VAN NATTA'S
WORKERS' COMPENSATION REPORTER

VOLUME 44

(Pages 657-1420)

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

44 Van Natta ____ (1992)

VAN NATTA'S
WORKERS' COMPENSATION REPORTER
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This binder and the enclosed pages 657-924 are the initial installment of Board orders for the second quarter of Volume 44, April-June 1992. These pages contain Board orders through May 8.

Subsequent installments arriving between now and July should be placed in this binder.

(This page may be discarded at the convenience of the user.)

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In the Matter of the Compensation of
ROBERT W. BRIGHT, JR., Claimant
WCB Case Nos. 90-15791 & 90-15790
ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of Referee Spangler's order which set aside its denial of claimant's aggravation claim for a left shoulder condition. On review, the issue is claimant's entitlement to additional temporary disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except the "Ultimate Findings of Fact," with the following supplementation.

The July 19, 1990 "aggravation" incident was unwitnessed.

When claimant and the plant manager arrived at the hospital, claimant's head was bent over toward his left shoulder. As they waited for claimant to be examined, they watched television and the plant manager noticed that claimant began holding his head upright.

The plant manager accompanied claimant in the examining room. Dr. Crocker asked claimant to move his left arm in front of his body and to the side and back. Claimant moved it very slowly and very gingerly. Dr. Crocker noted that claimant's range of motion was limited to 60 degrees abduction. Crocker did not notice any other objective signs of pain, except for claimant's elevated blood pressure and pulse, which he noted could be caused by anxiety.

Claimant was reexamined by Dr. Crocker on July 23, 1990. Crocker reported no evidence of muscle spasm indicating pain and that, while the objective indicators of claimant's physical condition had improved, his subjective complaints had increased.

Dr. Whitney, claimant's treating physician, examined and treated claimant with injections in both shoulders five times between July and December 1990. Whitney stated that on one visit claimant's "bad" shoulder would be his right shoulder and on the next visit claimant's left shoulder would be the "bad" shoulder. Whitney also noted that claimant's subjective pain symptoms changed rapidly, while the objective findings indicated that his physical condition had not changed since Whitney treated him in February 1990, prior to the alleged incident. An August 1990 arthrogram performed on claimant was negative.

CONCLUSIONS OF LAW AND OPINION

Because claimant requested a hearing after May 1, 1990 and the hearing was convened after July 1, 1990, we analyze this matter under the workers' compensation law as amended by Oregon Laws 1990 (Special Session) effective July 1, 1990. See 1990 Oregon Laws, ch. 2, Senate Bill 1197, Sec 54 (2); Ida M. Walker, 43 Van Natta 1402 (1991).

The Referee found that claimant established a compensable aggravation of his June 1989 compensable injury. On review, the parties argue over whether the medical evidence establishes a compensable aggravation. However, after our de novo review, we find that, because claimant's compensable June 1989 injury claim was not closed until after the date of the alleged July 1990 aggravation,

the issue is more accurately formulated as entitlement to temporary total disability (TTD). See Rodgers v. Weyerhaeuser Company, 88 Or App 458 (1987).

A worker whose temporary disability benefits have been properly terminated becomes entitled to resumption of temporary benefits, if prior to claim closure, the attending physician again authorizes time loss. Former OAR 436-60-0030(4)(a) and (6)(a); Rodgers v. Weyerhauser Company, supra. Futhermore, while claimant is not required to establish that his condition has worsened in order to be entitled to temporary disability, he must prove by a preponderance of the evidence that he was disabled during the time due to the compensable claim. ORS 656.210; Rodgers v. Weyerhauser Company, supra; Botefur v. City of Creswell, 94 Or App 627 (1987).

Here, shortly after his June 22, 1989 compensable left shoulder injury, claimant was released to return to modified work by Dr. Whitney. Claimant returned to work and, on April 26, 1990, was found medically stationary by Dr. Lanway, claimant's treating chiropractor. (Ex. 10). After the alleged July 19, 1990 "aggravation" incident, Dr. Crocker, an emergency room physician, noted limited left shoulder motion, prescribed medication and restricted claimant to light duty work. (Ex. 23-9). Shortly thereafter, Dr. Whitney noted a limited range of left shoulder motion, prescribed medication and authorized additional time loss. (Ex. 13A).

