."

ORS 656.262(10) provides:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

ORS 656.382 provides, in part:

> "(1) 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. To the extent an employer has caused the insurer to be charged such fees, such employer may be charged with those fees."

Subsection (2) provides that the fee shall be

> "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."

Claimant argues that our decisions in *Mischel v. Portland General Electric*, 89 Or App 140, 747 P2d 410 (1987), *rev den* 305 Or 576, 305 Or 671 (1988), and *Spivey v. SAIF*, 79 Or App 568, 720 P2d 755 (1986), are directly in point and allow an award of attorney fees, even if no compensation was due. The Board's decision was based on one of its own decisions to the effect that *Spivey* and *Mischel* were effectively overruled by *Ellis v. McCall Insulation*, 308 Or 74, 775 P2d 316 (1989). *Lloyd L. Cripe*, 41 Van Natta 1774 (1989).

In *Mischel v. Portland General Electric, supra*, we explained our holding in *Spivey v. SAIF, supra*, about the relationship between ORS 656.262(10) and ORS 656.382:

> "We do not read ORS 656.262(10) to say that attorney fees can be allowed under that statute only under the circumstances described in ORS 656.382. We understand it to provide that attorney fees that may be assessed under the circumstances described in ORS 656.382 may also be assessed for an unreasonable denial. ORS 656.382 does not impose additional restrictions on when attorney fees may be assessed under ORS 656.262(10). The Board could properly assess attorney

fees pursuant to ORS 656.262(10) and ORS 656.382, even though no compensation was then due." 89 Or App at 143.

After *Ellis v. McCall Insulation, supra*, that analysis is incorrect.

The cryptic holding regarding attorney fees in *Ellis v. McCall Insulation, supra*, can best be understood in the context of the facts there. We quote from the opinion:

> "In 1979, claimant injured his back. He filed a workers' compensation claim, which the insurer accepted. Ultimately, an award of 10 percent unscheduled permanent partial disability was rendered.
>
> "Immediately upon injury, claimant began chiropractic treatments. The insurer paid for all the treatments until December 1984. The insurer then decreased the number of treatments for which it would pay. For example, in December, the insurer paid for only three of 12 treatments and, from January through June 1985, the insurer paid for only six of 56 treatments. When claimant changed chiropractors in July 1985, the insurer stopped payments altogether. The insurer did not issue any formal denial of an obligation to pay the bills or advise claimant that the bills would not be paid; it just stopped paying.
>
> "Claimant began this proceeding to compel payment of the unpaid bills. The insurer countered that the unpaid bills were unrelated to claimant's compensable back injury. After a hearing, the referee stated that he agreed with the insurer. Nevertheless, he ordered the insurer to pay the bills because the insurer did not timely deny them. He also ordered the insurer to pay a penalty and attorney fees." 308 Or at 76.

In the Supreme Court, the claimant agreed that the chiropractic bills did not relate to his compensable injury but argued that the insurer had to pay them, because it did not timely deny owing them. The court held that the insurer was not liable for the bills.

The claimant had also sought attorney fees, because the insurer had not denied the "claim" within the time allowed by ORS 656.262. The court said:

> "In respect of attorney fees, the basis for an award of attorney fees, unlike the basis for an award of an 'additional amount,' is not hinged to 'amounts then due.' Instead, ORS 656.262(10) provides that attorney fees are to be assessed under ORS 656.382. ORS 656.382, in turn, is keyed to unreasonably resisting the payment of compensation. Here, the insurer did not unreasonably resist payment of compensation where the 'claims' were unrelated to claimant's compensable injury and the insurer is not liable for the unpaid bills." 308 Or at 78.

The Supreme Court's analysis was solely that there must be an unreasonable resistance to payment of compensation within the meaning of ORS 656.382. Whether the claimant was entitled to a penalty under ORS 656.262(10) is not relevant to the issue of attorney fees. Contrary to our analysis in *Mischel* and *Spivey*, the reference in the penalty statute to ORS 656.382 merely indicates that, even if a claimant is entitled to attorney fees under that section, he may also get penalties for the described conduct of his employer or the employer's insurer. That conduct is not meant to describe a basis for an award of attorney

fees, but it may constitute an unreasonable resistence to the payment of compensation under ORS 656.382(1).

It is also clear from *Ellis v. McCall Insulation, supra*, that, if the claim is not compensable, then there can be no unreasonable resistence to payment of compensation and, therefore, no entitlement to attorney fees. The claimant there had sought payment of the chiropractic bills as compensation for an industrial injury, and that issue had been litigated before the referee, the Board and this court. Consequently, the Supreme Court's determination that no attorney fees were to be awarded under ORS 656.382 was because, ultimately, it was decided that the claim was not compensable.

There is no material distinction between *Ellis* and the case under review. Claimant sought compensation for an aggravation and also attorney fees on the ground that the claim was not denied within 60 days. Because we conclude, as did the Board, that the denied aggravation claim is not compensable, it follows that employer has not unreasonably resisted payment of compensation, because there is no compensation awarded.

Affirmed.

Cite as 107 Or App 606 (1991) June 19, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Chuck H. Sibley, Claimant.

CHUCK H. **SIBLEY**, Petitioner,
v.
CITY OF PHOENIX and SAIF CORPORATION, Respondents.
(88-09196; CA A65697)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 12, 1991.
James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were James L. Francesconi and Francesconi & Associates, Portland.
David L. Runner, 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.
BUTTLER, P.J.
Affirmed.
De Muniz, J., concurring.

Claimant seeks review of an order of the Workers' Compensation Board reversing the referee and concluding that he has not established an occupational disease claim.

The findings of the Board are supported by substantial evidence. In 1986, claimant, Chief of Police for the City of Phoenix, began suffering hypertension as a result of emotional or psychological stress due to fears concerning his job security. The only issue on review is whether, as a matter of law, claimant's stress-related hypertension is compensable as an occupational disease under ORS 656.802(1)(c).

As amended in 1987, ORS 656.802(1) provides:

"As used in this chapter, 'occupational disease' means:

"(a) Any disease or infection arising out of and in the course of employment caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gasses, radiation or other conditions or substances to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death.

"(b) Any mental disorder arising out of and in the course of employment and which requires medical services or results in physical or mental disability or death.

"(c) Any series of traumatic events or occurrences arising out of and in the course of employment which requires medical services or results in physical disability or death."[1]

Claimant contends that various stress-causing incidents on the job were a "series of traumatic events or occurrences" and that the claim is compensable under subsection (1)(c). The Board held that subsection (1)(c) refers only to a series of physical traumas and that claimant's claim does not meet that requirement. It also held that the claim is not compensable under either ORS 656.802(1)(a) or (1)(b), and claimant does not dispute that holding.

No statute defines the phrase "traumatic events or occurrences." Claimant contends that subsection (1)(c) is a "catch all," intended to define a "general category" of occupational disease and to "preserve the various diseases which were experienced generally in the work force." He argues that, in amending ORS 656.802, the 1987 legislature intended only to codify existing case law and practice and did not intend to eliminate "an entire category of occupational disease" claims, such as claims for cardiovascular disease caused by emotional stress. He urges that the term "traumatic event" must be read to encompass emotional trauma, so that his claim, which is not compensable under subsection (1)(b) because it does not involve a mental disorder, is included within the definition of occupational disease.

We are not persuaded by claimant's rationale. What the legislature intended to do with the category of claims that claimant describes is not the subject of this review. The only question raised by the assignment of error is

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[1] The statute was amended in 1990, and currently provides:

"(1) As used in this chapter, 'occupational disease' means any disease or infection arising out of and in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death, including:

"(a) Any disease or infection caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gases, radiation or other substances.

"(b) Any mental disorder which requires medical services or results in physical or mental disability or death.

"(c) Any series of traumatic events or occurrences which requires medical services or results in physical disability or death."

whether this claim falls within ORS 656.802(1)(c). Reading the subsection in the broad way that claimant suggests to apply to emotional, as well as to physical, traumas would extend its coverage to circumstances that are described in subsection (1)(b), to which a different standard of proof applies. ORS 656.802(2).[2] We do not believe that the legislature intended that result and conclude that the trauma must be physical in order to be compensable under subsection (1)(c).

Assuming that the subsection is ambiguous, the legislative history confirms our conclusion. Legislative minutes about subsection (1)(c) leave no doubt that it was adopted for the express purpose of covering "micro-trauma" or "overuse" syndromes, such as degenerative back conditions, carpal tunnel syndrome and hearing loss, caused by repetitive *physical* trauma or activity. *See, e.g.*, Minutes, House Task Force on Occupational Diseases, April 30, 1987, 19, 23 and Exh I; Tape Recording, Senate Committee on Labor, April 30, 1987, Tape 133, Side A at 36-87. The Board did not err in its interpretation. *See Aetna Casualty Co. v. Aschbacher*, 107 Or App 494, ___ P2d ___ (1991).

Affirmed.

DE MUNIZ, J., concurring.

I agree with the majority that the legislative history compels the conclusion that claimant's hypertension does not come within ORS 656.802(1)(c). *See also Aetna Casualty Co. v. Aschbacher*, 107 Or App 494, ___ P2d ___ (1991). However, I am perplexed about why the legislature excluded an entire category of workers with physical problems requiring medical treatment resulting from on-the-job emotional stress. Claimant has made no constitutional challenge to that legislative determination.

Rossman, J., joins in this concurrence.

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[2] ORS 656.802(2) provides:

"Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter:

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

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

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

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

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Loren P. Curtis, Claimant.

SAIF CORPORATION and PRECISION CASTPARTS, Petitioners,
v.
LOREN P. **CURTIS**, Respondent.
(88-12404; CA A65942)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 15, 1991.
John T. Bagg, Assistant Attorney General, Salem, argued the cause for petitioners. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Phil H. Ringle, Jr., Gladstone, argued the cause for respondent. With him on the brief was Marva C. Fabien, Gladstone.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
BUTTLER, P.J.
Affirmed.

Employer seeks review of a decision of the Workers' Compensation Board affirming the referee and holding that claimant had good cause for filing his request for hearing on employer's denial more than 60 but less than 180 days after the notice of denial.[1] We conclude that the Board's findings are supported by substantial evidence and write only to address the legal issue raised by the petition.

SAIF sent the notice of denial by certified mail to claimant at the address provided by him, which was the home of his parents. The Board found that claimant's father signed for the letter, but did not remember what he had done with it, and that claimant never received the notice and did not learn of it until his treating doctor informed him that his bill for back surgery had been denied. By that time, more than 60 but less than 180 days had passed since the notice was mailed. He immediately contacted an attorney, who filed a request for hearing.

The Board concluded that claimant had established good cause, relying on our recent decision in *Giusti v. Adams*, 102 Or App 329, 794 P2d 451 (1990). There, we held that the Board's finding that the claimant had not received the notice of denial until after 60 days had passed supported its conclusion that the claimant had good cause for filing a late request for hearing within 180

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[1] ORS 656.319(1)(a) provides:

"With respect to objection by a claimant to denial of a claim for compensation under ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforceable unless:

"(a) A request for hearing is filed not later than the 60th day after the claimant was notified of the denial; or

"(b) The request is filed not later than the 180th day after notification of denial and the claimant establishes at a hearing that there was good cause for failure to file the request by the 60th day after notification of denial"

days, "because this claimant could not be expected or required to file a request for a hearing until he had actually been notified of the denial." 102 Or at 332.

Employer contends that it has met its obligation to give notice of the denial and that claimant has not met his burden to show good cause for his failure to timely appeal its denial. The Supreme Court held in *Norton v. Compensation Department*, 252 Or 75, 448 P2d 382 (1968), that notification to the claimant occurs when the notice is mailed, *see also Cowart v. SAIF*, 86 Or App 748, 740 P2d 249 (1987), rather than when it is received. That is to say that the time starts to run when the notice is mailed. That is not the issue here. We have held that a claimant's failure to receive a properly mailed notice can form the basis for a claim of good cause for failure to request a hearing within 60 days of the notice under appropriate circumstances. *Giusti v. Adams, supra*, 102 Or at 333.

Employer contends that the Board erred in concluding that claimant had shown good cause. The three cases on which employer primarily relies are not helpful to it. In *Anderson v.EBI Companies*, 79 Or App 345, 349, 718 P2d 1383, *rev den* 301 Or 445 (1986), the claimant, who was incarcerated, asked that all correspondence be sent to his mother's house. The notice of denial was sent to that address; however, the claimant did not actually receive it until after he was released from prison approximately one month later. He did not request a hearing until more than 180 days after the date of the denial. We held that the request was untimely. The question of good cause was not relevant, because the request for hearing had been filed more than 180 days after the denial had been mailed, beyond the time during which a claimant may show good cause. *See also Wright v. Bekins Moving and Storage Co.*, 97 Or App 45, 775 P2d 857, *rev den* 308 Or 466 (1989).

In *Kalakay v. City of Eugene*, 92 Or App 699, 759 P2d 336 (1988), the notice of denial was sent to the correct address for the claimant and her roommate, but the claimant did not personally receive it. She filed a request for hearing more than 180 days after the notice was sent. We affirmed the Board's decision that the request was untimely. Good cause was not an issue, because the request was not made within 180 days of notice of denial.

Neither *Anderson v. EBI, supra, Wright v. Bekins Moving and Storage Co., supra*, nor *Kalakay v. City of Eugene, supra*, presented the issue of good cause; they addressed only the validity of the notice and the timeliness of the request for hearing that was made more than 180 days after notice. They are not authority for the result that employer seeks and are not inconsistent with our opinion in *Giusti Wine Co. v. Adams, supra*, or the Board's opinion that nonreceipt of notice constitutes good cause under these circumstances.

As employer notes, we have long grappled with how we review the good cause determination. *See Anderson v. Publishers Paper Co.*, 93 Or App 516, 763 P2d 398 (1988); *Giusti Wine Co. v. Adams, supra*, 102 Or App at 334 (Graber, J., concurring.) In 1980, when our review of workers' compensation cases was *de novo*, the Supreme Court said, in *Brown v. EBI Companies*, 289 Or 455, 460 n 3, 616 P2d 457 (1980), that the Board's determination of good cause is a matter of "agency judgment in the sense stated in *McPherson v. Employment Division*, 285 Or 541, 591 P2d 1381 (1979)." We questioned the correctness of that statement in our opinion in *Anderson v. Publishers Paper Co., supra*, but did not need to meet squarely the issue of the standard for our review at that time. We decided only that the Board should reconsider its decision, considering, as required by *Sekermestrovich v. SAIF*, 280 Or 723, 573 P2d 275 (1977), whether the failure timely to request a hearing was mistake, inadvertence or excusable neglect under ORCP 71B(1). 78 Or App at 517.

In several cases subsequent to *Brown* and *Anderson*, but not subject to the 1987 legislative changes eliminating *de novo* review, Or Laws 1987, ch 884, 12a, we reviewed the question of good cause de novo, despite the Supreme Court's comment in *Brown*. *Anderson v. Publishers Paper Co., supra*, 93 Or App at 518; *Barr v. EBI Companies*, 88 Or App 132, 137, 744 P2d 582 (1987); *Voorhies v. Wood, Tatum, Mosser*, 81 Or App 336, 725 P2d 405, *rev den* 302 Or 342 (1986).

Even after the 1987 legislation, some of our opinions still read as though we were evaluating, in the first instance, whether the facts constituted good cause. *Giusti Wine Co. v. Adams, supra; Hempel v. SAIF*, 100 Or App 68, 70, 784 P2d 1111 (1990). In her concurring opinion in *Giusti*, Judge Graber took issue with the wording of the majority opinion suggesting that standard for review. She wrote: "The sole legal issue is whether the Board's conclusion erroneously interpreted a provision of law." 102 Or App at 334. In her view, the case had to be affirmed, because the Board's conclusion that the claimant had demonstrated good cause was consistent with the governing statutes and cases.

In *Freres Lumber Co. v. Jegglie*, 106 Or App 27, 806 P2d 164 (1991), we followed that analysis. The claimant had failed to file a request for hearing, because he believed that his attorney would handle the matter. The attorney had not timely filed the request for hearing, because he had not received notice of the denial, as required by statute. We held that the Board's decision that those circumstances constituted good cause was consistent with ORS 656.319(1)(b) and the cases decided thereunder.

We are persuaded that that is the correct standard for our review of the Board's decision under ORS 183.482(7) and (8). We may reverse the Board only if its findings are not supported by substantial evidence or if it has erroneously interpreted a provision of law. ORS 183.482(8)(a). As we have held, the Board's findings here are supported by substantial evidence. The Board's decision that the circumstances here constitute good cause is not erroneous as a matter of law.

Affirmed.

Cite as 107 Or App 638 (1991) June 19, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Betty S. Tee, Claimant.

BETTY S. **TEE**, Petitioner,
v.
ALBERTSONS, INC., Respondent.
(88-11538; CA A64558)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 15, 1991.
Phil Goldsmith, Portland, argued the cause for petitioner. With him on the brief were Robert K. Udziela, Stephen V. Piucci, and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.
Thomas M. Christ, Portland, argued the cause for respondent. With him on the brief was Mitchell, Lang & Smith, Portland.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
BUTTLER, P.J.
Affirmed.
Rossman, J., dissenting.

Claimant seeks review of a decision of the Workers' Compensation Board reversing the referee's order and holding that she is not permanently and totally disabled as a result of her compensable low back and leg injury and chronic pain syndrome.

The Board's findings are supported by substantial evidence on the whole record. Before her low back injury in 1984, claimant worked for employer as a meat wrapper; she has not worked since 1985. The Board found that she is employable without training for four to six hours per day as a telemarketer or hotel/motel inspector. Although, as claimant contends, the Board did not make an explicit finding that she is *physically* capable of doing those jobs, its finding that she is employable in them is sufficient.

ORS 656.206(1)(a) defines permanent total disability in part as any disability "which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation." A "suitable" occupation is "one which the worker has the ability and the training or experience to perform * * *." The Board's findings support its conclusion that the suggested employment is suitable.

The statute does not define the term "gainful." Claimant contends that, because she could earn only one-third as much as she did before the injury in either of the two suggested employments, neither of them is "gainful." It is well settled that the ability of a claimant to perform regular part-time work precludes an award for permanent total disability. *Lankford v. Commodore Corporation*, 92 Or App 622, 625, 759 P2d 329 (1988); *Georgia-Pacific Corp. v. Perry*, 92 Or App 56, 757 P2d 437, *rev den* 307 Or 77 (1988); *Pournelle v. SAIF*, 70 Or App 56, 60, 687 P2d 1134 (1984); *Hill v. SAIF*, 25 Or App 697, 701, 550 P2d 752, *rev den* (1976); *see Bohrer v. Weyerhaeuser Company*, 93 Or App 751, 763 P2d 1207 (1988). We have never measured "gainfulness" as used in ORS 656.206 in terms of the claimant's level of earnings or hours of employment.

Claimant relies on *Frame v. Crown Zellerbach*, 63 Or App 827, 665 P2d 879, *on recon* 65 Or App 801, 672 P2d 70 (1983), for the proposition that employment is "gainful" only if the earnings from the proposed employment bear a reasonable relationship to the worker's pre-injury earnings. However, the question in Frame was whether the claimant was eligible for vocational assistance. OAR 436-61-004(4) required the insurer to provide vocational assistance to any worker unable to return to "gainful employment." In discussing the meaning of the term in that context, we said:

> "The purpose of the workers' compensation legislation is to 'restore the injured worker as soon as possible and as near as possible to a condition of self support and maintenance as an able-bodied worker.' ORS 656.268(1). Workers' compensation was developed not just to compensate a worker who had been injured on the job, but also to enable the worker to reenter the job market and become employed again in a position as near as possible in pay and status to the one the claimant has been forced by injury to leave. There are no specific guidelines to determine what 'as near as possible' means; it must be determined on a case-by-case basis. *Gainful employment, in the light of the intent of the workers' compensation statutes (and the regulations of the Department), must bear a reasonable relationship to an individual's experience and background, including prior earnings.* For example, it would be unrealistic to expect that a worker could be seen as having been restored to employment 'as near as possible' to his or her former employment if he was formerly a diesel mechanic and is now working at a fast

food restaurant because that was the only job he could get without retraining." 63 Or App at 830. (Emphasis supplied.)

We adhere to the holding and analysis in *Frame*; however, the considerations were different in that case and the definition that we gave to "gainful" for the purpose of determining eligibility for vocational assistance does not apply here. In *Frame*, we correctly held that the term "gainful" in the context of eligibility for vocational assistance must be construed to require vocational assistance for workers who would not otherwise be able to return to work comparable to their pre-injury employment.

Implicit in the workers' compensation law is the legislature's recognition that not all workers will recover sufficiently from their compensable injuries to return to comparable work, even with vocational assistance. Those who do not are compensated for their level of permanent disability, either partial or total. ORS 656.206(1)(a) cannot be read to require that all workers who are unable to return to an occupation comparable in pay to their pre-injury occupation be compensated for permanent total disability, even if they are capable of *some* work. That would be contrary to the legislature's decision to compensate partial disability as partial disability. ORS 656.214(5). It would also frustrate the legislative goal of encouraging those who are capable of returning to work, even if only on a regular part-time basis, to do so. ORS 656.012(2)(c).

A worker is permanently and totally disabled if the injury has left her incapable of performing any service for which there exists a hypothetically normal labor market. *See, e.g., Wilson v. Weyerhaeuser*, 30 Or App 403, 567 P2d 567 (1977); *see also Harris v. SAIF*, 292 Or 683, 642 P2d 1147 (1982). The converse of that is also true: A worker who is capable of performing regularly any service for which there exists a hypothetically normal labor market can be gainfully employed and, therefore, is not permanently and totally disabled, as the term is used in ORS 656.206(1)(a).

Here, the evidence supports the Board's findings that claimant is capable of working regularly as a telemarketer or hotel/motel inspector, albeit on a part-time basis, and that the work is available. Although that employment may not pay as well as her pre-injury occupation, it is remunerative and is, therefore, gainful.[1] The Board did not err in concluding that claimant is not entitled to an award for permanent total disability.

Affirmed.

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[1] Claimant does not contend that she is entitled to additional vocational services or that she has been denied them.

ROSSMAN, J., dissenting.

The majority holds that the Board did not err in concluding that, because claimant is employable in jobs earning only one-third of her pre-injury wages, she is "gainfully" employable and is, therefore, ineligible for permanent total disability (PTD) benefits. I disagree.

We have already defined the statutory term "gainful employment" as that which "bear[s] a reasonable relationship to an individual's experience and background, including prior earnings." *Frame v. Crown Zellerbach*, 63 Or App 827, 831, 665 P2d 879, *on recon* 65 Or App 801, 672 P2d 70 (1983); *see also* ORS 656.340(6).[1] Although *Frame* involved eligibility for vocational assistance, I see no reason to limit the construction of "gainful employment" to that context.

The objectives of workers' compensation are the same in both the vocational assistance and disability benefits areas: to restore the worker to a position as near as possible in pay and status as existed before the injury. A term should be applied consistently in construing a statutory scheme. It is inappropriate to give differing meanings to the term when applying parts of the same law.