While these initial opinions support claimant's TTD claim, based on the subsequent depositions of Dr. Crocker and Dr. Whitney, we are persuaded that the proponderance of the evidence does not indicate that claimant was disabled due to his compensable claim.

At deposition, the insurer's counsel described to Crocker and Whitney an incident that occurred on July 19, 1990 at the hospital immediately after Crocker examined claimant. The incident was witnessed by the plant manager whose testimony about the incident was unrebutted at the hearing. During the medical examination at the hospital, claimant very slowly and very gingerly moved his arm in various directions. (Tr. 53-57 and Ex. 21-12 and 23-11). The incident in question occurred after the examination. Specifically, claimant stopped to purchase a soda pop and effortlessly used his left arm to put a prescription bottle on top of the vending machine, reach across his body to his pocket for change and reach up again to get the prescription bottle. (Id). Claimant demonstrated no pain while accomplishing these movements. (Id).

In learning of this incident, Dr. Crocker testified that claimant's ability to use his arm in that manner contradicted the range of motion findings he made when he examined claimant five minutes earlier. (Ex. 23-11). Crocker said "either [claimant] got well real fast or his reporting during the examination was unreliable." (Exs. 23-11 to 23-12). Dr. Whitney had the same reaction to the incident. Whitney testified that using his arm in that manner should have been very uncomfortable and difficult. (Ex. 21-12). Moreover, based on his exam, Whitney could not have expected that movement to have been accomplished voluntarily. (Exs. 21-12 to 21-13).

In exercising do novo review, we generally defer to the Referee's determination of witness credibility based on demeanor. Here, while the Referee found that the soda pop machine incident cast some doubt on claimant's credibility, the Referee concluded that "nothing about his demeanor leads me to conclude that he was a noncredible witness." We do not understand this statement to be a demeanor finding that claimant testified truthfully, and under the circumstances, we would not consider it entitled to deference were it intended as such.

After our review of the record in this case, we find that there are numerous inconsistencies between claimant's reported symptoms on the one hand and his

behavior and the objective medical evidence on the other, to cast substantial doubt on claimant's reliability. Moreover, in light of these inconsistencies, we conclude that the opinions of Drs. Crocker and Whitney were based on inaccurate and unreliable information from the claimant. Consequently, we do not consider their opinions to be persuasive evidence that claimant was unable to work during the time in question. See Miller v. Granite Construction, 78 Or App 473, 476 (1977). Accordingly, claimant has not established that he was disabled during the time in question due to his compensable injury claim.

ORDER

The Referee's order dated June 18, 1991 is reversed in part and affirmed in part. The insurer's denial of claimant's aggravation claim is reinstated and upheld. The Referee's award of a $2,000 assessed attorney fee is also reversed. The remainder of the order is affirmed.

April 1, 1992 Cite as 44 Van Natta 659 (1992)

In the Matter of the Compensation of
JAMES A. HILARY, Claimant
WCB Case No. 90-20640
ORDER ON REVIEW
Jolles, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of those portions of Referee Schultz' order which: (1) increased claimant's unscheduled permanent disability award for a cervical injury from 12 percent (38.4 degrees), as awarded by Determination Order, to 19 percent (60.8 degrees); and (2) increased claimant's scheduled permanent disability award for a right arm condition from 23 percent (44.16 degrees), as awarded by Determination Order, to 26 percent (49.92 degrees). On review, the issue is extent of scheduled and unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

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

Unscheduled Permanent Disability

Because claimant's condition became medically stationary on May 25, 1990, and his claim was closed by Determination Order on July 12, 1990, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq.

The parties stipulated that the appropriate values for age, formal education and skills are 1, 0, and 3, respectively.