The great disparity between claimant's pre- and post-injury earning capacity compels the result that the telemarketer and room inspector jobs are not gainful employment. They do not bear a reasonable relationship to her previous earnings and, as we explained in *Frame*, "[t]here is no requirement that a worker who has been offered *any* job paying *something*, even minimum wage, is gainfully employable * * *." 63 Or App at 831. (Emphasis in original.) I am especially concerned with today's holding because--assuming that there actually is a market for it--the telemarketing job might be used to deny PTD benefits in all cases, because the inference is that almost anyone, regardless of physical disability, can perform it. If that comes to pass, it will be because the majority has effectively eviscerated the term "gainful" from the statute.

Accordingly, I dissent.

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[1] In response to *Frame*, the 1987 Legislature amended ORS 656.340(6) to provide specifically that a worker is eligible for vocational assistance

> "(a) * * * if the worker will not be able to return to the previous employment or to any other available and suitable employment with the employer at the time of injury, and the worker has a substantial handicap to employment.
>
> "(b) As used in this subsection:
>
> "(A) a 'substantial handicap to employment' exists when the worker, because of the injury, lacks the necessary physical capacities, knowledge, skills and abilities to be employed in *suitable employment*.
>
> "(B) *'Suitable employment'* means:
>
> "* * * * *
>
> "(iii) Employment that produces a wage within 20 percent of that currently being paid for employment which was the worker's regular employment." (Emphasis supplied.)

See also ORS 656.340(14).

Cite as 107 Or App 669 (1991) June 19, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON

STORM **GILL**, D.C., Petitioner,
v.
DIRECTOR OF THE DEPARTMENT OF INSURANCE AND FINANCE, Respondent.
(89-11373; CA A64025)

Judicial Review from Director of Department of Insurance and Finance.
Argued and submitted December 18, 1990.
Donald Foss, Jr., Oregon City, argued the cause for petitioner. With him on the briefs was Greg Austin, Portland.
John Bagg, Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Richardson, Presiding Judge, and Newman and Deits, Judges.
NEWMAN, J.
Reversed.

Petitioner seeks review of an order of the Director of the Department of Insurance and Finance (Director) declaring that petitioner is ineligible to receive reimbursement for treatment of workers' compensation claimants from June 15, 1989, through June 14, 1990. ORS 656.254(3).[1] We reverse.

On July, 8, 1988, the Oregon State Board of Chiropractic Examiners (Board) issued to petitioner a Notice of Proposed Revocation or Suspension of Chiropractic License. It stated that the Board "proposes to revoke or suspend the Chiropractic License of [petitioner]. This revocation or suspension arises under the provisions of ORS 684.100." It contained these allegations:

> "On February 1, 1988, Mr. Gregory Coelho, a patient of Dr. Gill's, underwent surgery at Tuality Hospital in Hillsboro, Oregon. The surgery was performed by E. W. Berkeley, M.D., and the surgical procedure consisted of an anterior cervical diskectomy with inter-body fusion, C5-6, Cloward method. On February 2, 1988, Dr. Gill visited Mr. Coelho in his room at Tuality Hospital on two occasions and performed adjustments to Mr. Coelho's neck on Mr. Coelho's first postoperative day without the knowledge, consent, or approval of Mr. Coelho's surgeon, E. W. Berkeley, M.D., and without the knowledge or consent of personnel or staff of the Tuality Hospital."

The notice also provided as "particular reasons" for the proposed suspension or revocation that

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[1] ORS 656.254(3) provides, in part:
"[I]f the director *finds* that a health care practitioner has:
"* * * * *

"(b) Had the health care practitioner's license revoked or suspended by the practitioner's professional licensing board *for a violation of that profession's ethical standards*, the director may declare the health care practitioner ineligible for reimbursement for treating workers' compensation claimants for a period not to exceed three years or the period the practitioner's license is suspended or revoked, whichever period is the longer." (Emphasis supplied.)

"[t]his activity on Mr. Gill's part amounted to conduct which did or might have constituted a danger to the health or safety of his patient, Mr. Coelho, and such activity is and was unprofessional or dishonorable conduct within the meaning of ORS 684.100(1)(g)(A). Dr. Gill's failure to consult with E. W. Berkeley, M.D. as to the treatment he intended to provide Mr. Coelho was not consistent with the standard of care imposed upon the chiropractic profession and constitutes unprofessional or dishonorable conduct within the meaning of ORS 684.100(1)(g)(B)."

Petitioner entered into a consent order with the Board. In it, he admitted the truth of "the material, factual allegations contained in the Notice." He did not admit to any conclusion that he had violated ethical standards of his profession. The consent order suspended petitioner's license for 30 days and required him to pay a fine of $1,000 and to write letters of apology to Dr. Berkeley and the hospital staff. The consent order did not recite that petitioner had violated ethical standards of his profession or that the suspension, fine and other sanctions were imposed because the Board had found that he had violated ethical standards of his profession.

On May 31, 1989, the Director issued a proposed order under ORS 656.254(3) that declared petitioner ineligible to receive reimbursement for treating workers' compensation patients. The Director found that the Board had suspended petitioner's license, because he had violated the professional ethical standards set forth in ORS 684.100(1)(g)(A) and (B).[2] Petitioner requested and received a hearing pursuant to ORS 656.704(2).[3] The referee affirmed the Director's proposed order in its entirety. The order thereby became final and subject to judicial review.[4]

Petitioner asserts that the Director erred in finding that the consent order contained admissions of legal conclusions in addition to allegations. Petitioner argues that the consent order did not contain any conclusion that his fact admissions constituted a violation of any ethical standard. He asserts that the Director could not find that the Board suspended his license for a violation of his profession's ethical standards because the consent order does not recite that as a fact. We agree.

Under ORS 656.254(3)(b), the Director is limited to finding whether the health care practitioner's professional licensing board suspended his license for a violation of his profession's ethical standards. He could not conclude from the consent order that the Board had done that.

Reversed.

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[2] ORS 684.100(1) provides, in part:

"The board may refuse to grant a license to any applicant, may suspend or revoke such a license or may impose a civil penalty not to exceed $1,000 upon any of the following grounds:

"* * * * *

"(g) Unprofessional or dishonorable conduct which includes but is not limited to:

"(A) Any repeated conduct or practice contrary to recognized standard of ethics of the chiropractic profession or any conduct or practice which does or might constitute a danger to the health or

safety of a patient or the public or any conduct, practice, or condition which does or might impair a physician's ability safely and skillfully to practice chiropractic.

"(B) Wilful and repeated ordering or performance of unnecessary laboratory tests or studies; administration of unnecessary treatment; failure to obtain consultations or perform referrals when failing to do so is not consistent with the standard of care; or otherwise ordering or performing any chiropractic service, X-ray, or treatment which is contrary to recognized standards of practice of the chiropractic profession."

[3] ORS 656.704(2) provides:

"Actions and orders of the director and the conduct of hearings and other proceedings pursuant to ORS 656.001 to 656.794, and judicial review thereof, regarding all matters other than those concerning a claim under ORS 656.001 to 656.794, are subject only to ORS 183.310 to 183.550 and such procedural rules as the director may prescribe. The director may make arrangements with the board pursuant to ORS 656.726 to obtain the services of referees to conduct such proceedings or may make other arrangements to obtain personnel to conduct such proceedings. The director by rule shall prescribe the classes or orders issued by referees and other personnel that are final, appealable orders and those orders that are preliminary orders subject to revision by the director."

[4] Petitioner's petition for review designates the "Final Order of the Workers' Compensation Board" as the order from which petitioner seeks review. That order is an order of the Workers' Compensation Board Referee. It states that it is subject to review. Nonetheless, review is only of the Director's order, which became final as a result of the referee's order. We interpret the petition for review as adequate to raise the validity of the Director's order. *See* OAR 436-10-008(2)(a).

Cite as 107 Or App 721 (1991) June 19, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Paula J. Kerns, Claimant, and, In the Matter of the Complying Status of PAULA GUIDO-LEE, dba DANA'S HOUSEKEEPING, Employer.

PAULA J. **KERNS**, Petitioner-Cross-Respondent,

v.

PAULA **GUIDO-LEE**, dba DANA'S HOUSEKEEPING, Respondent-Cross-Petitioner, and SAIF CORPORATION, Respondent.

(WCB 87-13554; 87-13553; CA A64496)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 25, 1991.

James L. Edmunson, Eugene, argued the cause for petitioner-cross-respondent. With him on the brief were James L. Francesconi and Francesconi & Associates, Portland.

Ridgway K. Foley, Jr., Portland, argued the cause for respondent - cross-petitioner. With him on the brief was Schwabe, Williamson & Wyatt, Portland.

David L. Runner, Assistant Attorney General, Salem, waived appearance for respondent SAIF Corporation.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.
Affirmed on petition and on cross-petition.

Claimant seeks review of a Workers' Compensation Board order that concluded that she is a nonsubject worker and not entitled to compensation, because she is a "domestic servant" within the meaning of ORS 656.027(1). We affirm.

Claimant is a housekeeper. Employer, Dana's Housekeeping, is a referral service that had written agreements with claimant and others offering them housekeeping contracts with individual client homeowners. Claimant was paid by the homeowners; she then paid employer a portion of the money. Employer had no workers' compensation coverage in force from November, 1986, to June, 1987.

In May, 1987, claimant slipped and fell while she "was cleaning a private home and carrying out the trash * * *." She filed a claim against employer, and the Compliance Division of the Workers' Compensation Department issued a proposed and final order finding claimant to be a subject worker and employer to be a non-complying employer. Employer requested a hearing. The referee concluded that clai is a subject worker and that the "domestic servant" exception, as defined in ORS 656.027(1), does not apply, because

> "[w]hat controls the analysis in this case is not the *type* of work [claimant] was performing, but, rather, the nature of her employment *relationship* with [employer]." (Emphasis supplied.)

Employer requested review, and the Board reversed.[1] Relying on the plain language of ORS 656.027(1), it concluded that claimant was excluded from workers' compensation coverage, because she was employed as a domestic servant. Claimant petitioned for review; employer cross-petitioned, challenging the Board's finding that claimant is a worker, as defined by ORS 56.005(27).

Claimant argues that the Board erred in concluding that she is a domestic servant. She urges us to conclude, as a matter of law, that

> "the workers who are excluded from coverage under ORS 656.027(1) only are those who work directly for, and to the exclusive benefit of, private households who derive no profit and pass on no costs to any consumers."

Employer disputes claimant's contention that the applicability of the domestic servant exception should turn on her relationship with employer, rather than on the nature of the work that she performed. It argues that claimant is a nonsubject worker, because she was a "domestic servant" under the plain language of ORS 656.027(1):

> "All workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections:
>
> "(1) A worker employed as a domestic servant in or about a private home. *For the purposes of this subsection 'domestic servant' means any worker engaged in household domestic service.*" (Emphasis supplied.)

---

[1] The Board affirmed the referee's order that employer was a non-complying employer. Neither party challenges that ruling.

In support of its argument, employer compares the language in ORS 656.027(1) with the language in ORS 656.027(2), which excludes

> "[a] worker employed to do gardening, maintenance, repair, remodeling or similar work in or about the private home *of the person employing the worker.*" (Emphasis supplied.)

Employer reasons that, because ORS 656.027(2) expressly limits the identity of the "employer" and ORS 656.027(1) contains no such limitation, the legislature clearly intended to exclude an entire class of workers, *i.e., all* domestic servants, regardless of the identity of their employer.

What is relevant is the nature of the work performed and its relation to the home, not the identity of the persons arranging for, supervising, controlling or benefitting from the service. *See Gunter v. Mersereau*, 7 Or App 470, 473, 491 P2d 1205 (1971). Claimant slipped and fell while she was engaged in household domestic service, cleaning a private home. Therefore, at the time of her injury she was a nonsubject worker, because she was "a domestic servant in or about a private home."

Claimant urges us to construe the statute to exempt only those workers who contract with a private homeowner to provide direct, personal domestic service. She contends that, because the underlying rationale for the "domestic servant" exception is to relieve nonbusiness householders from the burden of providing workers' compensation coverage, we should not allow employer, a large commercial enterprise engaged for profit in the business of providing housekeeping services to individual client homeowners, to escape liability. We decline the suggestion to construe the statute as claimant suggests. *See McFarland v. SAIF*, 89 Or App 184, 748 P2d 150 (1988). Under the plain language of the statute, claimant is a domestic servant and is, therefore, not entitled to compensation.

In the light of our disposition of the petition, employer's cross-petition is moot.

Affirmed on petition and on cross-petition.

Cite as 107 Or App 762 (1991) June 19, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Herbert C. Ausbie, Claimant.

LIBERTY NORTHWEST INSURANCE CORPORATION and YORKE CONSTRUCTION, Petitioners,
v.
HERBERT C. **AUSBIE**, Respondent.
(88-08507; CA A63928)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 19, 1990.
Stafford J. Hazelett, Portland, argued the cause and filed the brief for petitioners.
Philip F. Schuster, II, Portland, argued the cause and filed the brief for respondent.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
PER CURIAM
Reversed and remanded for reconsideration in the light of Aetna Casualty Co. v. Aschbacher, 107 Or App 494, ___ P2d ___ (1991).

Employer seeks review of an order of the Workers' Compensation Board affirming the referee's holding that claimant had established the compensability of his preexisting foot condition. The Board found that the condition should be treated as an occupational disease rather than an injury. That decision is supported by substantial evidence and is affirmed. The Board also found that claimant had established that his work was a material contributing cause of the worsening of his symptoms and, citing its opinion in *Donna E. Aschbacher*, 41 Van Natta 1242 (1989), held that that was sufficient to establish the compensability of the claim.

We reversed the Board's order in *Donna E. Aschbacher, supra, Aetna Casualty Co. v. Aschbacher*, 107 Or App 494, ___ P2d ___ (1991), and held that, under the applicable version of ORS 656.802, a claimant must establish that the employment was the major contributing cause of the worsening of the underlying condition. Accordingly, the Board must reconsider its decision in the light of our opinion.

Reversed and remanded for reconsideration in the light of *Aetna Casualty Co. v. Aschbacher, supra*.

Cite as 107 Or App 764 (1991) June 19, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Carole J. Damm, Claimant.

LIBERTY NORTHWEST INSURANCE CORPORATION and WASHINGTON COUNTY SCHOOL DISTRICT #7,
Petitioners,
v.
CAROLE J. **DAMM**, Respondent.
(88-05479; CA A63929)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 19, 1990.
Stafford J. Hazelett, Portland, argued the cause and filed the brief for petitioners.
Richard F. McGinty, Salem, and Vick & Gutzler, Salem, filed the brief for respondent.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
PER CURIAM
Reversed and remanded for reconsideration in the light of *Aetna Casualty Co. v. Aschbacher*, 107 Or App 494, ___ P2d ___ (1991).

Employer seeks review of an order of the Workers' Compensation Board affirming the referee's determination that claimant had established the compensability of her back condition as an occupational disease.

The referee found that claimant's work was the major contributing cause of her disc herniation. The Board affirmed the referee but, citing its opinion in *Donna E. Aschbacher*, 41 Van Natta 1242 (1989), held that, under the version of ORS 656.802 that was applicable to her case, claimant needed only to show that events at work were a material, rather than the major, contributing cause of her disability or need for treatment.

Reversed and remanded for reconsideration in the light of *Aetna Casualty Co. v. Aschbacher*, 107 Or App 494, ___ P2d ___ (1991).

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of John O. Fisher, Claimant.

JOHN O. **FISHER**, Petitioner,
v.
DEPARTMENT OF FORESTRY and SAIF CORPORATION, Respondents.
(89-11179; CA A66957)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 17, 1991.
Christine Jensen, Eugene, argued the cause for petitioner. With her on the brief was Malagon, Moore & Johnson, Eugene.
John Reuling, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Joseph, Chief Judge, and Newman and Deits, Judges.
PER CURIAM
Affirmed.

Claimant challenges the Workers' Compensation Board's denial of his request for attorney fees that was based on SAIF's failure to provide discovery within 15 days of his demand for documents. Because claimant's demand occurred before his request for a hearing, the 15-day requirement did not apply. *O'Leary v. Valley View Cutting*, 107 Or App 103, ___ P2d ___ (1991).

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Roy E. Hubbard, Claimant.

ROSEBURG FOREST PRODUCTS, Petitioner,
v.
ROY E. **HUBBARD**, Respondent.
(88-10506; CA A64700)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 10, 1990.
Thomas M. Sheridan, Portland, argued the cause for petitioner. With him on the brief was Davis & Bostwick, Portland.
Malcolm J. Corrigall, Coos Bay, argued the cause for respondent. With him on the brief was Ormsbee & Corrigall, Coos Bay.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

PER CURIAM
Reversed and remanded for reconsideration in the light of *Aetna Casualty Co. v. Aschbacher*, 107 Or App 494 ___ P2d ___ (1991), and *Liberty Northwest Insurance Corp. v. Damm*, 107 Or App 764, ___ P2d ___ (1991).

Cite as 108 Or App 32 (1991) June 26, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Paul R. Lewis, Claimant

PAUL R. **LEWIS**, Petitioner,
v.
McCRACKEN MOTOR FREIGHT and LIBERTY NORTHWEST INSURANCE CORP., Respondents.
(WCB 88-19061, 88-19062; CA A65618)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 27, 1991.
James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Jon C. Correll and Malagon, Moore & Johnson, Eugene.
Stafford J. Hazelett, Portland, argued the cause and filed the brief for respondents.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
EDMONDS, J.
Affirmed.

Claimant seeks review of a Workers' Compensation Board order holding that he is not entitled to an award of permanent partial disability. The issue is whether the 1987 amendments to ORS 656.295(5) changed the requirement that he prove a worsening of his left knee condition since the last determination order. We affirm.

The Board found that claimant had compensably injured his left knee in February, 1986. The claim was closed in September, 1986, by a determination order that awarded no permanent disability. Claimant continued to experience pain and eventually underwent arthroscopic surgery in 1988. As a result, his claim was reopened. Employer then closed the claim with a notice of closure and without an award of permanent disability. That triggered this proceeding. The Board found that claimant's condition "has not permanently worsened since his claim was initially closed in September 1986."

ORS 656.295(5) provides:

> "The review by the board shall be based upon the record submitted to it under subsection (3) of this section and such oral or written argument as it may receive. *The board shall apply to the review of the claim such standards for the evaluation of disability as may be adopted by the director pursuant to ORS 656.726. Nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present evidence * * * that the degree of disability suffered by the claimant is more or less than the entitlement indicated by the standards adopted by the director under ORS 656.726.* However, if the board determines that a case has been improperly, incompletely or otherwise insufficiently developed or heard by the referee, it may remand the case to the referee for further evidence taking, correction or other necessary action." (Emphasis supplied.)

The emphasized language was added in 1987; it applies to all claims that have become medically stationary on or since January 1, 1988. Or Laws 1987, ch 884, 12, 62(2).[1]

ORS 656.273(1) also is pertinent to the issue in this case. It was not amended in 1987 or 1989. At the time of these proceedings, it provided:

"After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for *worsened conditions* resulting from the original injury." (Emphasis supplied.)[2]

In *Stepp v. SAIF*, 304 Or 375, 745 P2d 1207 (1987), the Supreme Court held that, under ORS 656.273(1), the claimant was not entitled to additional compensation for permanent disability compensation, because he had failed to establish a permanent worsening of his condition since the last arrangement of compensation. It said:

"On a worsening claim for additional PPD or PTD the referee, Evaluation Division and Board should first compare the claimant's present medical condition with the condition at the time of the earlier award or arrangement of compensation. *If that condition is unchanged or improved, no further inquiry is necessary, for there has been no worsening.*" 304 Or at 381. (Footnote omitted; emphasis supplied.)

Claimant assigns error to the Board's refusal to apply the disability rating standards of ORS 656.295(5). He argues that the 1987 amendment to that statute dictates that the standards be applied, because he became medically stationary after January 1, 1988. He also argues that, in the light of that amendment, *Stepp* is no longer good law. Employer argues that, because ORS 656.273(1) was not amended in 1987, *Stepp* controls.

The 1987 amendments to the Workers' Compensation Law included a mandate that the Evaluation Division, insurers, referees and the Board apply disability rating standards promulgated by the agency's director. Or Laws 1987, ch 884, 2, 10, 11 and 12. That mandate was an attempt to standardize the rating of permanent disabilities and to increase thereby the likelihood that an award of benefits for a permanent disability would be upheld on review. Minutes, Senate Committee on Labor 5 (June 9, 1987--comments of Virginia Culver, Evaluation Division Administrator). The amendments did not change ORS 656.273(1). There is no mention of that statute or *Stepp v. SAIF, supra*, in the legislative history. *Stepp* remains good law and, in the aggravation context, the disability rating standards mandated by ORS 656.295(5) apply only if a claimant first establishes a worsening. Here, claimant failed to prove that his knee condition has worsened since the 1986 determination order. It follows that the disability rating standards were not implicated and that the Board did not err.

Claimant also assigns error to the Board's reversal of the referee's award of a penalty and attorney fees. The Board determined that, under ORS 656.268(3)(a), the insurer's issuance of the Notice of Closure was improper and unreasonable, because claimant had not yet obtained permanent employment. Nonetheless, it concluded that claimant was not entitled to a penalty or attorney fees, because

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[1] Section 62(2) provides:

"For purposes of ORS 656.202, amendments by this Act to ORS 656.218, 656.268, 656.283, 656.295 and 656.319 shall not be considered to be the payment of benefits and shall apply to all claims which become medically stationary on or after January 1, 1988."

[2] ORS 656.273(1) was amended in the 1990 Special Session. Or Laws 1990, ch 2, 18(1). The amendment does not affect this case.

> "there are no 'amounts then due' upon which to base a penalty. Further, because there has been no unreasonable resistance to the payment of compensation, we do not assess an attorney fee." (Citation omitted.)

We agree. ORS 656.268(3)(f); ORS 656.382(1). See Randall v. Liberty Northwest Ins. Corp., 107 Or App 599, ___ P2d ___ (19, 1991).

Affirmed.

Cite as 108 Or App 57 (1991) July 3, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Charlene Toole, Claimant.
CHARLENE **TOOLE**, by and through the PROFESSIONAL LIABILITY FUND, Petitioner,
v.
EBI COMPANIES, Respondent.

In the Matter of the Compensation of Victor S. Lloyd, Claimant.
VICTOR S. **LLOYD**, by and through the PROFESSIONAL LIABILITY FUND, Petitioner-Cross-Respondent,
v.
PORT OF PORTLAND, Respondent - Cross-Petitioner.

In the Matter of the Compensation of Roger L. Shephard, Claimant.
ROGER L. **SHEPHARD**, by and through the PROFESSIONAL LIABILITY FUND, Petitioner,
v.
EBI COMPANIES, Respondent.
(WCB No. TP-89003, WCB No. TP-89022, WCB No. TP-89010; CA A62038 (Control), CA A62117, CA A62386)
(Cases Consolidated)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 7, 1990.
Frank Moscato, Portland, argued the cause for petitioners and cross-respondent. With him on the briefs were Deborah L. Sather and Cooney, Moscato & Crew, P.C., Portland.
Ridgway K. Foley, Portland, argued the cause for respondents and cross-petitioner. With him on the brief were M. Elizabeth Duncan and Schwabe, Williamson & Wyatt, Portland.
Before Richardson, Presiding Judge, and Joseph, Chief Judge, and Deits, Judge.
JOSEPH, C.J.
Reversed on petitions and on cross-petition.