The Referee concluded that: (1) claimant's adaptability factor should be 2.5; (2) claimant was entitled to an award for a C5-6 disc; and (3) claimant was entitled to an award for a chronic condition which limits repetitive use of his neck. The employer challenges each of these conclusions.

The employer argues that the correct adaptability factor is 1.5, since claimant's physician released him with permanent restrictions in the medium range. We do not agree.

Claimant returned to modified work in the light to sedentary range. This is the job claimant held at the time of hearing. Claimant has never returned to a job at or above the medium range jobs he performed prior to his injury. Accordingly, his 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 David A. Martina, 43 Van Natta 1900 (1991); Cleophas C. Chambliss, supra. Consequently, we agree with the Referee that the appropriate adaptability factor is 2.5.

The employer contends that claimant has not proven that his C5-6 disc bulge is due to his compensable injury. We do not agree. Any injury-related unoperated disc bulge or other disc derangement is entitled to a value of 4 percent. Former OAR 436-35-350(2). Claimant must establish that the C5-6 disc bulge is "due to" the compensable injury. ORS 656.214(5); Raymond S. Voller, 43 Van Natta 73 (1991).

After our de novo review, we conclude that claimant has established his disc bulge is due to the compensable injury. Dr. Fuchs opined: "This finding of disc protrusion is characteristic of the neurofunctional deficit that has become one of [claimant's] more common symptom patterns. This disc was apparently damaged on the job. Running heavy equipment over an uneven concrete surface probably jammed the involved disc causing the protrusion." Moreover, Dr. Pedersen reported that he found claimant's decreased grip strength, sensory loss and MRI findings (disc bulge) to be permanent sequelae of the compensable injury. We conclude claimant has proven the C5-6 disc bulge is due to the compensable injury.

The Referee found that claimant had a chronic condition limiting repetitive use of his head and neck. The employer argues claimant is not entitled to an award for a chronic condition. A chronic condition must be measured by a physician. See former OAR 436-35-005(1); William K. Nesvold 43 Van Natta 2767 (1991). The most recent medical reports in the record, from Dr. Fuchs, Dr. West and Dr. Pedersen, report that claimant has full range of motion of the neck. None of these reports document a chronic condition which limits repetitive use of claimant's neck. Accordingly, we find that claimant has not established that he has a chronic condition limiting repetitive use of his neck.

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 3, the sum is 4. When that value is multiplied by claimant's adaptability value 2.5, the product is 10. When that value is added to claimant's impairment value 4, the result is 14 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 14 percent.

Scheduled Permanent Disability

The Referee found claimant had 26 percent scheduled permanent partial disability of his right arm. In making this determination, the Referee relied on Dr. Pedersen's May 25, 1990 report. Dr. Pedersen found 7 percent impairment resulting from a grip strength deficit caused by damage to the median nerve. Dr. Pedersen also found 21 percent impairment for "sensory and brain impairments." Using these figures, the Referee found that under former OAR 436-35-110(3)(a) claimant was entitled to 22 percent impairment. Former OAR 436-35-110(3)(a) provides for a rating for sensory loss or grip strength loss due to median nerve damage.

The employer argues that claimant's impairment should have been rated under former OAR 436-35-110(8) which applies when grip strength loss is due to spinal nerve root injury. The employer argues that claimant's right arm problems are caused by nerve root impairment due to the compensable neck injury, not to an injury to the arm itself.

Dr. Pedersen's finding of 7 percent impairment resulting from grip strength loss due to damage to the median nerve is ratable under former OAR 436-35-110(3)(a). However, he gives no explanation of how the median nerve damage is related to the compensable neck injury. Moreover, Pedersen does not explain whether claimant's prior fracture of the right wrist could be responsible for the median nerve damage as opposed to the compensable neck injury. Accordingly, we are unable to rate claimant's impairment, because median nerve damage, which is ratable under the "standards" has not been proven to be related to claimant's compensable neck injury.

In addition, Dr. Pedersen's finding of 21 percent impairment for "sensory and brain impairments" is not ratable under the "standards."