In these consolidated cases, claimants had sustained compensable injuries and received workers' compensation benefits. Each claimant pursued a separate personal injury claim against a third party who was alleged to have negligently caused the compensable injury. ORS 656.154; ORS 656.578.[1] In each case, claimant lost the third party claim or received only a partial recovery. Claimants then asserted claims against their attorneys, alleging that the attorneys' negligence prevented appropriate recoveries on their third party claims. Those malpractice claims were settled without an admission of liability, and a payment was made to each claimant by the Oregon State Bar Professional Liability Fund (PLF).

After the malpractice settlements, EBI Companies and Port of Portland (insurers), who are the paying agents under the third party recovery statutes,[2] filed petitions with the Workers' Compensation Board, asserting liens against the settlement proceeds under ORS 656.580[3] in each case and requesting to be paid a share of the proceeds or that each settlement be declared void for lack of the paying agent's written approval.[4] On behalf of each claimant, PLF contested the Board's jurisdiction to rule on the petitions. The Board's order in each case held: (1) It had jurisdiction to decide a dispute over the distribution of the settlement proceeds; (2) the paying agent's lien attached to the settlement proceeds; and (3) each settlement was void for lack of the paying agent's approval. PLF seeks reversal of the Board's decision that it has jurisdiction to decide this issue or, in the alternative, reversal of the decision that a paying agent's lien can attach to a legal malpractice action recovery.

PLF argues that, under the third party recovery statutes, the Board had no jurisdiction over the settlement proceeds. It contends that the statutes expressly limit the Board's jurisdiction only to distribution of settlements between an injured worker and a third party who caused the compensable injury. *See* ORS 656.154; ORS 656.578; ORS 656.580; ORS 656.583; ORS 656.587; ORS 656.591. After oral argument in this court, PLF filed a memorandum citing *SAIF v. Wright*, 102 Or App 598, 795 P2d 604, *mod* 104 Or App 322, 801 P2d 848 (1990), *rev allowed* 311 Or 60 (1991), for the proposition that the Board does not have authority either to rule on insurers' petitions for distribution or to declare the settlements between claimants and PLF's insureds void.

Insurers argue that, according to case law, the Board has jurisdiction over all third party lien disputes. They rely on *EBI Companies v. Cooper*, 100 Or App 246, 249, 785 P2d 380 (1990); *Harvey v. Lou Surcamp Logging*, 100 Or App 227, 229 n 1, 785 P2d 383 (1990); and *Shipley v. SAIF*, 79 Or App 149, 152, 718 P2d 757, *rev den* 301 Or 338 (1986).

PLF misconstrues Wright. In that case, SAIF had denied a claim on the ground that the claimant was not a "subject worker" of any of three non-complying employers. The claimant appealed to the Board. While awaiting the Board's decision, the claimant and the third party that had caused the compensable injury[5] settled their case. The Board decided that the claimant was a "subject worker" of one of the employers, and SAIF began processing the claim. SAIF learned of the settlement only after the settlement proceeds had already been distributed to the claimant and his creditors. SAIF nonetheless moved the Board for an

> "order requiring [claimant] and his attorney * * * to distribute to SAIF Corporation the sum of $36,324.24 as its [ORS 656.593] share of the (unapproved) third party settlement made in this matter." 102 Or App at 600.

The Board denied SAIF's motion on the ground that SAIF was not the "paying agency" when the claimant settled his third party action. On review, we held that, although the Board had jurisdiction over SAIF's motion, it did not have the authority to grant the specific relief sought.[6] We said that, whatever tribunal might have authority to adjudicate the issues necessary for final resolution of a paying agent's claim in such circumstances, it is not the Workers' Compensation Board. 102 Or App at 601.

This case is factually different from *Wright*, and the issues are different. The applicability of the distribution statutes is disputed, because the proceeds are due to attorney malpractice, rather than to infliction of physical injury. The question is: Does the Board have the authority to decide whether

the proceeds of a settlement of a particular type of claim are distributable under the Workers' Compensation Law?

Numerous cases have acknowledged, or presumed, that the Board had the authority to decide various questions relating to proceeds sought to be distributed. In *Allen v. American Hardwoods*, 102 Or App 562, 795 P2d 592, *rev den* 310 Or 547 (1990), an Oregon workers' compensation insurer sought distribution of settlement proceeds obtained from a Michigan company by a deceased worker's beneficiary and an injured worker, both of whom were Oregon residents. Michigan law did not allow reimbursement to a workers' compensation insurer if only noneconomic loss had been recovered, which was true of both settlements involved. The Oregon insurer petitioned the Board for an order declaring its lien against the Michigan settlement proceeds valid. We agreed with the Board's choice of law analysis and affirmed its conclusion that Oregon law governs the validity of an Oregon insurer's liens on another state's third party settlement.

In *Shipley v. SAIF, supra*, the claimant sought review of a Board order that held that his recovery from a third party's insurance company, arising out of an earlier judgment against the company's insured for injuring the plaintiff, was subject to a lien under ORS 656.593(1). We upheld the Board without discussing its authority to decide the issue. In *EBI Companies v. Cooper, supra*, we decided that the Board had the authority to decide whether the claimant's election to assign his third party claim to the compensation carrier was obtained fraudulently and whether it could redistribute the proceeds of a settlement negotiated by the insurer:

> "ORS 656.591 gives the Board jurisdiction over the parties and the subject matter of an election by a worker to assign his third party claim to a paying agency. The Board's authority to order rescission of an election fraudulently obtained flows from the exercise of that jurisdiction, because an election that was induced by fraud is, in fact, no election." 100 Or App at 249.

The Board has also decided, without objection, whether an insurer is entitled to a share of a third party settlement, *Robertson v. Davcol, Inc.*, 99 Or App 542, 783 P2d 43 (1989), and to what parties it may distribute proceeds. *SAIF v. Cowart*, 65 Or App 733, 738, 672 P2d 389 (1983).[7]

We are persuaded by the logic of *EBI Companies v. Cooper, supra*: The Board has jurisdiction to resolve disputes between a claimant and a paying agent "as to what may be a just and proper distribution" of the proceeds from settlement of "any third party case," ORS 656.593(3); therefore, it has the authority to determine whether a particular agreement constitutes the settlement of a "third party case" under the act.[8]

The next question is whether the Board correctly concluded that the legal malpractice claims are "third party cases," so that insurers' liens would attach to the settlement proceeds. PLF argues that the plain and unambiguous language of the third party recovery statutes expressly limits a paying agent's lien to proceeds arising out of a claim against a third party who caused a worker's compensable injury. Insurers argue that this court's holding in Shipley v. SAIF, supra, rejected PLF's proposition that a paying agent's lien can only arise out of an action for the "negligence or wrong of a third person" who caused the compensable injury. They rely on this language in *Shipley*:

> "Plaintiff elected to seek recovery against the third party, and he successfully obtained an award of damages for the negligently inflicted injury. Only because the third party's insurer denied coverage did plaintiff have to initiate an action to recover the amount

of the judgment. *That action was ancillary to the action against the insured, because, without the judgment against the insured, no cause of action against the insurer could have existed. Plaintiff's ultimate recovery of the damages arose out of the negligent conduct of the third party*, and the proceeds are properly subject to a lien by SAIF." 79 Or App at 152. (Emphasis insurers'.)

On the basis of that language, insurers draw these conclusions: (1) Like the action against the third party's insurance carrier in Shipley, the malpractice actions here were ancillary to the third party actions because, without the claims against the third parties, no causes of action against the attorneys could exist; and (2) it is not critical that a judgment or a settlement be obtained in a third party action before the ancillary action is initiated. They also contend that, because they would have had liens on any recoveries had the third party actions for bodily injuries been properly prosecuted, the same policy considerations should apply to allow a lien to attach to proceeds of any ancillary action necessary for the full vindication of a claimant's third party claim.

PLF argues that a legal malpractice action is, by definition, not ancillary to the original cause of action.[9] It also maintains that, in Shipley, the paying agent's lien was held to attach to the judgment against the insurance carrier because that judgment was the means of collecting the bodily injury damages owed to the claimant by the third party who caused the compensable injury.

The purposes of the third party recovery statutes are to allocate "*whatever* the claimant recovers between him and the paying agency and to provide reimbursement to those responsible for statutory compensation of injured workers when damages or settlements are obtained against the persons whose acts caused the injuries." *Schlecht v. SAIF*, 60 Or App 449, 456, 653 P2d 1284 (1982). (Emphasis in original.) Third party liability includes, not only original tortfeasors, but also persons whose negligence worsens compensable injuries. See *Wimer v. Miller*, 235 Or 25, 383 P2d 1005 (1963); *SAIF v. Meredith*, 104 Or App 570, 802 P2d 95 (1990). However, a compensable injury is the foundation of the concept of a lien on third party recoveries. Legal malpractice results in harm distinct from any type of injury that conceivably could be compensable under the workers' compensation law. Even if the measure of damages is the recovery that was likely in the original action but for the malpractice, the recovery is compensation for harm caused by attorney negligence, not for a compensable injury.

Shipley v. SAIF, supra, is not dispositive here. The claimant there filed an action to enforce the judgment against the carrier's insured by proving that the carrier's policy covered the insured's liability to the claimant for bodily injury. That action was truly ancillary to the original negligence claim. Insurers' idea here that, under the third party recovery statutes, no judgment, settlement or right thereto needs to exist against a third party in order for an "ancillary" action to be initiated is not correct.

A paying agent's lien under ORS 656.580(2) and its right to a just and proper distribution under ORS 656.593(3) only apply to recovery from a third party. Within the meaning of ORS 656.154 and ORS 656.578, a third party is a person who could be held liable for causing a compensable injury to a worker. An attorney who incurs liability by negligently representing a worker is not a "third party." Therefore, a recovery for legal malpractice is not subject to a claim by a paying agent. The Board erred in concluding otherwise.

Because the attorneys who settled the malpractice claims against them were not "third parties," we do not reach the question of whether the Board may decide that a third party settlement is void under ORS 656.587.

Port, the self-insured employer of Lloyd (A62117), cross-petitions for review of the Board's order holding that the amount of its lien is $4,000, plus future expenses. It argues that the Board erred, as a matter of law, in construing its settlement agreement to be that claimant promised to dismiss his appeal if Port reduced its lien on the third party claim to $4,000, plus future expenses. It argues that claimant promised more than dismissal of his petition. It contends that he also promised to pay Port's lien from the malpractice proceeds and to allow Port to participate in settlement negotiations with PLF.

The Board might have had the authority to interpret the agreement between Port and claimant if Port's lien had attached to the legal malpractice claim; however, as a matter of law, Port's lien did not attach to it. Furthermore, interpretation of the agreement between Port and claimant is not a "matter concerning a claim." ORS 656.704. Therefore, the Board had no authority in the matter, and we reverse the order.

Reversed on petitions and on cross-petition.

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[1] 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, in part:

"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 * * * , 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."

[2] ORS 656.576 provides:

"As used in ORS 656.578 to 656.595 [the third party recovery statutes], 'paying agency' means the self-insured employer or insurer paying benefits to the worker or beneficiaries."

[3] ORS 656.580 provides, in part:

"(1) The worker * * * shall be paid the benefits provided by ORS 656.001 to 656.794 in the same manner and to the same extent as if no right of action existed against the * * * third party, until damages are recovered from such * * * third party.

"(2) The paying agency has a lien against the cause of action as provided by ORS 656.591 or 656.593, which lien shall be preferred to all claims except the cost of recovering such damages."

[4] ORS 656.593(3) provides:

"A claimant may settle any third party case with the approval of the paying agency, in which event the paying agency is authorized to accept such a share of the proceeds as may be just and proper and

the worker * * hall receive the amount to which the worker would be entitled for a recovery under subsections (1) and (2) of this section. Any conflict as to what may be a just and proper distribution shall be resolved by the board."

ORS 656.587 provides, in part:

"Any compromise by the worker * * * of any right of action against an employer or third party is void unless made with the written approval of the paying agency or, in the event of a dispute between the parties, by order of the board."

Only the Port of Portland (Port) requested the Board to declare the settlement between claimant and PLF void under ORS 656.587. An agreement between claimant Lloyd and Port, and its effect on Lloyd's settlement with PLF, are the focus of Port's cross-petition, discussed infra. EBI's petitions requested that the Board hold that it has liens on the malpractice proceeds under ORS 656.580(2) and ORS 656.593(3) and that the Board direct disbursement to it of the just and proper shares of the proceeds.

[5] ORS 656.005(7)(a) provides, in part:

"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."

In *Wright*, we concluded that, under the applicable statutes concerning settlement of third party actions, the Board has authority to do only two things: (1) order written approval of the settlement by the paying agency, if there is a dispute about the terms of the settlement, pursuant to ORS 656.587; and (2) once the settlement is approved, resolve any conflicts as to what is a just and proper distribution, pursuant to ORS 656.593(3). 102 Or App at 601. Those issues are not before us in this case.

[7] We have held that the Board has no authority to modify third party action settlement agreements. *See SAIF v. Cowart, supra*, 65 Or App at 738; *see also Estate of Troy Vance v. Williams*, 84 Or App 616, 734 P2d 1372 (1987).

[8] "As a matter of common law, a court having jurisdiction to decide a question ordinarily refrains from doing so until the question has first been decided by the specialized agency that has jurisdiction to decide it, but the court may still decide the question in reviewing the agency's decision." 4 Davis, *Administrative Law Treatise* 119, 22:11 (2d ed 1983).

[9] PLF suggests that an "ancillary" action is:

"one growing out of and axillary to another action or suit, * * * such as a bill for discovery, or a proceeding for the enforcement of a judgment, or to set aside fraudulent transfers of property. *Black's Law Dictionary*, 112 (4th ed. 1968)."

Cite as 108 Or App 93 (1991) July 3, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON

THE STATE OF OREGON, by and through the **STATE ACCIDENT INSURANCE FUND** CORPORATION, an instrumentality of the State of Oregon, Appellant - Cross-Respondent,

v.

FINNIS FIRMAN **MONTGOMERY** and RALPH FAULKNER, Respondents, CHARLES B. GILL, JR., and DAVID A. DAVIDSON, Respondents - Cross-Appellants, and ASSOCIATED OREGON LOGGERS, INC., an Oregon nonprofit corporation; AOL SERVICES, INC., an Oregon corporation; LOGGERS ASSURANCE COMPANY, INC., an Oregon corporation licensed to engage in the insurance business in Oregon; AOL SERVICES, INC., an Oregon corporation as Trustor; and ASSOCIATED OREGON LOGGERS, INC., an Oregon nonprofit corporation as Trustee of that certain Trust created by Agreement of August 7, 1981, Cross-Respondents.

(148908; CA A61161)

Appeal from Circuit Court, Marion County.

Duane R. Ertsgaard, Judge.

Submitted on record and briefs January 17, 1991.

Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, Salem, and William F. Gary and Sharon A. Rudnick, Special Assistant Attorneys General, and Harrang, Long, Watkinson, Arnold & Laird, P.C., Eugene, filed the briefs for appellant - cross-respondent.

Finis Firman Montgomery, Eugene, filed the brief pro se.

Robert J. Custis and Custis & Adlard, Salem, filed the brief for respondent Ralph Faulkner.

William B. Crow, Bruce A. Rubin, Carolyn E. Wells, Margaret Fiorino and Miller, Nash, Wiener, Hager & Carlsen, Portland, filed the briefs for respondents - cross-appellants.

No appearance for cross-respondents Associated Oregon Loggers, Inc., AOL Services, Inc., and Loggers Assurance Company, Inc.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P.J.

On appeal, judgment for Montgomery reversed and remanded; otherwise affirmed on appeal and on cross-appeal.

Plaintiff brought this action, which it styles as one for declaratory judgment, to recover damages for the misallocation of money and "lost corporate opportunities" that allegedly resulted from the negotiation and performance of contracts between it and Associated Oregon Loggers (AOL).[1] The thrust of plaintiff's allegations is that it and AOL entered into a contractual arrangement, the primary purpose of which was for AOL to receive from plaintiff and to distribute to AOL's members policyholders' dividends that plaintiff owed them. See ORS 656.526(2); OAR 836-80-150. Large amounts of money that plaintiff transmitted to AOL, both for dividends and for other purposes under the contract, were "diverted" to fund the establishment of an insurance company, Loggers Assurance Company, Inc. (LACO), which was controlled by AOL and competed with plaintiff

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[1] For purposes of this opinion, we use the acronym "AOL" to refer to Associated Oregon Loggers, Inc., and all of the entities affiliated with it.

We note that, in the main, our role is to decide cases as they are presented to us. We do not know why plaintiff took the declaratory judgment approach or why its principal theory of liability is that defendants breached fiduciary duties.

for the loggers' business. The damage claims are for "lost corporate opportunities," in the form of lost premiums and investment opportunities, and for the diverted dividends. Other facts will be stated in the parts of this opinion to which they are pertinent.

Plaintiff stated three claims. In the first, it alleged that defendant Montgomery breached his fiduciary duty by negotiating agreements and amendments on behalf of AOL while he was a director of plaintiff, without making appropriate disclosures. Plaintiff also contends that, over and above his involvement in the negotiations, Montgomery was the principal participant in the implementation of the contracts and in related improper activities designed to benefit AOL at plaintiff's expense. The third claim asserts that defendants Gill and Davidson, while they were officers of plaintiff, breached their fiduciary duties by failing to disclose to plaintiff facts of which they were aware concerning Montgomery's scheme that they allegedly learned about in the course of contract negotiations with Montgomery. In its second claim, plaintiff alleged that Gill, Davidson and defendant Faulkner, who succeeded Gill as plaintiff's president, are strictly liable under ORS 297.120 for the money lost through the diversion of the dividends.

Defendants moved for summary judgment on all claims, and the trial court granted the motion. It concluded, as explained in an opinion letter, *inter alia*:

> "1. As to dividends: Under the SAIF/AOL agreements, AOL was an agent for the loggers not SAIF, that the assignment of dividends was valid and that all of the declared dividends were paid. That any claim for non distribution is by the loggers against AOL not SAIF against these Defendants. Therefore, the State of Oregon and SAIF are not the real parties in interest.
>
> "2. The evidence submitted is insufficient to create a material issue of fact on the alleged loss of business opportunity and breach of fiduciary relationships * * *."

Plaintiff appeals from the resulting judgment.[2] We reverse the judgment on the claim against Montgomery and affirm in all other respects.

Although Montgomery argues otherwise, there can be no doubt that he was not entitled to summary judgment on the issue of liability. There was abundant evidence that he acted in derogation of plaintiff's interests in negotiating a series of contracts for AOL whereby it obtained increasing financial benefits from plaintiff. There was also evidence that he did not disclose relevant facts about the duality of his role generally or about the specific advantages that he sought to obtain for AOL that were not apparent from the contracts or negotiations themselves. If believed by a fact finder, that evidence would support a finding of liability against Montgomery.

The closer question is whether Montgomery established conclusively that the damages that plaintiff seeks were not caused by his breach. The trial court concluded that plaintiff had no claim for the converted dividends, because the loggers had assigned their right to them to AOL, and AOL was solely their agent for purposes of distribution. We do not agree that there was no conflict in the evidence as to whether AOL was plaintiff's agent rather than or as well as the

[2] The judgment also disposes of the other claims and parties.

loggers'. *See Paulson v. Western Life Insurance Co.*, 292 Or 38, 636 P2d 935 (1981). More fundamentally, that question is not decisive. Plaintiff's principal contention is that Montgomery failed to apprise it about the use to which AOL would put the dividends and that plaintiff consequently had to make "second payments" directly to the loggers. That contention is not answered by the existence or nonexistence of an agency relationship between plaintiff and AOL.

Montgomery argues that plaintiff was neither liable for nor did it pay dividends to the loggers to replace those that were not distributed by AOL. Rather, he contends, plaintiff simply "volunteered" to make payments to the loggers through a 1986 "settlement agreement," in return for which plaintiff acquired LACO. Montgomery asserts that plaintiff was under no legal obligation to make the payments and that any rights to dividends that the loggers enjoyed were under the agreements and their assignments to AOL by which they purportedly relinquished any right to payments of dividends directly from plaintiff. As we have noted, however, there are unresolved questions of fact about the contractual relationships of plaintiff, AOL and the loggers under the instruments. Whether the loggers could have waived, or did waive, any statutory and regulatory dividend rights cannot be decided before those questions are answered.[3]

Montgomery also argues that there was decisive evidence that plaintiff did not suffer any loss of corporate opportunities, because it acquired LACO and assurances of the loggers' business as part of the 1986 settlement. Montgomery's argument necessarily assumes that plaintiff therefore reacquired any business and investment opportunities that it had lost over the preceding three-year period, dollar for dollar. However, he offered no evidence to substantiate that factual assumption. The summary judgment for Montgomery was error.[4]

Plaintiff next assigns error to the summary judgment on the breach of fiduciary duty claim against Gill and Davidson. The essential premise of that claim is that those defendants had knowledge and failed to make disclosures about wrongful conduct or objectives on the part of Montgomery and AOL. Plaintiff argues that the only evidence that Gill and Davidson offered on the point was a "bare disclaimer" of knowledge and that that does not suffice for summary judgment. However, the evidence showed more than that. It established without refutation that what Gill and Davidson knew about Montgomery's and AOL's plans, at the time of the negotiations and through the time that they remained plaintiff's employees, revealed no improper objectives and no objective to use plaintiff's money improperly for proper or improper purposes. Plaintiff notes that there was evidence that Gill's and Davidson's consultations with Montgomery resulted in "a bad deal for SAIF Corporation because SAIF Corporation sold insurance at below cost and because the agreements contained inadequate controls to prevent AOL from accumulating capital." That is true, and it is irrelevant. Plaintiff's claim does not allege that its damages resulted from shortcomings in Gill's and Davidson's business acumen or negotiating skills. We agree with the trial court that they were entitled to summary judgment on the fiduciary duty claim.

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[3] We assume, but do not decide, Montgomery's premise that plaintiff could not recover the "second payments" as damages if it made them but was not legally required to.

[4] The other defendants argue that the action is barred by the applicable Statute of Limitations and that ORS 12.250, which makes the statute inapplicable to governmental bodies, does not apply to plaintiff. Because we affirm the judgment for those defendants on other grounds and because Montgomery does not raise that argument on appeal, we do not address it.

The summary judgment for them and Faulkner on the statutory claim was also proper. The dividends were payable from the Industrial Accident Fund (IAF). ORS 656.634(2) provides, in relevant part, that "the State of Oregon declares that it has no proprietary interest in [IAF]." ORS 297.120 provides for potential recovery from public officers for the loss of "public funds" with which they are entrusted. We agree with Gill, Davidson and Faulkner that at least those IAF moneys that have been committed to the payment of dividends are not public funds within the meaning of ORS 297.120. *Sprague v. Straub*, 252 Or 507, 522-23, 451 P2d 49 (1969); *see also Eckles v. State of Oregon*, 306 Or 380, 760 P2d 846 (1988), *appeal dismissed* ___ US ___ (1989) (separate opinion of Peterson, C.J.).[5]

Our disposition of the appeal moots Gill's, Davidson's and Faulkner's cross-assignments of error. Gill and Davidson also cross-appeal. They preface their cross-appellants' brief by stating that, if we "affirm the judgment below, the Court will not need to reach the issues on cross-appeal." Although that statement is a literal nonsequitur,[6] we understand it to mean that, if we affirm the portions of the judgment relating to Gill and Davidson that are challenged by plaintiff's appeal, the cross-appeal is to be deemed abandoned. We therefore affirm on the cross-appeal without discussion.[7]

On appeal, judgment for Montgomery reversed and remanded; otherwise affirmed on appeal and on cross-appeal.

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[5] We do not reach any of the arguments that we have not addressed that Gill, Davidson and Faulkner make in opposition to plaintiff's assignments relating to the claims against them.

[6] One of the assignments in the cross-appeal relates to the striking of Gill's and Davidson's cross-claims against AOL and its affiliates.

[7] Faulkner also filed a notice of cross-appeal but abandoned it pursuant to ORAP 5.55(3).

Cite as 108 Or App 101 (1991) July 3, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Michael J. Moody, Claimant.

MICHAEL J. **MOODY**, Petitioner.
v.
LIBERTY NORTHWEST INSURANCE CORP., and CON-VEY KEYSTONE, Respondents.
(88-18100; CA A66568)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 20, 1991.
Dean Heiling, Salem, argued the cause for petitioner. With him on the brief was Gatti, Gatti, Maier & Associates, Salem.
David O. Wilson, Eugene, argued the cause for respondents. With him on the brief was Employers Defense Counsel, Eugene.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
BUTTLER, P.J.
Affirmed.

Claimant seeks review of an order of the Workers' Compensation Board reversing the referee and upholding the denial of his aggravation claim.

Because we conclude that the Board did not misapply the law and because there is substantial evidence to support the Board's order, we affirm.

Claimant compensably injured his back and left knee in 1985, for which he received an award of 5 percent unscheduled permanent disability and 5 percent scheduled disability, respectively. In 1987, he filed an aggravation claim, by which he sought benefits for a psychological condition that he alleged had worsened as a result of the compensable injury. Employer denied the aggravation claim, but the referee held it to be compensable. A determination order in October, 1988, made an additional unscheduled award of 13 percent. The evaluation sheet on which the order was based shows that 5 percent of that award was allocated to claimant's disc problem and psychological disability, without any allocation between the two.

In November, 1988, claimant sought a reopening of the claim due to a worsening of his psychological condition. Employer denied the request; the referee held that the 1987 aggravation claim had been prematurely closed and, therefore, he did not address the aggravation claim. The Board reversed, holding that the claim had been properly closed, because claimant was medically stationary, and that claimant's psychological condition had not worsened. We write only to address one of claimant's contentions concerning the Board's analysis of the aggravation claim for his psychological condition.

The Board found that claimant's psychological condition had worsened symptomatically since the last arrangement of compensation. It concluded, however, that the medical history available to the evaluator at the time of the last arrangement of compensation showed that claimant would experience future periods of waxing and waning of symptoms and that the award anticipated that future waxing and waning. The Board found, additionally, that claimant's disability from the psychological condition was no worse than had been anticipated and that his symptoms had not required hospitalization or led to total disability for a period of more than 14 days. Accordingly, it held that he had not established a compensable aggravation. *See Gwynn v. SAIF*, 304 Or 345, 745 P2d 775 (1986).

Claimant contends that, because his October, 1988, award did not include a separate award of permanent partial disability for his psychological condition, no waxing and waning of symptoms could have been anticipated. There is evidence, however, that, in determining the benefits due in 1988, the evaluator considered claimant's psychological disability and included it in the award. Additionally, there was abundant evidence in the record at the time of the award that his symptoms would wax and wane.

Affirmed.

Cite as 108 Or App 105 (1991) July 3, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of the Beneficiaries of Javier Mendoza, Deceased, Claimant.

ANNETTE **MELL**, Beneficiary of Javier Mendoza, Deceased, Petitioner - Cross-Respondent,
v.
W.C. RANCH, INC., and SAIF CORPORATION, Respondents - Cross-Petitioners.
(88-06734; CA A64079 (Control), A64162)
(Cases Consolidated)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 13, 1991.

James L. Edmunson, Eugene, argued the cause for petitioner - cross-respondent. With him on the briefs were Brent Wells and Malagon, Moore & Johnson, Eugene.

Arden J. Olson, Assistant Attorney General, Salem, argued the cause for respondents - cross-petitioners. With him on the brief were Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, Michael D. Reynolds, Assistant Attorney General, and Thomas E. Ewing, Assistant Attorney General, Salem.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

BUTTLER, P.J.

Affirmed on petition and on cross-petition.

Claimant seeks review of an order of the Workers' Compensation Board reversing the referee and holding that her minor daughter is not entitled to workers' compensation benefits as the beneficiary of claimant's cohabitant, the deceased worker. Employer cross-petitions, contending that the Board erred in holding that claimant is entitled to benefits as the surviving cohabitant of the decedent. We affirm on the petition and on the cross-petition.

The Board's findings are supported by substantial evidence. The decedent married Tina Mendoza in November, 1982. In March, 1985, while still married to Tina, the decedent began living with claimant and her daughter Katie, who was then one year old. The evidence shows that the decedent treated Katie as if she were his daughter, that the decedent and claimant lived together as husband and wife and that claimant gave birth to their child Ashley after the decedent's death. The decedent was granted a dissolution of his marriage to Tina on February 19, 1986, but then moved to "set aside" the judgment in order to provide for the care and custody of their daughter, Melissa, provision for whom had been omitted from the judgment. That motion was granted, and a second so-called judgment of dissolution was entered on November 22, 1986. The decedent suffered a fatal injury on the job on September 11, 1987.

Under ORS 656.204(4), a minor child of a deceased worker is entitled to workers' compensation benefits. Benefits have been provided to Ashley. The only issue raised by the petition is whether Katie is also entitled to benefits. Claimant contends that, although Katie was not the decedent's natural child, she was his child and beneficiary for the purpose of workers' compensation benefits, because, as the term is defined in ORS 656.005(5), a child includes "a child toward whom the worker stands *in loco parentis*."[1]

The Board found that Katie has a natural father who pays support, that claimant applied for and received public assistance on behalf of Katie and that the decedent did not voluntarily assume the obligation of support or hold himself out to all segments of society as standing in the place of a parent. There is substantial evidence to support those findings, and they support the Board's conclusion that the decedent did not stand *in loco parentis* to Katie.

In its cross-petition, employer contends that claimant is not entitled to benefits under ORS 656.226 as the surviving cohabitant of the decedent. That statute provides:

> "In case an unmarried man and an unmarried woman have cohabited in this state as husband and wife for over one year prior to the

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[1] Claimant does not contend that Katie is entitled to benefits as a dependent of the decedent. ORS 656.005(2).

date of an accidental injury received by one or the other as a subject worker, and children are living as a result of that relation, the surviving cohabitant and the children are entitled to compensation under ORS 656.001 to 656.794 the same as if the man and woman had been legally married."

Employer contends that the setting aside of the first dissolution judgment had the effect of restoring the marriage and that, therefore, the dissolution of the decedent's marriage to Tina did not become final until a new dissolution judgment was entered on November 22, 1986. Under that analysis, the decedent was unmarried for just under eleven months when he died on September 11, 1987. Employer contends, accordingly, that claimant does not qualify for benefits under the statute, because the decedent and a claimant must have cohabited *and* have been unmarried for more than one year at the time of the injury.

We agree with employer that the statute requires that there have been over one year of continuous cohabitation during which both parties remained unmarried. However, we disagree with employer's conclusion that the decedent was unmarried for less than one year at the time of his death. Under ORS 107.115,[2] the February, 1986, dissolution of his marriage to Tina became final after the expiration of 30 days from the date of the decree, no appeal having been filed. After that, the court had the power to modify the judgment to provide for the custody and support of a minor child who was erroneously omitted from the judgment. ORS 107.135(1)(b).[3]

The February, 1986, dissolution judgment made no provision for the care, custody and control of the decedent's daughter Melissa and made no provision for her support. It simply dissolved the marriage. In his affidavit accompanying his motion to set aside the judgment, the decedent stated that he was willing to let his ex-wife have the child "so long as she took care of" her. It stated, however, that "since our dissolution of marriage, my ex-wife has been running around, drinking, with other men and is totally unfit to have care, custody and control of [the child]. That I am a fit and proper person to have care, custody and control of said child." The affidavit states no basis for attacking the

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[2] ORS 107.115(1) provides:

"A decree of annulment or dissolution of a marriage restores the parties thereto to the status of unmarried persons, unless a party is married to another person. * * * [B]ut the decree shall not be effective insofar as it affects the marital status of the parties until the expiration of 30 days from the date of the decree, or, if an appeal is taken, until the suit is determined on appeal, whichever is later."

[3] ORS 107.135(1)(b) provides:

"(1) The court has the power at any time after a decree of * * * dissolution of marriage * * * upon the motion of either party and after service of notice on the other party in the manner provided by law for service of a summons * * *, to:

"* * * * *

"(b) Make an order, after service of notice to the other party, providing for the future custody, support and welfare of minor children residing in the state, who, at the time of the decree was given, * * * were unknown to the court or were erroneously omitted from the decree[.]"

dissolution of the marriage, only for granting the decedent custody of his child. Accordingly, the court had no authority to set aside the judgment. The decedent's motion could only lawfully have been treated as a motion to modify the judgment to provide for the custody and support of the child who was "erroneously omitted from the decree." ORS 107.135(1)(b). For the same reasons, the second purported dissolution judgment should be treated only as a modification of the original judgment.[4]

Accordingly, the decedent had been unmarried for overone year when he died in September, 1987. The provisions of ORS 656.226 have been met, and claimant is entitled to benefits as the surviving cohabitant.

Affirmed on petition and on cross-petition.

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[4] Although the parties did not argue this point, we conclude that, because the error in the circuit court's order is one of law that relates to its jurisdiction to do what it purported to do, it is necessary to deal with the question in order to decide this case.

Cite as 108 Or App 145 (1991) July 3, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of David L. Burge, (Decedent), Claimant.

DEBORAH **BURGE**, Beneficiary of David L. Burge, Deceased, Petitioner,

v.

SAIF CORPORATION and ALEXANDER MANUFACTURING COMPANY, Respondents.

(WCB 88-20666; CA A65902)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 20, 1991.

Douglas E. Hojem, Pendleton, argued the cause for petitioner. With him on the brief was Corey, Byler, Rew, Lorenzen & Hojem, Pendleton.

John T. Bagg, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

ROSSMAN, J.

Affirmed.

Claimant, the beneficiary of a deceased worker, seeks review of an order of the Workers' Compensation Board holding that she is not entitled to death benefits.

The Board's findings are not contested and are supported by substantial evidence. Employer, a Portland-based firm, hired the decedent, a carpenter, to work on the installation of cabinetry and finish work in a new casino in Nevada. The decedent was a resident of Pendleton but had an apartment in Nevada, for which employer compensated him. The decedent was the lead worker and had authority to hire and fire the work crew and to set work schedules. He also kept time and production records. He was paid on an hourly basis, was not on call and was not paid for work done at home. Employer provided him with a van, tools and an occasional paid trip to Oregon.

The decedent's shift began at 6 a.m. and ended at 2:30 p.m. Frequently, members of the crew would meet after work at a local restaurant that was not on

the decedent's way home from work. The gatherings were strictly social; attendance was not required. Employer did not pay for or sponsor the post-work activities and derived no direct benefit from them. The decedent frequently joined the gatherings, and on July 6, at 8:30 p.m., after having been at the restaurant for approximately six hours, he was killed in a one-car accident while driving to his apartment. His blood alcohol level at the time of death was .13, which, the evidence shows, means that he had consumed the equivalent of 11 to 12 beers.

Claimant contends that the Board erred in concluding, on the basis of those findings, that the decedent's death did not occur in the course of his employment. She contends that the decedent was a "traveling employee" and that his death is therefore compensable, unless it occurred as the result of a departure from his employment. *See, e.g., Slaughter v. SAIF*, 60 Or App 610, 654 P2d 1123 (1982).

In *SAIF v. Reel*, 303 Or 210, 735 P2d 364 (1987), the claimant was injured in an explosion in his living quarters near a remote job site. He was not required to live at that location, but chose to do so. The Court said:

> "Workers' compensation should be awarded to a worker when the employe has been directed, as part of his duties, to remain at a particular place or locality until directed otherwise or for a specified length of time. * * *
> "* * * * *
> "The real issue in this case is not whether this claimant was a traveling employe, but whether he was directed to live at or near the job site as an integral part of his employment." 303 Or at 216.

The court held that the problem of work relatedness is best resolved "by examining the contractual relationship of the parties to determine if the claimant's injury 'arose out of and in the course of' his employment. ORS 656.005(8)(a)." 303 Or 216. Because the claimant was injured in his living quarters, the court said that the "real issue" was whether the claimant was directed by the employer to live at or near the job site. He was not, and that fact formed the basis for the court's conclusion that the injury was not work related. 303 Or 218.

Here, although the decedent was directed to live near the job site, that fact is not determinative; his death did not occur because of that requirement. Even if decedent was a traveling employee, *see SAIF v. Reel, supra*, 303 Or at 216, his death is not compensable, because it occurred during personal activities that had nothing to do with the job or the requirement that he live near the job site and that, therefore, constituted a "departure" from his employment. *See SAIF v. Barajas*, 107 Or App 73, ___ P2d ___ (1991). As in *SAIF v. Reel, supra*, the issue is whether the activities that resulted in the decedent's death were reasonably related to his employment. 303 Or at 216; *see* ORS 656.005(7)(a).[1] We hold that, on these facts, the Board correctly concluded that decedent had "left the legitimate scope of his employment at the time of death."

Affirmed.

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[1] ORS 656.005(7)(a)(B) provides that a compensable injury does not include an 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."

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Daniel C. Reddekopp, Claimant.

DANIEL C. **REDDEKOPP**, Petitioner,
v.
SAIF CORPORATION and COASTWAY CONSTRUCTION, Respondents.
(WCB 89-09956; CA A67456)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 3, 1991.
Brad G. Garber, Salem, argued the cause for petitioner. With him on the brief was Michael B. Dye, Salem.
John Reuling, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Richardson, Presiding Judge, and Newman and Deits, Judges.

PER CURIAM
Reversed and remanded for reconsideration.

Claimant seeks review of an order of the Workers' Compensation Board that affirmed and adopted the referee's order that upheld SAIF's denial of medical benefits. Claimant argues, and SAIF concedes, that the referee relied on certain medical reports that were not admitted in evidence. Because the referee's findings and conclusions, adopted by the Board, are not based on evidence in the record, we reverse and remand for reconsideration.

Reversed and remanded for reconsideration.

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Richard J. Fleischer, Sr., Claimant.

LIBERTY NORTHWEST INSURANCE CORP. and ST. CHARLES MEDICAL CENTER, Petitioners,
v.
RICHARD J. **FLEISCHER**, SR., Respondent.
(89-06085; CA A66079)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 1, 1991.
Stafford J. Hazelett, Portland, argued the cause and filed the brief for petitioners.
J. Michael Alexander, Salem, argued the cause for respondent. With him on the brief was Burt, Swanson, Lathen, Alexander & McCann, Salem.
Before Richardson, Presiding Judge, and Rossman and Deits, Judges.

PER CURIAM
Reversed and remanded for reconsideration. *Aetna Casualty Co. v. Aschbacher*, 107 Or App 494, ___ P2d ___ (1991).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Duane L. Jones, Claimant.

Duane L. JONES,
Petitioner,

v.

OREGON STATE
CORRECTIONAL INSTITUTION
and Inmate Injury Fund,
Respondents.

(88-10417; CA A64627)

Judicial Review from Workers' Compensation Board.

On petitioner's petition for reconsideration filed June 19, 1991; opinion filed May 15, 1991, 107 Or App 78, 810 P2d 1318.

Merrill Schneider, Portland, for petition.

No appearance *contra.*

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

BUTTLER, P. J.

Reconsideration allowed; former opinion withdrawn; reversed and remanded to Workers' Compensation Board for award of attorney fees.

BUTTLER, P. J.

Claimant has filed a petition for review, which we treat as a motion for reconsideration, ORAP 9.15, of our May 15, 1991, decision. 107 Or App 78, 810 P2d 1318 (1991). We allow the motion, withdraw our former opinion and reverse and remand the case to the Board. In that opinion, we held that ORS 656.386(1) provides no basis for an award of insurer-paid attorney fees to a claimant when the employer withdraws its denial of the claim after the claimant's request for hearing has been filed but before the referee has decided the matter. On June 19, 1991, the Governor signed into law Senate Bill 540, which amends ORS 656.386(1) so that it now expressly provides for attorney fees under those circumstances.

The statute now provides that if "an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held, a reasonable attorney fee shall be allowed." The amendment, which became effective on its passage, "applies to all claims for which an order relating to the issue on which attorney fees are sought has not become final on or before the effective date of this 1991 Act, regardless of the date of injury." SB 540, § 3.

Reconsideration allowed; former opinion withdrawn; reversed and remanded to the Workers' Compensation Board for award of attorney fees.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Randolph P. Gaul, Claimant.

NORDSTROM, INC.,
Petitioner,

v.

Randolph P. GAUL,
Respondent.

(WCB 88-04876; CA A64421)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 18, 1991.

Mildred J. Carmack, Portland, argued the cause for petitioner. On the brief were Ridgway K. Foley, Jr. and Schwabe, Williamson & Wyatt, Portland.

James Edmunson, Eugene, argued the cause and filed the brief for respondent.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Affirmed.

NEWMAN, J.

Employer seeks review of a Workers' Compensation Board order that affirmed the referee and held that claimant's injury was a material contributing cause of his psychological condition and, therefore, that that condition was compensable. We affirm.

The Board adopted the referee's findings. On July 25, 1987, claimant injured his back at work. He could not thereafter perform the same tasks. Employer accepted the injury claim. On April 27, 1988, a determination order awarded claimant time loss benefits and permanent partial disability for the injury.

During roughly the same period, claimant was beset by tragedy. His father died, his brother molested his daughter and, later, died of hypothermia, his sister was raped and murdered, his mother developed cancer and had open heart surgery and his daughter was molested again. On March 9, 1988, Dr. Richard recommended exercise for the injury and antidepressants and counseling "for [claimant's] family problems." On March 24, Dr. Pasquesi diagnosed claimant as physically impaired due to the injury and "under a great deal of stress, both from his industrial accident and also from other unrelated problems." Claimant saw a psychologist, Dr.

Worthington, on May 26. He diagnosed "major depression, single episode, with melancholia * * * related to a number of material contributing factors, including the pain and overall life disruption caused by [claimant's] physical injury, as well as the various family concerns." On June 2, employer denied that claimant's psychological condition was compensable.[1]

Claimant requested a hearing on employer's denial and on the April determination order. He asserted that the determination order was issued prematurely because, among other things, his psychological condition was compensable and was not stationary when the determination order was issued.

The Board found that the psychological condition was compensable, because claimant had proved by a preponderance of the evidence that the injury was a material contributing cause of it. The Board also found that the determination order was issued prematurely, because it did not address claimant's psychological condition, and that there was a reasonable medical expectation at the time when his claim was closed that treatment would improve that condition. Finally, the Board increased claimant's temporary total disability rate to include incentive pay that he received while employed.

Employer assigns error to the Board's ruling that claimant had to prove by a preponderance of the evidence that the injury was a material contributing cause of the psychological condition. It argues that the Board applied the wrong legal standard, because claimant had a claim for a mental disorder as an occupational disease under ORS 656.802(2)(d). Accordingly, it asserts that the psychological condition was not compensable, because he did not prove by clear and convincing evidence that the injury was the major contributing cause of it.

Claimant does not make an occupational disease claim. In *Jeld-Wen, Inc. v. Page,* 73 Or App 136, 698 P2d 61 (1985), the claimant suffered a compensable physical injury and was hospitalized roughly three years later for paranoid psychosis. We held that the claimant had sustained his burden of proving that the psychological condition was compensable:

> "A claimant asserting the compensability of a psychiatric condition following an industrial injury must prove by a preponderance of the evidence that the work-related injury was a material cause of the condition * * *." 73 Or App at 139.

We adhered to that rule in *Grace v. SAIF,* 76 Or App 511, 515, 709 P2d 1146 (1985), *Wilkerson v. Davila,* 88 Or App 298, 299, 744 P2d 1331 (1987), and, most recently, in *Mal v. Unique Building Maintenance Co.,* 93 Or App 703, 763 P2d 751 (1988). In the last case, the employer argued that the claimant's psychological condition was not compensable, because a psychiatrist had stated that her compensable back injury was not the major contributing cause of it. We held that

[1] Claimant made a claim for a psychological condition by letter to employer on May 23, 1988. *See* ORS 656.262(2).

the psychological condition was compensable:

> "[The psychiatrist's] opinion is not determinative * * * because it addressed the occupational disease standard, whether the condition was the major contributing cause of her condition, but he did not address the question of whether the work injury was a *material* cause, which is the correct standard. *See Jeld-Wen, Inc. v. Page, supra,* 73 Or App at 140." 93 Or App at 708.

The Board applied the correct legal standard here.

Employer also assigns error to the Board's finding that the injury was a material contributing cause of the psychological condition. We review that finding for substantial evidence. ORS 183.482(7) and (8). Both physicians and the psychologist who treated claimant diagnosed that the injury in part caused the psychological condition. The Board's finding that the injury was a material contributing cause of that condition is reasonable in the light of countervailing as well as supporting evidence and, therefore, is supported by substantial evidence. *Garcia v. Boise Cascade Corp.,* 309 Or 292, 295, 787 P2d 884 (1990).

Employer also assigns error to the Board's finding that the determination order was issued prematurely. It asserts that there was not a reasonable medical expectation that treatment would materially improve claimant's psychological condition. ORS 656.005(17).[2] The determination order that closed claimant's back injury claim stated that his psychological condition was within normal limits. Before it was issued, however, Richard had prescribed antidepressants and recommended that claimant seek counseling. Pasquesi had stated that he could not "pass judgment * * * [on claimant's] psychological state." Worthington's diagnosis after the determination order was issued confirmed that, at the time that it was issued, there was a reasonable medical expectation that further treatment would improve claimant's condition and that, therefore, his medical condition was not stationary. *See Schuening v. J.R. Simplot & Company,* 84 Or App 622, 625, 735 P2d 1, *rev den* 303 Or 590 (1987). The Board was

correct to consider claimant's psychological condition in determining whether the claim was ready for closure. *See Utrera v. Dept. of General Services,* 89 Or App 114, 116, 747 P2d 405 (1987). There was substantial evidence to support the Board's finding that claimant's condition was not stationary; therefore, the determination order was issued prematurely.

Employer also assigns error to the Board's inclusion of incentive pay in claimant's temporary total disability rate. It argues that he did not regularly earn incentive pay. OAR 436-60-020(8)(i).[3] In 1987, claimant earned incentive pay of

[2] ORS 656.005(17) provides:

" 'Medically stationary' means that no further material improvement would reasonably be expected from medical treatment, or the passage of time."

[3] OAR 436-60-020(8)(i) provides:

"Incentive pay shall be considered only when regularly earned. If incentive pay earnings vary, use the averaging method described in subsection (a) * * *."

$100 in each of seven months and $200 and $212.50 in two other months. There was substantial evidence to support the Board's finding that claimant regularly earned incentive pay. The Board did not err when it considered that in fixing the temporary total disability rate.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Patricia K. Yost, Claimant.