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. Pedersen found mild but significant findings in both sensory and motor exam procedures, mild weakness of the right deltoid, mild to moderate weakness of the right grip and mild weakness in the right wrist extensors. The dominant right hand grip strength was 15 to 20 percent less that the left, whereas the dominant hand is normally 15-20 percent stronger. Along with the sensory and MRI findings, the grip strength loss was considered by Pedersen to be a permanent sequela of the compensable injury. Dr. Pedersen also found continued findings of paresthesia in the C5 and C6 dermatomes. In addition, claimant testified he experienced inflammation of his neck and right shoulder, tingling in his arm and noticeable weakness of the right arm since the compensable injury.

Under these circumstances, we find it highly probable that claimant's loss of use or function exceeds the 0 percent allowed under the "standards." Accordingly, we conclude that claimant has sustained 20 percent loss of use or function of his right arm. Therefore, we modify the Referee's 26 percent award.

The employer had requested a hearing seeking reduction of the Determination Order award. When the employer's attempt to reduce claimant's award was unsuccessful, the Referee awarded a carrier paid attorney fee of $750, pursuant

to ORS 656.382(2). Inasmuch as we have reduced claimant's scheduled permanent disability award below that granted by the Determination Order, we also modify the Referee's attorney fee award. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing concerning the extent of unscheduled permanent disability issue is $600, 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), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney might go uncompensated.

ORDER

The Referee's order dated June 14, 1991 is modified. In lieu of the Referee's award and in addition to the Determination Order award of 12 percent (38.4 degrees), claimant is awarded 2 percent (6.4 degrees) unscheduled permanent partial disability, giving claimant a total unscheduled permanent disability award to date of 14 percent (44.8 degrees). In lieu of the Determination Order and the Referee's award totaling 26 percent (49.92 degrees), claimant is awarded 20 percent (38.4 degrees) scheduled permanent partial disability. In lieu of the Referee's $750 carrier-paid attorney fee, claimant is awarded an assessed attorney fee of $600, payable by the employer.

In the Matter of the Compensation of
JEAN E. STUMP, Claimant
WCB Case No. 90-19219
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
H. Thomas Anderson (Saif), Defense Attorney

Reviewed by Board Members Gunn and Tenenbaum.

The SAIF Corporation requests review of Referee Quillinan's order that granted claimant an award of permanent total disability. On review, the issue is permanent total disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

To prove entitlement to permanent total disability, claimant must establish that she is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206; Wilson v. Weyerhaeuser, 30 Or App 403 (1977). There is no dispute that claimant retains some physical capacity. Therefore, the question is whether claimant has established permanent and total disability with the "odd lot" doctrine, under which a disabled worker may remain capable of performing work of some kind but still be foreclosed from obtaining gainful employment due to a combination of medical and nonmedical disabilities. Welch v. Banister Pipeline, 70 Or App 699 (1984). Claimant must establish that she is willing to seek regular gainful employment and has made reasonable efforts to obtain such work, unless such efforts would be futile. SAIF v. Stephen, 308 Or 41 (1989).

With respect to claimant's physical disability, Dr. Slack opined that claimant is capable of performing part-time sedentary work for up to 15 hours a

week, provided that she could vary her hours and work position as dictated by her level of comfort. He further added, however, that claimant would be in pain much of the time and that, given the physical constraints under which she would work, it would be unlikely that she would be able to comply with a regular schedule consistently enough to satisfy an employer. Considering claimant's physical limitations, as well as her age of 68 years, her tenth grade education and other social and vocational factors, Byron McNaught, a vocational expert, testified that claimant is unable to hold regular gainful employment in the labor market.

SAIF introduced no testimony or evidence to rebut either Dr. Slack or Mr. McNaught. Rather, it contends that claimant is not permanently and totally disabled, because she is currently self-employed as the owner of the Crow's Nest Tavern and performs some management duties, such as record-keeping, banking and scheduling. We disagree.