AMERICAN NURSING and St. Paul Fire And Marine Insurance Co., *Petitioners,*

v.

Patricia K. YOST, *Respondent.*

(WCB 87-04550; CA A64695)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 18, 1991.

Mildred J. Carmack, Portland, argued the cause for petitioners. On the brief were Ridgway K. Foley, Jr., and Schwabe, Williamson & Wyatt, Portland.

Corey B. Smith, Salem, argued the cause and filed the brief for respondent.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Affirmed.

NEWMAN, J.

Employer seeks review of a Workers' Compensation Board order that affirmed the referee and held that claimant's psychological condition is compensable. We affirm.

The Board adopted the referee's findings. On June 14, 1986, claimant suffered a back injury at work. Dr. Snodgrass diagnosed a contusion and chronic lumbosacral strain. Dr. Cruickshank diagnosed chronic lumbosacral strain and an anxiety tension state. On March 17, 1987, employer accepted a claim for the injury. A determination order awarded her 10 percent unscheduled disability.

Claimant and her family together had received intermittent counseling from Brown for three years until July, 1985. Brown testified that, during that period, claimant had

had significant personal and family problems and a "low mood state." She continued to work full time, and she and her family sought no counseling until she was injured. She returned alone to Brown in May, 1987. He testified that the mild depression that she had had before the injury had worsened. He explained that she had been able to cope with her problems before the injury because she had worked full time but that, thereafter, she became distraught over the chronic pain that the injury caused and by the prospect of permanent disability and loss of work. On January 4, 1988, she was hospitalized for depression. Dr. Glass, a psychiatrist, diagnosed a depressive reaction "related to the problems with her back." Dr. Colbach diagnosed that she was "very emotionally volatile and emotionally fragile" but that "the major contributing cause to the depression * * * was not her back, but other things, especially family difficulties." On April 28, employer denied that her psychological condition was compensable. The referee found, and the Board agreed, that claimant had proved by a preponderance of the evidence that the injury was a material contributing cause of the psychological condition and that it was compensable.

Employer assigns error to the Board's ruling that claimant's burden was to prove by a preponderance of the evidence that the injury was a material contributing cause of the psychological condition. It argues that claimant had a claim for a mental disorder as an occupational disease under

ORS 656.802(2)(d) and that the psychological condition was not compensable, because she did not prove by clear and convincing evidence that the injury was the major contributing cause of it. Employer, however, does not argue that, because claimant may have had a preexisting condition, the Board applied the wrong standard. We review for legal error. ORS 183.482(8). The Board applied the correct legal standard. *Nordstrom, Inc. v. Gaul,* 108 Or App 237, ___ P2d ___ (1991).

Employer also assigns error to the Board's finding that the injury was a material contributing cause of the psychological condition. It argues that there was no substantial evidence to support that finding. It asserts that the condition preexisted the injury and was not worsened by it. It further asserts that the diagnoses of Brown and Glass are unpersuasive.

The Board was entitled to give weight to all of the diagnoses. Brown concluded that claimant's depression following the injury was caused by it. Shortly after claimant had been hospitalized, Glass concluded that she could "handle [her problems] as long as she was able to work effectively. When she was unable to work, things deteriorated, with her mood." Although Colbach stated that personal problems were the major cause of her depression, he acknowledged that "some of [it] could be attributed to the industrial injury." There was substantial evidence to support the Board's finding that claimant's injury was a material contributing cause of the psychological condition. *See Garcia v. Boise Cascade,* 309 Or 292, 295, 787 P2d 884 (1990).

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Linda A. Stevenson, Claimant.

Linda A. STEVENSON,
Petitioner,

v.

BLUE CROSS OF OREGON
and SAIF Corporation,
Respondents.

(87-07020, 86-15450; CA A63987)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 21, 1990.

Glen S. Shearer, Portland, argued the cause for petitioner. With him on the brief was Schouboe, Marvin & Furniss, Portland.

David L. Runner, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Affirmed.

NEWMAN, J.

Claimant petitions for judicial review of a Workers' Compensation Board order that held that her tendonitis is not compensable and that denied her penalties and attorney fees on that claim. We affirm.

The Board found:

"In November, 1984, claimant began working for the employer as a staple clerk; she became a file clerk after six months. Subsequently, claimant began exhibiting a rash, red sores, itchiness, and bumps on her hands.

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

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

"On May 21, 1986, claimant filed a claim for aching in her left hand, arm and shoulder, and red spots and a rash on her

left hand, dating back to May 5, 1986. The 801 form listed claimant's injury or disease as tendinitis [*sic*]. On June 6, 1986, SAIF indicated on the 801 that the claim had been accepted. On that same date, 1986, SAIF sent a notice of claim acceptance to claimant for a condition of 'cellulitis/ eczema; contact dermatitis.'

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

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

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

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

"Some portion of claimant's tendinitis [*sic*] and dermatitis conditions are attributable to emotional and functional factors.

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

The Board affirmed the portion of the referee's order that denied compensation for the tendonitis. It also adopted the portion of the referee's opinion dealing with claimant's psychological condition. The referee wrote:

"[T]he report by Dr. Button simply states that there was severe functional interference in his examination of claimant's hands, and that psychiatric evaluation may be beneficial. Dr. Button diagnosed no condition, and did not relate any psychiatric problems to work. [A letter from Orthopaedic Consultants] merely says there are psychological factors interfering with claimant's physical recovery. Again, there is no indication that work had anything to do with these factors. * * * Dr. Janzer, a psychiatrist, said that claimant's problems are psychiatric in nature, and specifically said that these problems predated claimant's injury. Finally, * * * Dr. Winslow mentioned psychological problems, and said nothing regarding their relation to work. Claimant has not presented any evidence that she has any psychological condition related to her accepted injury or to her work."

Claimant contends that she presented a "prima facie case" for compensability of the tendonitis. She also appears to argue that, even without medical evidence, causation of her condition is so clear that it should be compensable as a matter of law. We review the Board's findings for substantial evidence in the whole record to support them. ORS 656.298(6); ORS 183.482(7), (8); *see Garcia v. Boise Cascade Corp.*, 309 Or 292, 296, 787 P2d 884 (1990).

The Board found the opinions of Drs. Winslow and Won ambiguous and conclusory. Winslow originally diagnosed tendonitis and cellulitis and characterized both

conditions as job related. He later concurred in the opinion of Dr. Button, a hand and arm specialist, that claimant's hand and arm complaints were functional and that she may never have had tendonitis. Winslow never explained how claimant's work caused the tendonitis and did not say that her work was the major contributing cause of the condition.

Won did not examine claimant until nearly four months after she had left work. He diagnosed chronic strain or sprain of the neck, left shoulder and hand and later diagnosed carpal tunnel syndrome, chronic cervicothoracic joint dysfunction and tendonitis of the left elbow. He stated that claimant was "injured" on her job on May 16, 1986, and made no other causal connection between the conditions and claimant's work.

The Board did not err in rejecting Winslow's and Won's opinions. Substantial evidence in the whole record supports the Board's finding that claimant's work was not the major contributing cause of her tendonitis. *Dethlefs v. Hyster Co.,* 295 Or 298, 310, 667 P2d 487 (1983).

Claimant also assigns as error that the Board concluded that SAIF had not accepted her claim for tendonitis. She argues that, under *Bauman v. SAIF,* 295 Or 788, 670 P2d 1027 (1983), once an insurer accepts a claim, it cannot subsequently withdraw its acceptance and deny compensability. *Bauman* applies, however, only after an insurer has accepted a claim.

On June 2, 1986, claimant filed an 801 form claiming two conditions, a skin rash and tendonitis. On June 6, 1986, a SAIF employee placed a check in the "accepted" box on the claim form, in the section reserved for insurer use. SAIF did not then send the marked claim form to claimant. On the same day, however, SAIF sent a notice to claimant that informed her of its acceptance of her "cellulitis/eczema; contact dermatitis" claim. Claimant contends that the check mark on the insurance form constitutes acceptance of her claim for tendonitis as well as for dermatitis.

Claimant had to show that SAIF specifically accepted her tendonitis claim and officially notified her of that acceptance. *Georgia-Pacific v. Piwowar,* 305 Or 494, 500, 753 P2d 948 (1988); *see also Johnson v. Spectra Physics,* 303 Or 49,

56, 733 P2d 1367 (1987). The Board found that SAIF had not accepted the tendonitis claim, and there is substantial evidence to support that finding.

Claimant also asserts that SAIF accepted her claim by paying for medical and vocational evaluations of the condition. Even if SAIF paid for the evaluations, that does not constitute acceptance. ORS 656.262(9) provides:

"Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability."

Claimant also assigns error to the Board's holding that the psychological conditions that she allegedly developed as a result of her injuries were not compensable. Her only compensable condition was her hand rash. There is substantial evidence in the record that her psychological conditions were not causally related to the rash. The Board did not err in its conclusion.

Claimant's final assignment is that the Board erred in holding that she was not entitled to penalties and attorney fees for SAIF's failure to accept or reject the tendonitis claim in a timely fashion. The Board refused to consider this argument, because claimant had failed adequately to raise the issue before the referee. We agree. Claimant raised, and the referee addressed, penalty and fee issues with respect to several claims, but not with respect to the tendonitis claim.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Paul Jackson, Claimant.

AETNA CASUALTY COMPANY and Continental Porsche Audi,
Petitioners,

v.

Paul JACKSON,
Respondent.

(87-09537; CA A60904)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 18, 1990.

Allen W. Lyons, Portland, argued the cause for petitioners. On the brief were Thaddeus J. Hettle and Scheminske & Lyons, Portland.

Daina Upite and Royce, Swanson & Thomas, Portland, filed the brief for respondent.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Reversed.

DEITS, J.

Continental Porsche Audi (employer) seeks review of an order of the Workers' Compensation Board holding that claimant is entitled to an award of attorney fees under ORS

656.262(10)[1] and ORS 656.382(1),[2] because employer failed to comply with the time requirements for discovery. We reverse.

Claimant was injured in April, 1985. The claim was closed in August, 1985, by a determination order that awarded no permanent disability. The claim was reopened for an aggravation claim and was again closed by a determination order, issued on April 10, 1987, that awarded claimant 20 percent unscheduled permanent partial disability. Two weeks later, claimant was paid the full award. Employer then submitted a form 1503, requesting reduction of the award. In response to that request, the Evaluation Division issued an order on May 12, 1987, reducing claimant's permanent disability award to 15 percent. Claimant filed a request for hearing to challenge the reduction. The request included a demand for documents. It was later supplemented to include a request for a penalty and attorney fee for employer's failure to comply with the time requirements for providing a copy of the form 1503.

The parties agree that employer did not comply with the discovery requirements of *former* OAR 438-07-015(2), because the document was not furnished within 15 days after the discovery demand. They also agree that claimant had been paid the full amount due under the April, 1987, determination order.

The referee did not award a penalty, because there were no "amounts then due," as required by ORS 656.262(10), but did award attorney fees. On review and on reconsideration, the Board affirmed the referee's order. It concluded that attorney fees were justified, because employer did not provide the form to claimant's counsel within 15 days after claimant's discovery demand, as required by *former* OAR 438-07-015(2),[3] and that the failure constituted an "unreasonable resistance to compensation" under ORS 656.382(1). It also said that the award was warranted, because mailing a copy of the form 1503 to claimant, but not to claimant's attorney, was an impermissible contact with a claimant in violation of ORS 656.331(1)(b).[4] The Board awarded attorney fees of $900.

Employer argues that its failure to provide the form to claimant and his attorney does not provide a basis to impose attorney fees under ORS 656.262(10) or ORS 656.382(1). It contends that, although it did not fully comply with the discovery requirements in the Board's rules, it did

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[1] ORS 656.262(10) provides:

"If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

[2] ORS 656.382(1) provides:

"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 be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee as provided in subsection (2) of this section. To the extent an employer has caused the insurer to be charged such fees, such employer may be charged with those fees."

not resist or delay payment of compensation to claimant and that, therefore, he is not entitled to attorney fees under the statutes.

In *Randall v. Liberty Northwest Ins. Corp.*, 107 Or App 599, ___ P2d ___ (1991), we held that ORS 656.262(10) does not provide an independent basis for the award of

attorney fees. They must be awarded under ORS 656.382. One of the bases for the Board's award here was that employer had violated the Board's rule that requires compliance with its discovery requirements and provides that "failure to comply with this section may be considered unreasonable delay or refusal under ORS 656.262(10)." However, under *Randall,* the Board's rule does not provide authority for awarding attorney fees, because ORS 656.262(10) does not authorize fees.

The award of attorney fees was also based on the Board's conclusion that the failure to comply with the discovery rules constituted an unreasonable resistance to payment of compensation under ORS 656.382(1). That can be a proper basis on which to award attorney fees. Failure to provide discovery can interfere with the payment of compensation. In *Morgan v. Stimson Lumber Company,* 288 Or 595, 607 P2d 150, *mod* 289 Or 93, 610 P2d 830 (1980), the Supreme Court considered whether the rule that failure to comply with discovery requirements could be considered an unreasonable delay or refusal to pay compensation is within the Board's authority. The court held that it is:

> "The Board is entitled to take the view, within its responsibility for and experience with administering hearings, that a practice of prompt disclosure of all relevant information to the claimant will generally expedite the disposition of a claim and the eventual payment, and that failure or delay in such disclosure will tend to obstruct or delay a proper disposition and payment of a claim." 288 Or at 604.

In this case, however, employer had paid the entire award before its discovery violation. It could not unreasonably resist the payment of compensation that had all been paid. The award of attorney fees was improper.

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[3] *Former* OAR 438-07-015(2) provided:

"Documents pertaining to claims are obtained by mailing a copy of the Request for Hearing, or a written demand, to the insurer. Within fifteen (15) days of said mailing the insurer shall furnish the claimant, without cost, copies of all medical and vocational reports, records of compensation paid, and other documents pertaining to the claim(s) which are then or come to be in the possession of the insurer, except that evidence offered solely for impeachment need not be so disclosed. *Failure to comply with this section may be considered unreasonable delay or refusal under ORS 656.262(10).*" (Emphasis supplied.)

[4] ORS 656.331(1)(b) provides:

"Notwithstanding any other provision of ORS 656.001 to 656.794, if an injured worker is represented by an attorney and the attorney has given written notice of such representation:

"* * * * *

"(b) An insurer or self-insured employer 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 Board also justified its award of attorney fees on employer's alleged violation of ORS 656.331(1)(b). Even assuming that attorney fees can be awarded on that basis, claimant never actually received the 1503 form and, therefore, no impermissible contact actually occurred.

Reversed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

F. Owen BLACK, M.D.,
Petitioner,
v.
DEPARTMENT OF INSURANCE AND FINANCE
and Weyerhaeuser Co.,
Respondents.

(WCB 89-17333; CA A65274)

Judicial Review from Department of Insurance and Finance.

Argued and submitted May 3, 1991.

Christopher D. Moore, Eugene, argued the cause for petitioner. With him on the briefs were Malagon, Moore & Johnson and James L. Edmunson, Eugene.

Jerry Brown, McMinnville, argued the cause for respondent Weyerhaeuser Co. With him on the brief were Gene Platt and Cummins, Brown, Goodman, et al, McMinnville.

David L. Runner, Assistant Attorney General, Salem, argued the cause for respondent Department of Insurance and Finance. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

EDMONDS, J.

Affirmed.

EDMONDS, J.

Petitioner, a physician, seeks review of an order of the Director of the Department of Insurance and Finance (director) that he be paid $700 as a fee for deposition testi-

mony in a workers' compensation proceeding.[1] He challenges the validity of OAR 436-10-090(31),[2] the rule under which the fee was calculated. We review the order under ORS 656.704(2) and ORS 183.482 and the challenge to the rule under ORS 183.400(2).[3] We affirm.

Weyerhaeuser Co. deposed petitioner regarding a claim made by one of its employees. The deposition took approximately four hours. Petitioner billed Weyerhaeuser Co. $1,250 for his testimony but was paid only $700 in accordance with OAR 436-10-090(31). Petitioner appealed to the director for an additional payment of $550. The director concluded that the $700 payment was appropriate.

Petitioner asserts that the director is without statutory authority to regulate medical deposition fees and that OAR 436-10-090(31) is invalid. He argues that depositions

are not "medical services" within the meaning of ORS 656.245(1)[4] and, therefore, that ORS 656.248(4)[5] does not empower the director to promulgate rules for deposition testimony fees. The director argues, *inter alia*, that OAR 436-10-090(31) is authorized by ORS 656.726(3) and, therefore, is valid.

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[1] While review was pending in this court on the Director's initial order, he withdrew his order. On reconsideration, he affirmed his earlier order. Petitioner filed an amended petition for review of the order on reconsideration. That order is the subject of our review.

[2] When these proceedings were instituted, what is now OAR 436-10-090(31) was OAR 436-10-090(21). For convenience, we refer to the rule as OAR 436-10-090(31). It provides:

"Fees and codes for a deposition (includes preparation time):

"a. First hour	$300 * * *
"b. Each subsequent hour	$100 * * *"

[3] ORS 183.400 provides, in part:

"(2) The validity of any applicable rule may also be determined by a court, upon review of an order in any manner provided by law or pursuant to ORS 183.480 or upon enforcement of such rule or order in the manner provided by law.

"(3) Judicial review of a rule shall be limited to an examination of:

"(a) The rule under review;

"(b) The statutory provisions authorizing the rule; and

"(c) Copies of all documents necessary to demonstrate compliance with applicable rulemaking procedures.

"(4) The court shall declare the rule invalid only if it finds that the rule:

"(a) Violates constitutional provisions;

"(b) Exceeds the statutory authority of the agency; or

"(c) Was adopted without compliance with applicable rulemaking procedures."

[4] ORS 656.245(1) provides:

"For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires, including such *medical services as may be required after a determination of permanent disability. Such medical services shall include medical, surgical, hospital, nursing, ambulances and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services.* The duty to provide such medical services continues for the life of the worker." (Emphasis supplied.)

[5] ORS 656.248(4) provides:

"If no usual and customary fee has been established for a given service or procedure the director may, in compliance with ORS 183.310 to 656.794, promulgate a reasonable rate, which shall be the same within any given area for all primary health care providers to be paid for that service or procedure."

ORS 656.726(3) provides, in part:

> "The director hereby is charged with duties of administration, regulation and enforcement of ORS 654.001 to 656.295, 654.750 to 654.780 and 656.001 to 656.794. To that end, the director may:
>
> "(a) Make and declare all rules which are reasonably required in the performance of the director's duties."

ORS 656.726(3) delegates to the director the authority to promulgate rules that are required to carry out the performance of its duties. A rule promulgated under that statute is valid if it is within the range of discretion allowed by the more general policies of the Workers' Compensation Law. *See Planned Parenthood Assn. v. Dept. of Human Res.*, 297 Or 562, 574, 687 P2d 785 (1984) (citation omitted); ORS 183.400(4)(b). Those policies include the fair and just provision of medical benefits and compensation to injured workers. ORS 656.012. Medical testimony and the payment for it carry out those policies. We hold that ORS 656.726(3) empowers the director to establish rates of payment for medical depositions.

We need not address petitioner's other arguments or assignments of error regarding ORS 656.245 and ORS 656.248.

Affirmed.

No. 506 August 21, 1991 453

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

BOB WILKES FALLING, INC.,
Petitioner,

v.

The filings of the
NATIONAL COUNCIL ON
COMPENSATION INSURANCE
and SAIF Corporation,
Respondents.

(88-10-18; CA A65963)

Judicial Review from Department of Insurance and Finance.

Argued and submitted June 12, 1991.

Martha C. Evans, Eugene, argued the cause for petitioner. With her on the brief was DePaolis, Evans, Shepard & Vallerand, Eugene.

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 National Council on Compensation Insurance.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

EDMONDS, J.

Order regarding Northwest Timber, Inc., and Lake Price Logging reversed and remanded for reconsideration; otherwise affirmed.

EDMONDS, J.

Petitioner seeks review of a final order of the Department of Insurance and Finance that ordered petitioner to pay additional workers' compensation premiums assessed by SAIF. We review for substantial evidence and errors of law, ORS 183.480; ORS 183.482, and reverse.

Petitioner is in the business of falling and bucking timber. It requires its workers to provide their own transportation to logging sites. Purportedly, it paid money to its workers to reimburse them for travel expenses to the sites and deducted it as a business expense from its payroll report. SAIF audited petitioner's records and determined that the money should have been included as payroll. After a hearing, the department issued a final order[1] in which it found that petitioner hired Northwest Timber, Inc., and Lake Price Logging, each operated by one individual, to cut timber. It held that those individuals were subject employees, not independent contractors, under the criteria set forth in *Castle Homes, Inc. v. Whaite,* 95 Or App 269, 768 P2d 215 (1989), and the petitioner owned premiums for their converage.

Petitioner asserts that department violated ORS chapter 183 when it failed to issue a proposed order; that no substantial evidence supports department's findings regarding petitioner's travel reimbursements; that the reimbursements were erroneously included in its payroll; and that department erred in concluding that Northwest Timber, Inc., and Lake Price Logging were not independent contractors.

We hold that a proposed order was not required by ORS 183.460, ORS 183.415(11)(g) or (h), ORS 183.646 or OAR 137-03-060(1) before the final order was entered, because department's acting deputy administrator reviewed the entire record on reconsideration. We also hold that substantial evidence supports department's findings regarding petitioner's travel reimbursements and that department did not err when it concluded that the reimbursements should have been included in petitioner's payroll for the purpose of calculating premiums.

Regarding the department's determination that the individuals employed by Northwest Timber, Inc., and Lake Price Logging were subject employees, we remand for recon-

[1] Department issued a final order and then issued an amended final order, in which a citation error was corrected.

sideration in the light of *Little Donkey Enterprises, Inc. v. SAIF*, 107 Or App 400, 812 P2d 25 (1991).

Order regarding Northwest Timber, Inc., and Lake Price Logging reversed and remanded for reconsideration; otherwise affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Ernest C. Richter, Claimant.

Ernest C. RICHTER,
Petitioner,

v.

PACIFIC AUTO BODY & PAINT,
Argonaut Insurance Companies,
Dean's Body & Paint Company, Inc.
and SAIF Corporation,
Respondents.

(WCB Nos. 88-04556, 86-13711,
85-12160; CA A64845)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 28, 1991.

Karen M. Werner, Eugene, argued the cause and filed the brief for petitioner.

Bradley R. Scheminske, Portland, argued the cause for respondents Pacific Auto Body & Paint and Argonaut Insurance Companies. On the brief were Nancy J. Meserow and Scheminske & Lyons, Portland.

No appearance by respondents Dean's Body & Paint Company, Inc. and SAIF Corporation.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

PER CURIAM

Reversed in part and remanded for award of attorney fees; otherwise affirmed.

PER CURIAM

Substantial evidence supports the Workers' Compensation Board's conclusion that claimant lacked good cause for failing to appear at his hearings, and the Board did not err in dismissing his request for a hearing on the issue of the extent of disability. *See* ORS 656.298(6); ORS 183.482(8).

Claimant also argues that he is entitled to attorney fees under ORS 656.386, because Argonaut Insurance Companies, as insurer of Pacific Auto Body & Paint, rescinded its denial of compensability of chiropractic treatment. After the Board's decision in this case, the legislature amended ORS

656.386 to provide for attorney fees in this situation, and the amendment applies retroactively to those cases in which the order was not final on or before the effective date of the act. SB 540, § 3 (1991).

Reversed in part and remanded for award of attorney fees; otherwise affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Carla J. Schrock, Claimant.

Carla J. SCHROCK,
Petitioner,
v.
SAIF CORPORATION
and Rock Of Ages Home,
Respondents.

(WCB 89-09148; CA A67012)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 12, 1991.

Charles D. Maier and Gatti, Gatti, Maier & Associates, Salem, filed the brief for petitioner.

Thomas E. Ewing, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and Jerome Lidz, Assistant Attorney General, Salem.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

PER CURIAM

Reversed in part and remanded for award of attorney fees; otherwise affirmed.

PER CURIAM

The Workers' Compensation Board did not err in upholding employer's denial of chiropractic treatment.

Employer rescinded its denial of ultrasound treatment at the hearing, and claimant sought attorney fees under ORS 656.386. After the Board's decision denying attorney fees, the legislature amended ORS 656.386 to allow for attorney fees in this type of situation. That amendment applies retroactively to cases in which the order was not final on or before the effective date of the act. SB 540, § 3 (1991).

Reversed in part and remanded for award of attorney fees; otherwise affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Margaret Nemecek, Claimant.

LIBERTY NORTHWEST INSURANCE CORP.
and Salem Hospital,
Petitioners,

v.

Margaret NEMECEK,
Respondent.

(WCB 89-00148; CA A67402)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 24, 1991.

Stafford J. Hazelett, Portland, argued the cause and filed the brief for petitioners.

Brad G. Garber, Salem, argued the cause for respondent. With him on the brief was Michael B. Dye, Salem.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

PER CURIAM

Reversed and remanded for reconsideration.

Edmonds, J., dissenting.

PER CURIAM

Employer seeks review of an order of the Workers' Compensation Board affirming and adopting the referee's order, which concluded that claimant's occupational disease claim was compensable, because her work was a material contributing cause of the condition. Employer asserts that the Board relied on an erroneous interpretation of ORS 656.802. Employer is correct. We recently decided that the 1987 legislature did not intend to change the major contributing cause standard. *Aetna Casualty Co. v. Aschbacher,* 107 Or App 494, ___ P2d ___ (1991).

Although the referee's opinion suggested that one of the four doctors' reports would support a finding that claimant's work was the major contributing cause of her condition, and we think the record contains substantial evidence to support such a finding, neither the referee nor the Board made that finding. Rather, the referee concluded that "all of the medical opinions in the record establish *at the very least* that claimant's work was a material contributing cause." (Emphasis supplied.) Therefore, we must reverse and remand for reconsideration of whether claimant's work was the major contributing cause of her condition. *Liberty Northwest Ins. Corp. v. Damm,* 107 Or App 764, ___ P2d ___ (1991).

Reversed and remanded for reconsideration.

EDMONDS, J., dissenting.

The majority says:

> "Although the referee's opinion suggested that one of the four doctors' reports would support a finding that claimant's work was the major contributing cause of her condition, and we think the record contains substantial evidence to support such a finding, neither the referee nor the Board made that finding." 108 Or App at 491.

The majority is wrong in saying that the referee and the Board did not find that claimant's work was the *major* contributing cause of her condition. In the referee's opinion, which the Board adopted, he first made findings. Under *"OPINION AND CONCLUSIONS,"* the referee said:

> "I am persuaded that Dr. Jones' reports and deposition testimony support a finding that claimant's work at SM – being on her feet for long hours on a hard surface – was at least the *major* cause, if not the sole cause, of her plantar fasciitis [*sic*] condition. This is more than what is required to establish compensability under the current occupational disease law, as construed by the Board in *Aschbacher.*" (Emphasis supplied.)

The referee concluded:

> "In sum, all of the medical opinions in the record establish at the very least that claimant's work was a material contributing cause of her plantar fasciitis [*sic*] symptoms. * * * Based upon claimant's credible testimony, the above discussed medical evidence, and the previously discussed applicable law, I conclude that claimant has established the compensability of her right foot plantar fasciitis [*sic*] occupational disease claim."

The majority's remand so that the Board can apply the "major contributing cause test" is an unnecessary action in the light of the concerted effort by the referee to say that claimant's claim was compensable, regardless of whether a "major" or "material" contributing cause standard was used.

I dissent.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Albert W. Vanslyke, Claimant.

Albert W. VANSLYKE,
Petitioner - Cross-Respondent,

v.

FRED MEYER, INC.,
Respondent - Cross-Petitioner.

(WCB 89-24556; CA A67929)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 12, 1991.

Charles D. Maier and Gatti, Gatti, Maier & Associates, Salem, filed the brief for petitioner - cross-respondent.

Jerald Keene, Portland, argued the cause for respondent - cross-petitioner. With him on the brief was Roberts, Reinisch, MacKenzie, Healey & Wilson, Portland.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

PER CURIAM

Affirmed on petition; cross-petition dismissed as moot.

PER CURIAM

Claimant seeks review of an order of the Workers' Compensation Board that affirmed the referee's order holding that the Hearings Division lacked jurisdiction to correct an alleged error in a final and unappealed Board order concerning claimant's entitlement to attorney fees. Employer cross-petitions for review, contending that the Board erred in refusing to provide, without charge, a transcript of the closing arguments at the hearing. We affirm on the petition.

The remedies for review of alleged errors in a Board order are to petition the Board for reconsideration or to seek judicial review. OAR 438-11-035(2); ORS 656.298. Claimant failed to pursue those remedies, and the Board's order became final. ORS 656.295(8). The Hearings Division could not correct an error in that order. The Board correctly affirmed the referee's order.

In the light of our disposition of the petition, we need not reach the cross-petition.

Affirmed on petition; cross-petition dismissed as moot.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Gilbert V. Wootton, Claimant.

Gilbert V. WOOTTON,
Petitioner,

v.

STADELI PUMP & CONSTRUCTION,
and EBI Companies,
Respondents.

(88-06038; CA A65378)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 11, 1991.

Arthur P. Klosterman, Salem, argued the cause for petitioner. With him on the brief was The Law Offices of Brian R. Whitehead, Salem.

Lin A. Zimmerman, Portland, argued the cause for respondents. With him on the brief was Beers, Zimmerman, et al, Portland.

Before Richardson, Presiding Judge, and Joseph, Chief Judge,* and Deits, Judge.

DEITS, J.

Affirmed.

* Joseph, C. J., *vice* Newman, J.

DEITS, J.

In this workers' compensation case, claimant seeks review of a Workers' Compensation Board order that held that his worsened back condition is the responsibility of a California employer. We affirm.

Claimant suffered a compensable back injury in Oregon on August 8, 1980, for which he was awarded 55 percent permanent partial disability by employer. On August 18, 1987, claimant suffered another injury to his back while working in California. The California employer accepted his claim for that injury and has paid claimant temporary disability benefits and benefits for medical services. He may be entitled to permanent total disability (PTD) under California law, but that has yet to be determined. He also filed an Oregon aggravation claim after the California injury. Employer denied the claim, asserting that, under *Miville v. SAIF*, 76 Or App 603, 710 P2d 159 (1985), acceptance of the 1987 California claim relieved the Oregon employer of any further responsibility for the 1980 Oregon injury. The Board upheld the denial.

Claimant argues that the Board erred, as a matter of law, in upholding denial of his aggravation claim. The parties agree that the 1987 California injury contributed independently to claimant's present disability and that his 1980 Oregon injury remains a material contributing cause of his current condition. Claimant acknowledges that, if this case involved two Oregon employers, responsibility would shift to the second employer. *Colwell v. Trotman,* 47 Or App 855, 858, 615 P2d 1094 (1980). Under California law, however, responsibility does not shift to the last employer, but is apportioned between employers, on the basis of the percentage of disability attributed to each.[1] Claimant argues that, because of that, if the last injurious exposure rule is applied and the Oregon employer is absolved of responsibility for his disability, he will not be fully compensated, because he will only receive compensation for that portion of the injury for which the California employer is responsible. Claimant contends that that

result is inconsistent with our holding in *Miville v. SAIF, supra.*

In *Miville,* the claimant had suffered a compensable back injury in 1980, while working for an Oregon employer. Subsequently, he suffered off-the-job injuries and on-the-job injuries in Washington and Indiana. He then returned to Oregon, received chiropractic treatment and filed a claim for aggravation of his 1980 injury. The Oregon employer denied the claim, and the Board upheld the denial. On review, we found that the out-of-state injury had independently contributed to the claimant's condition and that the earlier Oregon injury had materially contributed to his present disability. Our analysis required us to choose between the holding of *Grable v. Weyerhaeuser Company,* 291 Or 387, 631 P2d 768 (1981), that, if a compensable on-the-job injury and a subsequent off-the-job injury both materially contribute to the claimant's worsened condition, the employer remains responsible, and that of *Smith v. Ed's Pancake House,* 27 Or App 361, 556 P2d 158 (1976), where we held that, in the case of successive injuries and successive employers, the second employer is responsible for a new injury that independently contributes to a disability, even if the earlier injury remains a material contributing cause of the disability. We said that

> "the rationale of *Grable* should apply when a claimant has suffered an on-the-job injury in another state for which he has claimed, but has not been awarded, compensation, and the medical evidence is that the original Oregon injury materially contributed to the claimant's present disability, even though the out-of-state injuries contributed independently to the present disability. * * * If claimant has not filed a claim in [the other state], or if he has done so and has been awarded compensation, [the Oregon insurer] is not responsible for claimant's present condition." *Miville v. SAIF, supra,* 76 Or App at 607.

We concluded that, to hold otherwise, would result in the worker being uncompensated for injuries that clearly were work-related.

[1] Apparently, under California law, responsibility for medical services and temporary disability is not apportioned.

Claimant argues that, under *Miville,* responsibility should not shift to an employer in another state unless, under the laws of that state, the claimant will be fully compensated for his disability. The Board rejected that argument, adopting

the order of the referee:

> "Certainly, a rule that distinguishes between those states that apportion permanent disability to a preexisting injury and those that shift responsibility could be applied systematically. I, however, decline to apply such a rule because, in essence, it would allow foreign jurisdictions to decide and dictate to Oregon employers/insurers what benefits they owe while denying the Oregon employers/insurers due process rights of participating in or defending against the decision of the foreign jurisdiction. Additionally, it would create apportionment in Oregon where it does not currently exist. *Inkley v. Forest Fiber Products Co.,* 288 Or 337[, 605 P2d 1175] (1980); *Boise Cascade Corp. v. Starbuck,* 296 Or 238[, 675 P2d 1044] (1984)."

We also implicitly rejected claimant's argument in *Olson v. EBI Co.,* 78 Or App 261, 715 P2d 1348 (1986). In that case, the claimant had suffered a compensable injury to his neck and back in 1979, while working in Oregon. In 1983, he again injured his neck and back, while working in California for a California employer. He filed an aggravation claim with the Oregon employer for the California injury. We found that the new injury independently contributed to the claimant's disability. We also found that the 1979 Oregon injury was a material contributing cause of the disability. We concluded that, because the California injury independently contributed to the claimant's disability and because California had not rejected his claim, the Oregon employer was no longer responsible for the claimant's injury:

> "In *Miville v. SAIF,* 76 Or App 603, 710 P2d 159 (1985), we held, under similar circumstances, that the policy stated in *Grable v. Weyerhaeuser Company,* [*supra*], would require the Oregon employer to remain responsible *if* the claimant had filed a claim in the foreign state where the second injury occurred and that claim had been rejected and *if* the Oregon injury was a material contributing cause of his present disability. Here, no claim was filed in California. We hold, therefore, that the Oregon employer is not responsible for claimant's disability." 78 Or App at 264.

Here, the California injury did independently contribute to the claimant's condition. The California employer did not reject the claim but, in fact, accepted it and is paying temporary disability and medical service benefits to claimant.[2] There is no requirement that a claimant must be compensated by an out-of-state employer to the same extent that

[2] It is not a certainty that claimant will not be fully compensated for his disability. Although California law does allow for apportionment of PTD, assuming that claimant is found to be eligible for PTD, it is possible that responsibility for claimant's injury may not be apportioned. Further, under California law, the Subsequent Injury Relief Fund provides relief under some circumstances to workers who are not receiving full compensation for a disability.

he would be in Oregon in order for responsibility to shift under the last injurious exposure rule to the out-of-state employer. We hold, therefore, that the Board properly upheld employer's denial of claimant's aggravation claim.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Stephen A. Scarratt, Claimant.

Stephen A. SCARRATT,
Petitioner,

v.

H. A. ANDERSON CONSTRUCTION CO., and Liberty Northwest Insurance,
Respondents.

(88-12306; CA A64724)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 11, 1991.

Nelson Hall, Portland, argued the cause for petitioner. On the brief were Lawrence Baron and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Stafford J. Hazelett, Portland, argued the cause and filed the brief for respondents.

Before Richardson, Presiding Judge, and Joseph, Chief Judge,* and Deits, Judge.

DEITS, J.

Affirmed as to denial of attorney fees and penalties; otherwise reversed and remanded for reconsideration.

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* Joseph, C. J., *vice* Newman, J.

DEITS, J.

Claimant assigns error to the Workers' Compensation Board's decision that an injury resulting from using a jackhammer at work caused only a temporary worsening of the symptoms of his pre-existing arthritic condition. He contends that the Board should not have decided whether the injury resulted in a worsening of his underlying condition and that the Board's finding that he had suffered only a temporary increase in symptoms was not supported by substantial evidence. He also requests that we uphold the attorney fees and penalties that the referee had awarded for unreasonable denial and that the Board set aside.

Claimant was employed by a construction company. On August 19, 1987, he used a jackhammer for the first time.

He developed pain and swelling in his wrists and hands, and a visible knot developed in one wrist. He had had no prior wrist injuries, nor had he suffered similar pain and swelling. He immediately showed his hands to his supervisor, who then placed him on lighter work. Claimant filed this claim in January, 1988, and sought medical treatment in February. Another physician evaluated him in September, 1988. Both physicians diagnosed claimant as having a pre-existing bilateral wrist degenerative osteoarthritis that became symptomatic while he was jackhammering. Since February, 1988, claimant has worked as a mail handler. He has had no significant wrist or hand problems on that job, but the symptoms recur when he does certain activities, such as hammering and mowing the lawn. Employer denied his claim in June, 1988.

The referee found that,

> "although claimant had pre-existing arthritis, claimant was essentially asymptomatic prior to this exposure on August 19, 1987. He was able to function without difficulty or restrictions as a construction worker up to this point.
>
> "This exposure, i.e. period of jackhammer use, was sufficiently discrete and defined in duration and nature so as to constitute an industrial injury rather than an occupational disease. Following this period of exposure, claimant had a distinct change in his wrists with persisting symptomatology which led to limitation in his work activities, and eventually the need for medical evaluation and treatment. The work

> activity thus precipitated the disability and the need for treatment."

The referee also found that the denial was unreasonable. She ordered that the denial be set aside, remanded the case for processing, awarded attorney fees and assessed a penalty.

The Board held that claimant has a compensable condition defined as "a temporary increase in his wrist symptoms." It also held that the injury did not result in a worsening of the underlying arthritic condition. The Board then "reinstated the insurer's denial insofar as it pertains to a denial of claimant's underlying wrist condition." It also modified the attorney fees award concerning the denial and reversed the assessment of a penalty and attorney fees for an unreasonable denial.

Claimant contends that, in deciding that the underlying condition had not worsened, the Board addressed an issue that was not before it and was not necessary to resolve the case. He asserts that "the Board should have limited the issue to simply whether claimant suffered a compensable injury."

The Board did not err in addressing whether claimant's underlying condition had worsened. An employer is responsible for injuries that arise out of and in the course of employment. ORS 656.005(7). An employer is not, however, responsible for conditions that are not related to an occupational injury or for conditions that existed before the injury occurred and were not worsened by the injury. *Barrett v. D &*

H Drywall, 300 Or 325, 329, 709 P2d 1083 (1985), *clarified* 300 Or 553, 555, 715 P2d 90 (1986). A worker may suffer symptoms, even though the underlying condition has not worsened. Under the occupational disease statute, ORS 656.802, a worker cannot be compensated for symptoms of a pre-existing disease if the underlying condition has not worsened. *Weller v. Union Carbide,* 288 Or 27, 602 P2d 259 (1979). However, disabling symptoms of an underlying disease *are* compensable if they are caused by an occupational injury, even if the underlying disease has not worsened. ORS 656.005(7)(a); *Barrett v. D & H Drywall, supra,* 300 Or at 330. Similarly, symptoms that require medical services are

compensable if they are caused by an occupational injury, even if the underlying disease has not worsened.

Claimant contends that the Board should have concluded its review as soon as it found that some symptoms were compensable. We disagree. The Board may distinguish between a compensable and a noncompensable condition when a claimant has both, as it did in *Roy Bier,* 35 Van Natta 1825 (1983):

> "Even [the doctors] agree that the twisting incident * * * caused an increase in claimant's symptoms. Accordingly, [insurer's] denial of the industrial injury claim must be set aside.
>
> "We wish to make it clear, however, that we are not saying that [insurer] is responsible for claimant's degenerative back condition. Because there is insufficient evidence to prove that the industrial injury worsened the degenerative condition, [insurer] is not responsible for it. [*Insurer*] *is only responsible for symptoms caused by the industrial injury.* Although the evidence is contradictory, we find that there is sufficient evidence to prove that claimant's continuing * * * pain is related to the compensable injury." (Emphasis supplied.)

Thus, in defining a specific compensable injury, it is appropriate to examine any pre-existing condition and the relationship between the injury and the condition. The Board's determination that claimant's underlying condition was not worsened was relevant to its decision as to the nature of claimant's compensable condition.

Claimant also complains that the Board's order does not clearly define the compensable condition:

> "A second problem with the Board's order on Review is that it's [*sic*] Order to affirm in part, modify in part, and reverse in part the Referee's Opinion and Order is not clear; further explanation is required. If the employer is not responsible for the underlying condition, what is it responsible for? Certainly, under the case law, the employer is minimally responsible for all ongoing symptoms resulting from the injury. This has to be clarified."

The Board found that claimant had suffered a "temporary increase in * * * wrist symptoms." Under *Barrett v. D & H Drywall, supra,* 300 Or at 329, employer is responsible

for symptoms of claimant's arthritis that are "due to" the compensable injury. It is unclear from the Board's order, however, which, if any, of claimant's ongoing symptoms the Board considered to be "due to" the injury. Therefore, it is necessary to remand for clarification of its holding.

Claimant further argues that the finding that "claimant's use of a jackhammer materially contributed to a temporary increase in his wrist symptoms" is not supported by substantial evidence. In view of our conclusion that the Board's decision needs to be clarified, it is unnecessary to address this issue.

Claimant also argues that the Board erred in failing to award penalties and attorney fees under ORS 656.262(10) and ORS 656.382(1) for unreasonable delay and resistance to payment of compensation. The Board concluded that employer's denial was not 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, Argonaut 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 Ginter 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* 289 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)."

We conclude that the Board's finding that employer acted reasonably is supported by substantial evidence.

Affirmed as to denial of attorney fees and penalties; otherwise reversed and remanded for reconsideration.

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Kenneth A. Hendershott, Claimant.

DEPARTMENT OF JUSTICE, INMATE INSURANCE FUND, Petitioner,
v.
KENNETH A. **HENDERSHOTT**, Respondent.
(WCB 87-17525; CA A61286)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 14, 1990.
David L. Runner, Assistant Attorney General, Salem, argued the cause for petitioner. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Ralph M. Yenne, Salem, argued the cause and filed the brief for respondent.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
WARREN, P.J.
Award of attorney fees for unreasonable denial affirmed; award of attorney fees for services on Board review reversed.

Department of Justice Inmate Injury Fund (petitioner) seeks reversal of the Workers' Compensation Board's order affirming an award of attorney fees by the referee and awarding additional attorney fees for services rendered by claimant's attorney on Board review. We affirm in part and reverse in part.

Claimant is an inmate at the Oregon State Penitentiary. He filed a claim for nerve damage to his hands and forearms on August 14, 1987, alleging that the condition was related to work that he had performed at the forest camp. Petitioner initially denied the claim on October 20, 1987, and claimant requested a hearing. At the hearing, petitioner stipulated that it had rescinded its denial and that its denial had been unreasonable. The referee concluded that claimant was not entitled to a penalty, but awarded attorney fees because of petitioner's unreasonable denial. On review, the Board affirmed the referee's order and awarded claimant additional attorney fees for services rendered on Board review.

Petitioner contends that the Board erred both in affirming the referee's order awarding attorney fees and in awarding fees for services rendered on Board review. The Board did not err in affirming the *referee's* award of attorney fees. In *Jones v. OSCI*, 108 Or App 230, ___ P2d ___ (1991), we concluded that Senate Bill 540, amending ORS 656.386(1), expressly provides for attorney fees under the circumstances in this case.

However, the Board did err in awarding fees for services on Board review. ORS 656.382(2) authorizes fees only when a claimant's right to compensation is at risk on review. *Howard v. Willamette Poultry*, 101 Or App 584, 587, 792 P2d 447 (1990). Attorney fees are not "compensation." *Dotson v. Bohemia, Inc.*, 80 Or App 233, 236, 720 P2d 1345, *rev den* 302 Or 35 (1986). Because claimant's right to attorney fees was the only issue on review, his right to compensation was not at risk. Therefore, he was not entitled to attorney fees under ORS 656.382(2), and the Board erred in awarding them.

Award of attorney fees for unreasonable denial affirmed; award of attorney fees for services on Board review reversed.

Cite as 108 Or App 596 (1991) September 4, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Kathlene R. Zimmerly, Claimant.

HOUSING AUTHORITY OF PORTLAND and LIBERTY NORTHWEST INSURANCE CORP.,
Petitioners,
v.
KATHLENE R. **ZIMMERLY**, Respondent.
(88-09124; CA A66672)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 22, 1991.
Kenneth E. Bemis, Portland, argued the cause for petitioners. On the brief were Craig A. Crispin and Bullard, Korshoj, Smith & Jernstedt, Portland.
James L. Francesconi, Portland, argued the cause for respondent. With him on the brief was Francesconi & Associates, P.C., Portland.
Before Warren, Presiding Judge, and Joseph, Chief Judge, and Riggs, Judge.
WARREN, P.J.
Reversed and remanded for reconsideration.

Employer seeks review of an order of the Workers' Compensation Board that affirmed the referee's decision that claimant's mental disorder is compensable. Employer is correct that the Board erroneously applied the "material contributing cause" test, rather than requiring claimant to prove that her work conditions were the major contributing cause of her mental disorder. *Aetna Casualty Co. v. Aschbacher*, 107 Or App 494, 812 P2d 844 (1991).

Because the issue may recur on remand, we also address employer's argument that the Board erred in concluding that the conditions causing claimant stress are not "conditions generally inherent in every working situation." ORS 656.802(2)(b).

Claimant has a history of mental illness from at least 1980, when she was diagnosed as major affective/major depressive after she attempted to commit suicide. Claimant began working for employer in 1981. Her job as a Service Coordinator for the housing program was to evaluate applicants, inspect housing and complete a large amount of paperwork. In 1987, in an accident unrelated to her work, she broke her thumb on her dominant hand, and she fell increasingly behind in her workload. She underwent surgery on the thumb, and her doctor released her for light duty work only. Employer assigned a secretary to do claimant's job until she was released to perform it again. The secretary moved into claimant's office, and claimant moved into his office. The secretary's office was some distance from the Service Coordinators' offices and had no telephone. Employer assigned claimant to work on property damage claims. Claimant felt completely incompetent to do that work, and on February 26, 1988, she left work, resolving to commit suicide. A co-worker warned claimant's therapist, and claimant was hospitalized and diagnosed as suffering a recurrent major depression and having a borderline personality disorder.

ORS 656.802(2) provides, in part:

> "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 supplied.)

The first question is whether the emphasized language refers to conditions present in every employment or only to conditions generally inherent in the particular claimant's job. The Board made the more universal reading. It found that the primary conditions causing claimant's mental disorder were the changes in her duties and workstation. It concluded that, because those conditions were stressful and were not generally inherent in every working situation, claimant's mental disorder is compensable. Accordingly, it did not address whether the other stressful conditions were also inherent in every work situation.[1]

This is the first appellate court opinion to interpret ORS 656.802(2)(b), which was added to the statute in 1987 as part of House Bill 2271.[2] Or Laws 1987, ch 713, 4. We believe that the language of the statute is clear and that the Board correctly understood the meaning of the phrase "generally inherent in every working situation." The legislature intended to preclude claims for mental disorders that arise from conditions that are common to all employments. Mental disorders resulting from other employment-related causes remain compensable.

The Board correctly understood the statute, but its order does not adequately explain why the conditions here, that is, changes in claimant's duties and workstation, are not generally inherent in every employment situation.[3]

Reversed and remanded for reconsideration.

---

[1] We reject employer's contention that the conditions causing claimant's mental disorder did not "exist in a real and objective sense," ORS 656.802(2)(a), because her perception that she was going to be fired had no basis in fact. The Board found that the primary causes of her mental disorder were her job reassignment and the relocation to a different office. Those were real events.

[2] *Sibley v. City of Phoenix*, 107 Or App 606, ___ P2d ___ (1991), deals with ORS 656.802(1).

[3] The Board stated:

"We conclude that claimant's displacement from her office and her duty changes are claimant's primary stressors. We further conclude that these are not 'conditions generally inherent in every working situation.' Thus, without deciding whether claimant's other stressors are inherent in every work situation, we find that the office and duty changes, alone, were a material cause of claimant's depressive disorder. As a result, claimant's claim does not come within the scope of the exclusion for conditions generally inherent in every working situation. Furthermore, the insurer has not maintained that claimant's office and duty changes were reasonable disciplinary, corrective or job performance evaluation actions by the employer."

Cite as 108 Or App 605 (1991) September 4, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Linda J. Hasslen, Claimant.

BOISE CASCADE CORPORATION, Petitioner,
v.
LINDA J. **HASSLEN**, Respondent.
(WCB 88-20402; CA A65824)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 29, 1991.
Adam T. Stamper, Medford, argued the cause for petitioner. With him on the brief were Kimberly D. Wallan and Cowling & Heysell, Medford.
Robert Wollheim, Portland, argued the cause for respondent. With him on the brief was Welch, Bruun & Green, Portland.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

WARREN, P.J.
Reversed and remanded for reconsideration of current treatment needs.

Employer seeks review of a Workers' Compensation Board order that set aside two denials on the ground that employer had improperly denied prospective medical benefits. We reverse and remand.

Claimant worked for employer as a green chain offbearer. She filed a claim for low back pain, which employer accepted and for which she received an award of ten percent unscheduled permanent partial disability. Claimant continued to receive treatment for her low back condition and submitted medical bills for payment by employer. Employer paid those bills until October 25, 1988, when employer issued a denial:

> "Medical investigation has resulted in a determination that your *current condition requiring medical treatment is unrelated* to the acute lumbar strain sustained for which Boise Cascade Corporation accepted responsibility. * * * Medical treatment for your *current condition* should more appropriately be provided under any group health insurance you may have." (Emphasis supplied.)

On November 15, 1988, employer issued a second denial:

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

Claimant requested a hearing.

The referee set aside the denials, finding that the medical services were reasonable and necessary for treatment of claimant's industrial injury. Employer requested review, and the Board affirmed the referee, holding that, because the denials were not addressed to specific medical services rendered or claimed, they were prospective and therefore invalid under *Evanite Fiber Corp. v. Striplin*, 99 Or App 353, 781 P2d 1262 (1989). The Board did not reach the question whether the claimed medical services were reasonable and necessary to treat claimant's industrial injury.

The only question that we need address is whether employer's denials were procedurally adequate.[1] We have held that an employer can issue a denial either for a specific unpaid claim or for a current claimed need for treatment. *Green Thumb v. Basl*, 106 Or App 98, 806 P2d 186 (1991). However, an employer may not deny its future responsibility relating to an accepted claim. The first denial in this case, issued on October 25, asserts that claimant's "current condition" is unrelated to her industrial injury. That was a valid denial under *Green Thumb v. Basl, supra*. Claimant would not be precluded by its terms from filing a claim for medical treatment in the future, if her condition should warrant it. *See e.g., Liberty Northwest Insurance Corp. v. Bird*, 99 Or App 560, 564, 783 P2d 33 (1989), *rev den* 309 Or 645 (1990). The Board erred in holding that that denial was prospective.

The November 15 denial presents a more difficult question. Employer sought to deny claimant's "current treatment needs." That is proper under *Evanite v. Striplin, supra*. However, employer also denied responsibility for "any disability as compensably related to this injury." That portion of the denial is prospective, because it attempts to deny benefits for any disability resulting from the injury that gave rise to the accepted claim. Accordingly, it is invalid and of no effect.

As to the valid portions of the denials, the case is remanded to the Board for it to consider whether the requested medical services are reasonable and necessary to treat claimant's compensable industrial injury.

Reversed and remanded for reconsideration of current treatment needs.

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[1] If the denials are procedurally adequate, the Board must consider whether the medical services are reasonable and necessary to treat the claimant's compensable injury.

Cite as 108 Or App 623 (1991) September 4, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Robert A. Lusk, Claimant.

BBC BROWN BOVERI and AETNA CASUALTY COMPANY, Petitioners - Cross-Respondents,
v.
ROBERT A. **LUSK**, CLARK ULLMAN WELDING and SAIF CORPORATION, Respondents - Cross-Respondents, and **COMBUSTION ENGINEERING** and CNA INSURANCE COMPANY, Respondents - Cross-Petitioners.
(88-10360, 88-10361, 88-10362; CA A66084)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 12, 1991.
Thaddeus J. Hettle, Portland, argued the cause for petitioners - cross-respondents. With him on the brief was Scheminske & Lyons, Portland.
Craig A. Staples, Portland, argued the cause for respondents - cross-petitioners. With him on the brief was Roberts, Reinisch, Mackenzie, Healey & Wilson, P.C., Portland.
No appearance for respondents - cross-respondents Robert A. Lusk, Clark Ullman Welding adn SAIF Corporation.
Before Joseph, Chief Judge, and Riggs and Edmonds, Judges.
EDMONDS, J.
Reversed on petition; reversed and remanded for reconsideration of attorney fees on cross-petition.

BBC Brown Boveri (BBC) and Aetna Insurance Company (Aetna), its insurer, seek review of a Workers' Compensation Board order that set aside their denial of claimant's hearing loss claim and held them responsible for that condition as of June 23, 1986. Combustion Engineering (Combustion) cross-petitions and assigns error to the determination that claimant's counsel was entitled to attorney fees.

The referee found:

> "Claimant is 56 years of age and for the past 20 years has been a boiler maker which subjects him to much loud noise from hammers, grinders and welders. Claimant noticed a gradual loss of his hearing and testing on June 23, 1986, revealed a bilateral hearing loss. He was prescribed hearing aids which he has worn ever since. BBC Brown Boveri was the last employer prior to the diagnosis of the hearing loss.
>
> "On December 22, 1987, claimant's hearing was again tested and it was found to be worse than when it was tested in June 1986. Dr. Lipman, an ear specialist, opined that claimant's hearing loss indicated in the hearing test of June 1986 was due to the effects of the loud noise claimant was subject to in hiw work up to that time. Dr. Lipman further opined that claimant's increased hearing loss between June 1986 and December 1987 was attributable to the effects of the loud noise incurred in his work between June 1986 and December 1987. Claimant worked on several occasions for Combustion Engineering in 1987 and [Combustion] was the last employer prior to the diagnosis of an increased hearing loss in December 1987.
>
> "On April 28, 1988, Aetna Insurance Company wrote to the claimant and denied compensability and responsibility for his claim in behalf of its insured, BBC Brown Boveri. Claimant made a claim for his hearing loss against Combustion Engineering. The parties stipulated that the insurer for Combustion Engineering [CNA] never issued a denial of the claimant's claim.
>
> "During the hearing the insurer's [sic] for BBC Brown Boveri and Combustion Engineering conceded that the claim was compensable but each denied responsibility."

The Board adopted those findings, with this supplementation:

> "Claimant was last employed by [Combustion] between November 16, 1987 and November 19, 1987.
>
> "The onset of claimant's permanent disability occurred by June 23, 1986, while claimant was employed by [BBC].
>
> "Claimant's work exposure after June 23, 1986, while employed by [Combustion], caused additional permanent disability and independently contributed to a worsening of his condition."

The Board concluded that BBC is responsible for claimant's hearing loss as of June 23, 1986, and that Combustion is responsible for its worsening as of November 16, 1987. On that basis, the Board ordered each employer to pay one-half of the assessed attorney fees.

BBC argues that claimant's only contact with it was in 1986, when he applied for employment, failed a welding test and was not hired. Therefore, it

contends the Board's finding that claimant was employed by BBC before June 23, 1986, is not supported by substantial evidence. Combustion argues that, because the pre-employment test benefitted BBC by ensuring that it would employ only qualified workers, BBC became claimant's employer.

In *Dykes v. SAIF*, 47 Or App 187, 613 P2d 1106 (1980), we upheld the denial of workers' compensation benefits on the basis that the claimant was not a worker performing services "for a remuneration" under what is now ORS 656.027(27).[1] The claimant was injured while he performed a physical agility test in the course of applying for a position as a deputy sheriff. Here, the record reveals that, before June 23, 1986, claimant's only contact with BBC was on April 29 and 30, 1986, when he performed a welding test for a position as a boiler maker and participated in an orientation "school." Claimant failed the test and was not hired at that time. As in *Dykes*, claimant was not performing services for remuneration when his hearing loss was first discovered. It follows that he was not a "worker," and that BBC could not have been employer under ORS 656.005(13).[2] We agree with BBC that, because there is not substantial evidence to support the Board's ruling, the Board erred in setting aside BBC's denial, holding it responsible for claimant's hearing loss claim as of June 23, 1986, and on that basis allowing attorney fees. Because of that conclusion, we need not address BBC's other assignments of error.

On the cross-petition, Combustion argues that ORS 656.386(1)[3] is "the only possible authorization" for the award of attorney fees to claimant and that, because it "never denied claimant's right to compensation [and] * * * the referee did not make a determination on that issue," the statute is inapplicable. We

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[1] ORS 656.005(27) provides, in part:

" 'Worker' means any person, including a minor whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer * * * ."

[2] ORS 656.005(13) provides:

" 'Employer' means any person * * * who contracts to pay a remuneration for and secures the right to direct and control the services of any person."

[3] ORS 656.386(1) provides:

"In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee. *If an attorney is instrumental in obtaining compensation for a claimant a hearing by the referee is not held, a reasonable attorney fee shall be allowed.* Attorney fees provided for in this section shall be paid by the insurer or self-insured employer." (Emphasis supplied.)

The italicized language was added by Oregon Laws 1991, chapter 312, section 1. It applies "to all claims for which an order relating to the issue on which attorney fees are sought has not become final on or before the effective date of this 1991 Act, regardless of the date of injury." Or Laws 1991, ch 312, Section 3.

remand for reconsideration in the light of ORS 656.386(1), as amended by Oregon Law 1991, chapter 312, section 1. *See Jones v. OSCI*, 108 Or App 230, ___ P2d ___ (1991).

Reversed on petition; reversed and remanded for reconsideration of attorney fees on cross-petition.

Cite as 108 Or App 653 (1991) September 11, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Juan A. Garcia, Claimant.

JUAN A. **GARCIA**, Petitioner,
v.
SAIF CORPORATION and BASIN FRESH FARMS, Respondents.
(89-08301; CA A67698)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 8, 1991.
Brad G. Garber, Salem, argued the cause for petitioner. With him on the brief was Michael B. Dye, Salem.
David L. Runner, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
BUTTLER, P.J.
Reversed and remanded to Board for consideration of penalties and attorney fees.

Claimant seeks review of an order of the Workers' Compensation Board reversing the referee and holding that SAIF could properly deny an injury claim that it had processed and accepted for an alleged noncomplying employer pursuant to ORS 656.054.[1]

On December 7, 1987, claimant was injured while working at Basin Fresh Farms, Inc. (Basin Fresh), then managed by James and Sandra Clark as a partnership doing business as T. W. Holsteins, under a lease with Basin Fresh. On that date, the stock of Basin Fresh was transferred to Melvin Ferguson, as trustee for Basin Fresh creditors; however, Ferguson had no control over the operations of the farm until January 5, 1988, when the Clarks transferred all of their rights in Basin Fresh to Ferguson, who agreed to hold them harmless from any claims made against them arising out of the operation of the farm.

At the time claimant was injured, T. W. Holsteins had a workers' compensation policy with SAIF; however, at its request, on February 9, 1988, the policy with SAIF was cancelled as of October 1, 1987.

On April 17, 1988, claimant filed claims against T. W. Holsteins and Basin Fresh, which SAIF denied on January 14, 1988, and April 13, respectively, on the ground that it did not provide insurance coverage for those entities on the date of the injury. Claimant filed a request for hearing on the denials, and listed, among other issues, the Workers' Compensation Division's failure to process the claim under ORS 656.307. On April 27, 1988, claimant wrote to the Hearings Division with reference to the claim against Basin Fresh, and requested that the matter be joined for hearing with the claim against T. W. Holstein.

After becoming aware of SAIF's denials of the claims against T. W. Holsteins and Basin Fresh, the Compliance Section of the Evaluation Division began an investigation concerning the compliance of Basin Fresh. On May 19, 1988, on the basis of the February agreement between the Clarks and Ferguson, the Compliance Section notified SAIF that Ferguson, as trustee for the benefit of the creditors of Basin Fresh, was a subject employer and was not insured; it asked SAIF to process a claim against Ferguson for claimant, as a claim against a noncomplying employer, pursuant to ORS 656.054. On June 2, 1988, SAIF accepted the claim against Ferguson, and began paying temporary total disability benefits to claimant. On the same date, SAIF wrote to claimant's counsel in response to a letter from him requesting the designation of a paying agent:

> "SAIF Corporation was notified by letter of May 19, 1988, from the Investigative Unit that Melvin D. Ferguson, Attorney, trustee for Basin Fresh Farms, was subject and noncomplying. SAIF Corporation has verbally notified Compliance that they have accepted [claimant's] claim for injury of December 7, 1987.
> "Under the circumstances, the department will not need to issue a .307 Order."

On August 17, 1988, claimant and SAIF entered into a stipulated order of dismissal of a request for hearing on the claim against Ferguson:

> "IT IS HEREBY STIPULATED by claimant, claimant's attorney, Stanley Fields and SAIF * * * as follows:
> "Claimant filed a claim for back injury sustained on or about December 7, 1987. At the time of claimant's injury or occupational disease exposure, claimant was working for a non-complying employer.
>
> "The claim was referred to SAIF Corporation for processing by the Workers' Compensation Division. The claim was accepted and processed under the above claim number.
>
> "Claimant, by this document, requests a hearing to appeal the rate of temporary total disability benefits and raise other issues.
>
> "The parties agree to settle all issues raised or raiseable at this time as follows:
>
> "a. SAIF Agrees to adjust claimant's earnings to $1,250 per month and to retroactively pay the increase in benefits from December 21, 1987, to July 21, 1988, in the amount of $619.69.
> "b. From the additional temporary total disability, and not in addition thereto, claimant's attorney is allowed a fee of 25 percent of the additional temporary total disability, not to exceed $750.
> "c. The Request for Hearing is dismissed with prejudice."

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[1] ORS 656.054(1) provides, in part:

"A compensable injury to a subject worker while in the employ of a noncomplying employer is compensable to the same extent as if the employer had complied with ORS 656.001 to 656.794. The director shall refer the claim for such an injury to the State Accident Insurance Fund Corporation within 60 days of the date the director has notice of the claim. A claim for compensation made by such a worker shall be processed by the State Accident Insurance Fund Corporation in the same manner as a claim made by a worker employed by a carrier-insured employer * * *."

Ferguson later requested a hearing concerning the noncomplying employer determination. Claimant did not appear at the December, 1988, hearing of that matter, relying on SAIF's having accepted the claim and his reasonable understanding that his right to compensation was not at issue. SAIF also waived appearance.

On January 24, 1989, a referee set aside the proposed order declaring Ferguson to be a noncomplying employer, because no employment relationship existed between claimant and Ferguson on the date of the injury and because any agreement between the Clarks and Ferguson to hold the Clarks harmless was a matter between those parties that did not affect the status of claimant's relationship with Ferguson. On March 9, 1989, for reasons that are not apparent on the record, the referee dismissed claimant's requests for hearings on the claims pending against T. W. Holsteins and Basin Fresh. That order became final.

On March 30, 1989, SAIF unilaterally terminated claimant's benefits on the claim against Ferguson, although claimant had not yet been declared medically stationary or released for work and had not returned to work. Claimant requested a hearing on the termination of his benefits. The referee held that SAIF had acted unreasonably, reinstated the acceptance and assessed a penalty and attorney fees because of the unilateral termination of benefits and the unreasonable delay in the payment of compensation. The Board reversed the referee, holding that SAIF was authorized to deny the claim when it discovered that Ferguson was not a noncomplying employer.

SAIF contends that this case is like *D Maintenance Company v. Mischke*, 84 Or App 218, 733 P2d 903, *rev den* 303 Or 483 (1987) and *Oak Crest Care Center v. Bond*, 101 Or App 15, 789 P2d 6, *rev den* 310 Or 121 (1990), where we said that the rule in *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027 (1983), prohibiting back-up denials, was not intended to prevent a denial of a previously accepted claim when the insurer discovers that it did not provide coverage to the employer on the date of the injury. If there is no coverage, there is no basis for payment, and the insurer cannot be held accountable. However, the situation here is different: In the two cases cited, the dispute was between insurance companies; the claimant's right to compensation was not at risk. Here, a denial of coverage under the circumstances created by SAIF would result in a loss of benefits to claimant for an injury that no one disputes arose out of his employment.

Claimant satisfied his obligation under the workers' compensation statutes by filing claims with each of the two entities potentially responsible for his injury. Having done that, he had no other duty but to establish that his injury was related to his employment. When the Compliance Section called upon SAIF to process the claim against Ferguson, SAIF had the duty to investigate claimant's status as an employee and to join any potentially responsible employers or insurers, just as it would have had if it had been processing a claim against its own insured. ORS 656.054(1); *Priest v. City of Hermiston*, 106 Or App 732, 809 P2d 1370 (1991). In disregard of that obligation and without any investigation, it accepted the claim against Ferguson and advised claimant that he did not need to pursue his claims or his hearing requests against the other potentially responsible entities. Having done that, SAIF may not deny the previously accepted claim on the basis of a lack of coverage.[2]

Reversed and remanded to the Board for consideration of penalties and attorney fees.

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[2] In its brief, SAIF says that "[a]s far as the record reflects, claimant still has a viable claim against the Clarks' partnership (dba T. W. Holsteins) or Basin Fresh as a noncomplying employer." In view of the dismissal of the requests for hearing on those claims, which became final, it is doubtful that either of them is viable.

Cite as 108 Or App 698 (1991) September 11, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Diane R. Douglas, Claimant.

FAIRLAWN CARE CENTER and LIBERTY NORTHWEST INSURANCE CORP., Petitioners,
v.
DIANE R. **DOUGLAS**, Respondent.
(WCB 88-19222; CA A65929)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 13, 1991.
Jerald P. Keene, Portland, argued the cause for petitioners. With him on the brief was Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C., Portland.
Robert E. Nelson, Gresham, argued the cause and filed the brief for respondent.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
ROSSMAN, J.
Affirmed.

Employer seeks review of a Workers' Compensation Board (Board) order reversing the referee and requiring that it pay temporary total disability benefits to claimant. We affirm.

There is substantial evidence to support the Board's findings:

> "Claimant sustained a compensable back injury on June 16, 1988. She subsequently received temporary total disability benefits. In September 1988, after obtaining claimant's physical limitations from the treating physician, the employer offered modified work within the light range to claimant.
>
> "The employer's September 13, 1988 offer letter did not satisfy all the requirements of the administrative rules [OAR 436-60-030(5).][1] Missing was the requirement of specifying a beginning date and time as well as an ending date. The employer's offer asked claimant to call during business hours if she wanted to accept the modified job.[2]

---

[1] OAR 436-60-030(5) provides, in part:

> "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 conditions:
>
> "* * * * *
>
> "(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." (Emphasis supplied.)

[2] The letter stated that, "if you wish to accept the light duty position described in this letter, please contact me at * * * during the hours of 9:00 am - 5:00 pm, Monday - Friday."

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

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

The referee concluded that employer's failure to specify starting and ending dates of employment did not nullify the offer, because the request that claimant call in to accept the job meant that a specific starting date had not been set and that claimant was "given some leeway" as to when to start the job and to contact employer about her decision. Therefore, the referee determined that employer had complied with the rule.

Before the Board, claimant did not object to the omission of the starting date of employment; rather, she argued that employer did not make the offer in good faith and that the letter did not comply with the rule, because it did not state the duration of the job. The Board concluded that, because the letter did not specify the starting date and duration of the job, it was only in substantial compliance with the rule and that, because the rule must be strictly adhered to, *substantial* compliance is not sufficient. *Eastman v. Georgia Pacific Corp.*, 79 Or App 610, 613, 719 P2d 1310 (1986). We conclude that the Board correctly held that the job offer letter did not adequately specify the starting date of the offered employment. The rule unambiguously requires that the employer specify the starting date, *see Eastman v. Georgia Pacific Corp., supra*, not, as employer contends, that question may be left to the claimant.

Affirmed.

Cite as 108 Or App 717 (1991) September 11, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Eddie Borrego, Claimant, and
In the Matter of the Complying Status of Morris Salter, Employer.

MORRIS **SALTER**, Petitioner,
v.
SAIF CORPORATION and EDDIE BORREGO, Respondents.
(88-18219 and 88-18220; CA A67685)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 26, 1991.
Paul A. Dakopolos, Salem, argued the cause for petitioner. With him on the brief was Garrett, Seideman, Hemann, Robertson, Paulus, Jennings & Comstock, P.C., Salem.
David L. Runner, Assistant Attorney General, Salem, argued the cause for respondent SAIF Corporation. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
No appearance for respondent Borrego.
Before Buttler, Presiding Judge, and Richardson and Rossman, Judges.
ROSSMAN, J.
Reversed and remanded.

Claimant was allegedly injured while working for the putative employer, Morris Salter (Salter). The Compliance Section of the Workers' Compensation Division issued a proposed order finding that Salter was a noncomplying employer

and requesting that SAIF process the claim pursuant to ORS 656.054. Salter requested a hearing as to the order of noncompliance. SAIF denied the claim. Salter issued his own denial, and claimant's attorney requested a hearing on Salter's denial. After that, SAIF rescinded its denial. It did not notify Salter of his right to request a hearing on the question of compensability, as required by former OAR 436-80-060(1)(d).

SAIF waived appearance at the hearing. The parties tried the issues of compliance and compensability to the referee. The referee found that claimant was the employee of Salter. She further found that claimant had not met his burden to show that he was injured in the course of his employment with Salter. Although the referee did not expressly hold that Salter was a noncomplying employer, that conclusion is implicit in her holding that claimant was an employee of Salter, as there has never been a contention made that he is not a subject worker and Salter admits that he had no workers' compensation insurance.

The Board decided that the referee lacked jurisdiction to consider whether the claim was compensable. Relying on *Clark v. Linn*, 98 Or App 393, 779 P2d 203 (1989), the Board held that Salter had no authority to deny the claim; accordingly, the denial was invalid and without effect, and claimant's request for hearing on that denial was a nullity and did not give the referee "jurisdiction" over the question of compensability. Salter had not requested a hearing on SAIF's ultimate acceptance of the claim and the Board believed that the compensability of the claim had not been put to issue by Salter's request for hearing on the noncomplying employer order. It held that the only issue before the referee had been the question of compliance, and stated that, in such a case, its only function is to appoint a referee to hold a hearing. The order of the referee then becomes the order of the Director, which is reviewable by the Court of Appeals. ORS 656.740(4). Believing that the referee had not reached the issue of compliance, the Board remanded the case to the referee for a determination of that question. Salter seeks review.

SAIF argues that, because Salter had made no written request for hearing on the question of compensability as required by ORS 656.283(3),[1] the matter was not properly before the referee.[2] We conclude that the question of compensability was properly before the referee. As we have said, the referee implicitly concluded that Salter was non-complying. Although it is true that employer did not file a written request for hearing on compensability, the requirements of ORS 656.283(3) are not jurisdictional. The question of compensability was raised orally and was tried to the referee without objection by SAIF or

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[1] ORS 656.283 provides, in part:

> "[A]ny 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, requesting the hearing, stating that a hearing is desired, and mailed to the board."

[2] In its brief, SAIF originally conceded that the Board erred in concluding that the referee did not have jurisdiction to consider the compensability of the claim, in light of the fact that the statutes provide no deadline within which an employer may request a hearing on compensability, but see OAR 436-80-060(2)(d), and the matter had been tried to the referee. At oral argument, SAIF withdrew its concession.

claimant. Thus, although the question of compensability had not been raised by Salter before the hearing, Salter did raise the issue at the hearing, and that was sufficient to put it to the referee. The Board erred in holding that the question of compensability was not properly before the referee. On remand, it should consider that question, de novo.

Reversed and remanded.

Cite as 108 Or App 721 (1991) September 11, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Mickey D. Simpson, Claimant.

MICKEY D. **SIMPSON**, Petitioner,
v.
SKYLINE CORPORATION and CNA INSURANCE COMPANIES, Respondents.
(WCB 89-17573; CA A67889)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 26, 1991.
Arthur P. Klosterman, Salem, argued the cause for petitioner. With him on the brief was Whitehead & Klosterman, Salem.
Jerry K. Brown, McMinnville, argued the cause for respondents. With him on the brief was Cummins, Brown, Goodman, Fish & Peterson, P.C., McMinnville.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
ROSSMAN, J.
Affirmed.

Claimant seeks review of an order the Workers' Compensation Board that affirmed the referee's denial of his request for attorney fees. Claimant sustained a compensable injury while working for employer. The claim was closed by a determination order, which made an award of unscheduled permanent partial disability benefits. Claimant was referred to vocational assistance and later received a Notice of Ineligibility for benefits on the ground that he had voluntarily left a suitable light duty position with employer.

Claimant's attorney sought review of the Notice of Ineligibility pursuant to ORS 656.283(2) and OAR 436-120-210. The Director of the Department issued an order requiring insurer to refer claimant to a vocational counselor for an eligibility evaluation, and, if claimant was found to be eligible, for services.

Claimant was found to be eligible for services. At the hearing requested by claimant for the purpose of obtaining insurer-paid attorney fees, it was stipulated that claimant's attorney spent three hours in relation to claimant's claim for vocational assistance, and that claimant's efforts were instrumental in gaining eligibility. The referee held that a fee was authorized to be paid out of compensation, but that ORS 656.386(1) provided no basis for an award of insurer-paid fees. The Board affirmed, and on review, claimant again contends that he is entitled to insurer-paid attorney fees under ORS 656.386(1) as amended by the legislature in 1991, for having succeeded in overturning employer's denial of his claim for vocational services.[1]

The short answer is that the question of whether claimant is entitled to vocational assistance concerns only the availability of a certain type of benefit, rather than whether claimant's condition was caused by his industrial injury, and, therefore, ORS 656.386(1) is not applicable. *Short v. SAIF*, 305 Or 541, 545, 754 P2d 575 (1988).

Affirmed.

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[1] The statute now 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. If an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held, a reasonable attorney fee shall be allowed. Attorney fees provided for in this section shall be paid by the insurer or self-insured employer."

Cite as 108 Or App 771 (1991) September 11, 1991

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Kathleen M. Payne, Claimant.

CITY OF PORTLAND, Petitioner,
v.
KATHLEEN M. **PAYNE**, Respondent.
(88-14535; CA A66838)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 7, 1991.
David L. Jorling, Deputy City Attorney, Portland, argued the cause and filed the brief for petitioner.
Victor Calzaretta, Portland, argued the cause and filed the brief for respondent.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
PER CURIAM--Reversed and remanded for reconsideration.

Employer seeks review of the Workers' Compensation Board's order reversing the referee in part and holding that claimant's mental stress condition is compensable. We agree with the Board's interpretation of ORS 656.802(2)(b)[1] and its conclusion that the phrase "generally inherent in every working situation" means "usually present in all jobs and occupations." *Housing Authority of Portland v. Zimmerly*, 108 Or App 596, ___ P2d ___ (1991). The Board held, however, that in order to establish a mental disorder under ORS 656.802(1)(b), claimant need only show that her employment materially contributed to her mental disorder. We reverse and remand the case for reconsideration in the light of *Aetna Casualty Co. v. Aschbacher*, 107 Or App 494, 812 P2d 844 (1991).

Reversed and remanded for reconsideration.

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[1] At the relevant time, ORS 656.802(2)(b) provided, in part:

"Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter:
"* * * * *
"(b) Unless the employment conditions producing the mental disorder are conditions other than conditions inherent in every working situation."

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
Ernest F. Erck, Claimant.

Ernest F. ERCK,
Petitioner on Review,

v.

BROWN OLDSMOBILE
and EBI Companies,
Respondents on Review.

(WCB No. 86-05134; CA A47689; SC S36203)

On review from the Court of Appeals.*

Argued and submitted November 2, 1989.

Robert K. Udziela, Portland, argued the cause for petitioner on review. With him on the petition were Phil Goldsmith, Donald R. Wilson, and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Randy G. Rice, Portland, argued the cause and filed the response for respondents on review.

Before Peterson, Chief Justice, and Linde,** Carson, Jones,*** Gillette, Van Hoomissen, and Fadeley, Justices.

CARSON, J.

The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is affirmed.

* Judicial Review from Workers' Compensation Board. 95 Or App 400, 768 P2d 946 (1989).

** Linde, J., retired January 31, 1990.

*** Jones, J., resigned April 30, 1990.

CARSON, J.

The issue in this workers' compensation case is how the Workers' Compensation Board (Board) must treat a referee's express credibility finding on review of the referee's order. The Court of Appeals, concluding that the Board's order was supported by substantial evidence, and otherwise was proper, affirmed the Board order reversing the referee's award of permanent total disability. *Erck v. Brown Oldsmobile,* 95 Or App 400, 768 P2d 946 (1989). We allowed review to address the requirements for a Board order that reverses an order of a referee, when the latter includes a credibility finding. We affirm the decision of the Court of Appeals.

Background

Claimant was 62 years old and had a ninth grade education at the time of the hearing before the referee. He had worked as an automobile body painter since 1947—vir-

tually his entire adult life. In 1984, claimant was diagnosed with isocyanate asthma, a form of pulmonary disease caused by exposure to certain chemicals in the automobile paint used in his work. He filed a claim for workers' compensation benefits. In 1985, a workers' compensation referee found that claimant was permanently partially disabled. At the time of the hearing in this case, claimant had not worked since leaving his job as an auto-body painter.

From February to October 1985, claimant received statutorily required "return-to-work" assistance from Orion Rehabilitation Service, Inc.[1] His case then was referred to Hetfield Associates, Inc., another provider of vocational rehabilitation services. Claimant testified that the vocational counselor at Hetfield did nothing to help him return to work. The counselor maintained that claimant did not cooperate in her efforts to provide vocational assistance, as claimant had no desire to return to work. After some effort to provide claimant with return-to-work assistance, and after several letters to him warning that his failure to cooperate would lead

to termination of the assistance, his vocational assistance was discontinued in April 1986.[2]

Meanwhile, claimant's claim was closed by a determination order in February 1986, awarding 30 percent (96 degrees) unscheduled permanent partial disability. Claimant requested a hearing on the extent of his disability, asserting that he was permanently totally disabled. ORS 656.268(9) (formerly 656.268(6)). The referee considered the hearing testimony both of claimant and of the Hetfield vocational counselor regarding the extent of claimant's cooperation in the vocational assistance.[3] The referee concluded:

> "Given the impact on claimant of his substantial loss of pulmonary function and his ouster from his only known trade and skill, as well as his lack of education and training, it would appear that he participated in vocational rehabilitation efforts about as far as he was able.
>
> "It is my observation that claimant was an honest, credible witness in his own behalf, and I conclude that the lack of motivation is an unfair charge * * *."

[1] ORS 656.340(1) requires the employer/insurer to provide vocational assistance to an injured worker who is eligible for assistance in returning to work.

[2] OAR 436-120-045 (formerly numbered 436-120-090) provides that the eligibility of a worker for vocational assistance ends when (among other things) the "worker has failed, after written warning, to cooperate in the development of a return-to-work plan."

[3] ORS 656.206(3) provides that the "worker has the burden of proving permanent total disability status and must establish that the worker is willing to seek regular gainful employment and that the worker has made reasonable efforts to obtain such employment." OAR 436-30-055(3)(b) provides that in order for a worker to be determined permanently totally disabled, the worker must "[s]how a willingness to seek regular work at a suitable and gainful occupation and make reasonable efforts to find such work, or *actively participate in a vocational assistance program* unless the medical condition makes such efforts futile." (Emphasis added.) Non-cooperation in vocational rehabilitation efforts thus may establish an unwillingness to seek employment, or a lack of reasonable efforts to obtain employment, for purposes of ORS 656.206(3), which consequently will preclude a finding of permanent total disability. *See Taylor v. SAIF*, 67 Or App 193, 196, 677 P2d 756 (1984); *Willamette Poultry v. Wilson*, 60 Or App 755, 761, 654 P2d 1154 (1982), *rev den* 294 Or 569 (1983) (illustrating application of the rule).

The referee issued an opinion and order concluding that claimant was permanently totally disabled. The insurer requested Board review of the referee's order. The Board reversed the referee's order and awarded claimant 45 percent (144 degrees) permanent partial disability in addition to the 30 percent awarded by the 1986 determination order. The Board explained:

> "We disagree with the Referee's analysis. Claimant's treating doctor indicated that he was capable of light work on a full-time basis. The vocational counselor who attempted to help him opined that he was employable. Although there is evidence that claimant is reserved and noncommunicative, there is no indication that these difficulties were so severe as to excuse claimant's failure to maintain contact with the vocational counselor. He had no apparent difficulty communicating with his doctors or at the hearing. We conclude that claimant, in essence, refused vocational assistance and that he has failed to establish that he is willing to seek regular gainful employment or that he has made reasonable efforts to obtain such employment. ORS 656.206(3). He, therefore, is not entitled to an award of permanent total disability."

In upholding the Board's order, the Court of Appeals concluded: "The Board's order is sufficient for review, there is substantial evidence to support its findings, and its reasoning connects those findings to the conclusion." *Erck v. Brown Oldsmobile, supra,* 95 Or App at 401.

The Claims Process

A worker's claim for benefits under the Workers' Compensation Law potentially is subject to several levels of review. The injured worker first must give written "notice of an accident resulting in an injury" to the employer. ORS 656.265. This is treated as notice of a claim. The employer or its insurer must either accept or deny the claim within the statutory time period (60 days at the time the claim was filed in this case). ORS 656.262(6). If the claim is denied, the worker may request a hearing on the denial within 60 days after notice of the denial is mailed. ORS 656.262(8); 656.319; 656.283(3). The referee who presides over the hearing is required to issue an order deciding the matter within 30 days of the hearing. ORS 656.289(1). Either party may then request Board review of the referee's order within 30 days. ORS 656.289(3).

Review by the Board is based upon the record developed before the referee and oral or written argument by the parties. ORS 656.295(5). "The board may affirm, reverse, modify or supplement the order of the referee and make such disposition of the case as it determines to be appropriate." ORS 656.295(6). That is, the Board reviews *de novo. See*

Sahnow v. Fireman's Fund Ins. Co., 260 Or 564, 491 P2d 997 (1971) (description of this scope of review as *de novo*). Either party then may request judicial review of the Board's order by the Court of Appeals, ORS 656.298(1), which review is "on the entire record forwarded by the board." ORS 656.298(6).

The Court of Appeals reviews the Board order under the standards set forth in ORS 183.482(7) and (8),[4] part of which includes a review to determine whether the Board erroneously interpreted a provision of law and whether the Board's order is supported by "substantial evidence in the record." *Id.* Following a decision by the Court of Appeals, either party may petition this court for review of the Court of Appeals' decision. ORS 2.520.

The point of the recitation above is that a worker's claim for benefits may be evaluated as many as five times; the first three (the employer/insurer, the referee, and the Board) may include factfinding,[5] while the last two (the Court of Appeals and this court) are reviews of legal issues under the standards set forth in ORS 183.482(7) and (8).

Claimant's Position

Claimant does not contend that a referee must in all cases make credibility findings. Rather, he argues that when a referee does make express findings regarding a witness's credibility (as was the case here), the Board either must adopt those findings or explain why it departed from them. He argues that failure to do so constitutes an erroneous interpretation of a provision of law, requiring that the Court of Appeals remand the case under ORS 183.482(8)(a)(B). Alternatively, he argues that the Court of Appeals "misapplied the substantial evidence rule" when it affirmed the Board order. *See* ORS 183.482(8)(c).

Under the provisions of ORS 183.482(8) relevant to this case, the Court of Appeals (1) may reverse or remand a Board order if the Board has erroneously interpreted a provision of law, and (2) shall reverse the Board order if it is not supported by substantial evidence in the record. Claimant argues that the Board's failure to explain its "rejection" of the referee's credibility findings requires reversal and

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[4] ORS 183.482 provides, in part:

"(7) Review of a contested case shall be confined to the record, the court shall not substitute its judgment for that of the agency as to any issue of fact or agency discretion. * * *

"(8)(a) The court may affirm, reverse or remand the order. If the court finds that the agency has erroneously interpreted a provision of law and that a correct interpretation compels a particular action, it shall:

"(A) Set aside or modify the order; or

"(B) Remand the case to the agency for further action under a correct interpretation of the provision of law.

"(b) The court shall remand the order to the agency if it finds the agency's exercise of discretion to be:

"(A) Outside the range of discretion delegated to the agency by law;

"(B) Inconsistent with an agency rule, an officially stated agency position, or a prior agency practice, if the inconsistency is not explained by the agency; or

"(C) Otherwise in violation of a constitutional or statutory provision.

"(c) The court shall set aside or remand the order if it finds that the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding."

[5] Under circumstances not here relevant, the Board may receive additional evidence. ORS 656.295(5).

remand under either of the foregoing provisions. For the reasons discussed below, we do not believe the statutory scheme for Board review of a referee's decision contains such a requirement.

Erroneous Interpretation of a Provision of Law

The crux of claimant's first argument is that our cases relating to the deference to be given a factfinder upon review constitute a "provision of law," ORS 183.482(8)(a), that requires the Board to justify its rejection of a referee's explicit credibility findings. To support this position, claimant relies on cases from this court, from the Court of Appeals, and from the federal courts, all stating that a factfinder's credibility assessments are to be given deference upon review.

Claimant is correct in his argument that on *de novo* review, a reviewing entity normally gives deference to findings made below, especially when they relate to witness credibility. For example, in *Ryf v. Hoffman Construction Co.*, 254 Or 624, 631, 459 P2d 991 (1969), this court—on *de novo* review of a workers' compensation award—stated: "[W]e * * * have to give some weight to the fact that the Hearing Officer, and he alone, has the opportunity to observe the

claimant and other witnesses, a factor which we have regarded as highly significant in reviewing other cases on appeal." *See also Haines Com'l Equip. Co. v. Butler,* 268 Or 660, 664, 522 P2d 472 (1974) ("we accord great weight to [a trial court's findings of fact] when, as in this case, the testimony was conflicting"); *Bragger v. Oregon Trail Savings,* 275 Or 219, 221, 550 P2d 421 (1976) ("[t]he trial judge is in a much better position to assess the credibility of the witnesses than is this court and his conclusion * * * is entitled to considerable weight").

As claimant notes, prior to 1987, the Court of Appeals reviewed Board orders *de novo,* and it rarely (if ever) reversed the Board's adoption of a referee's finding on credibility without an explanation. *See, e.g., Coastal Farm Supply v. Hultberg,* 84 Or App 282, 285, 734 P2d 1 (1987) ("we generally defer to the referee's determination of credibility, when it is based on the referee's opportunity to observe the witnesses").

We agree that on *de novo* review, it is good practice for an agency or court to give weight to the factfinder's credibility assessments. However, the issue is not whether such practice is commendable, but whether it is statutorily mandated. Nowhere in ORS 656.298(6) (incorporating the ORS 183.482(7) and (8) standard of review) do we find a *requirement* that the Board explain its conclusions that are contrary to a referee's credibility determination. The Board's statutory charge is to "affirm, reverse, modify or supplement the order of the referee and make such disposition of the case

as it determines to be appropriate." ORS 656.295(6).[6] The issue on judicial review under ORS 183.482(8)(a) is whether the Board's order (regardless of what the referee's order

stated) shows an erroneous interpretation of a provision of law.

In summary, we do not read ORS 656.298(6) to impose, as a matter of law, a requirement that the Board explain its rejection of a referee's express credibility findings. By failing to address a referee's credibility findings, the Board does not erroneously interpret a provision of law, requiring that the Court of Appeals reverse the Board's order.[7]

Order Not Supported by Substantial Evidence in the Record

Claimant next argues that the Court of Appeals should have remanded this case to the Board because the Board "had to explain why it rejected the referee's findings even on issues other than credibility." Claimant invites this court to hold that "a Board order reversing a referee can be sustained under the substantial evidence test only if the Board explains why it has rejected the referee's contrary findings." In failing to remand the case, claimant argues, the Court of Appeals "adopted an overly literal interpretation of the substantial evidence rule."

"Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding." ORS 183.482(8)(c). Claimant appears to argue that the Board's failure to address the referee's credibility finding, together with the other evidence in the record (contradicting the Board's findings), do not add up to a record that, "viewed as a whole, would permit a reasonable person to make that finding." In essence, claimant asserts that the Board's finding that claimant "failed to

[6] In response to this court's questions, claimant argued that the Board was a "reviewing" agency, rather than a "deciding" agency. We disagree. A request for a hearing is made to the Board, which then refers the request to a referee. ORS 656.283(4). In essence, the referee aids the operation of the Board by conducting an evidentiary hearing and producing an order. Although the Board *may* adopt the referee's order, it is the decision and order of the Board that the Court of Appeals examines. Thus, even though we refer to the Board's function as *de novo* review, it truly is a deciding agency. This referee-Board function in the workers' compensation arena contrasts with the more independent relationship between a referee and the agency in other contexts. *See, e.g.*, ORS 657.270 (Employment Division, not Employment Appeals Board, designates referee to conduct hearing).

[7] We note that the value of a credibility finding varies widely, depending upon the nature of the issue to which it is relevant. In some cases, a finding that one witness is credible necessarily is a finding that another witness is not credible. For example, if "A" testifies that the traffic light was green and "B" testifies that the light was red, a statement by a referee that he finds "B's" testimony credible also is a finding that "A's" testimony is not credible.

But a finding that the testimony of one witness is credible often has no implication for the credibility of other witnesses. A referee's statement that he finds a claimant to be "an honest, credible witness in his own behalf," for example, does not necessarily signify that the referee finds other testimony to be not credible; it simply depends upon the nature of the factual issue to which the testimony relates. In the present case, we assume—but do not decide—that the referee found the testimony of the vocational rehabilitation counselor not to be credible.

cooperate in the development of a return-to-work plan" is not supported by substantial evidence unless the Board explains why it departed from the referee's credibility assessment.

This position represents a misunderstanding of an appellate court's scope of review when evaluating the Board's order for substantial evidence. To comply with ORS 183.482(8)(c) (made applicable to judicial review of Board orders by ORS 656.298(6)), an agency order should include findings of fact that support its conclusions of law. *See* ORS 183.470. The Board's findings must, in turn, be supported by substantial evidence. Although the Board should seriously consider the testimony the referee believes to be reliable, the "substantial evidence" standard does not require the Board to adopt the referee's findings or to "explain away" disparities between the Board's and the referee's determinations. *Cf. Garcia v. Boise Cascade Corp.*, 309 Or 292, 296, 787 P2d 884 (1990) ("[t]he appropriate question was not whether substantial evidence supported claimant's claim, but whether substantial evidence supported the referee's decision"). It is adequate for the Board to address the "credibility" issue by clearly setting forth its findings. It is the Court of Appeals' responsibility in this process to ensure that those findings are reasonable in light of the entire record.

Conclusion and Disposition

Did the Court of Appeals err in finding that the Board's order was supported by substantial evidence and, implicitly, that the Board did not erroneously interpret a provision of law? The Board made the following findings:

> "[T]he vocational counselor attempted to develop a return-to-work plan, but claimant did not maintain contact with her or return her calls. In February 1986, the counselor sent claimant a letter warning him that failure to participate could result in the termination of vocational services. Claimant's attorney replied to the letter, stating that claimant did not understand how vocational services would help him, but that he was willing to cooperate. After this, the counselor attempted to contact claimant on a number of occasions, but received no reply. Vocational assistance was terminated in April 1986 on the ground that claimant had not participated in developing a return-to-work plan. Claimant did not protest or appeal the termination of vocational services."

From these findings and others, the Board concluded that "claimant, in essence, refused vocational assistance and that he has failed to establish that he is willing to seek regular gainful employment or that he has made reasonable efforts to obtain such employment."

The record, viewed as a whole, contains substantial evidence supporting the Board's findings and conclusions and its order followed from its conclusions. ORS 183.482(8)(c). The Court of Appeals applied the correct standard of review in holding that the Board did not err.

The decision of the Court of Appeals is affirmed. The order of the Workers' Compensation Board is affirmed.

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