Professor Larson states:

> "The determination of permanent total disability status does not turn upon whether the claimant has money-earning capacity, but rather upon whether the claimant is currently employable or able to sell his services on a regular basis in a hypothetically normal labor market.
>
> "* * * * *
>
> "The essence of the test is the probable dependability with which the claimant can sell his services in a competitive labor market, undistorted by such factors as business booms, sympathy of a particular employer or friends, temporary good luck, or the superhuman efforts of the claimant to rise above his crippling handicaps." 2 Larson, Workermen's Compensation Law 10-101, 57.21 (1986). See also Harris v. SAIF, 292 Or 683 (1982).

Although claimant is able to perform some sedentary activities at her restaurant, the evidence preponderates that most of her time there is spent socializing with employees and customers. She is unable to participate actively and physically in the operation of the business and has had to hire a full-time manager to perform the duties she had performed prior to her most recent injury. Claimant's limited ability to function in this protected environment does not demonstrate that she possesses the ability to sell her services on a regular basis in a hypothetically normal labor market. Wilson v. Weyerhaueser, supra.

SAIF last contends that, in determining whether claimant is permanently and totally disabled, the Referee erred in considering claimant's preexisting conditions back conditions related to her 1980 compensable injury. We disagree and adopt the Referee's conclusions and reasoning.

After our review of the record, we conclude that claimant is no longer able to perform regular work at a gainful and suitable occupation. Moreover, considering Mr. McNaught's testimony, any efforts to obtain employment would have been futile. Finally, we conclude that claimant is willing to work and would probably still be working full-time but for her compensable injury. Accordingly, we conclude that claimant is permanently and totally disabled. The Referee's order is affirmed.

Because the SAIF Corporation initiated the request for 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 a reasonable fee for claimant's attorney's services on review is $1,200, to be paid by the SAIF Corporation. 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 February 13, 1991, as amended April 16, 1991, is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,200, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
CARL M. KEETON, Claimant
WCB Case No. 90-08540
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee T. Lavere Johnson's order that upheld the SAIF Corporation's denial of his aggravation claim for a left leg (knee) condition. On review, the issues are the constitutionality of the application of SB 1197 to this case, compensability, and aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Constitutional Issues

Because claimant requested a hearing after May 1, 1990 and a hearing was convened after July 1, 1990, his claim is properly analyzed under the 1990 revisions to the Workers' Compensation Act. See Ida M. Walker, 43 Van Natta 1402 (1991).

Claimant asserts that application of Oregon Laws 1990 (Special Session), chapter 2, (SB 1197) to his case constitutes either an unconstitutional ex post facto law or an unconstitutional abridgement of freedom of contract.

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).

We do not find claimant's constitutional arguments persuasive. First, inasmuch as claimant has not demonstrated how application of the 1990 amendments constitute an abridgement of his constitutional freedom of contract, we decline to address that argument. Second, the legislature clearly intended retroactive application of SB 1197, with certain exceptions not applicable here. See Whipple v. Howser, 291 Or 475 (1981); Ida M. Walker, 43 Van Natta 1402 (1991). Furthermore, with the exception of ex post facto laws, which are confined to penal laws, there is no constitutional prohibition to the legislature providing that laws be applied retroactively. Hall v. Northwest Outward Bound School, 280 Or 655 (1977); see also State ex rel Borisoff v. Workers' Comp. Board, 104 Or App 603 (1990); Ida M. Walker, supra. We note that claimant characterizes the retroactive application of SB 1197 in his case as an unconstitutional ex post facto law. However, as noted above, ex post facto laws are limited to criminal laws. Accordingly, we do not find the application of SB 1197 to claimant's case to be unconstitutional.

Compensability

It is claimant's burden to prove by a preponderance of the evidence that his accepted 1987 left knee injury which combined with his preexisting degenerative arthritis is and remains the major contributing cause of his disability and need for treatment. ORS 656.005(7)(a)(B); Lareta C. Creasey, 43 Van Natta 1735 (1991).

The record contains three medical opinions relating to the cause of claimant's disability and need for treatment. On December 8, 1989, Dr. Struckman, orthopedist, examined claimant and opined that claimant's current condition and resulting need for the proposed total left knee arthroplasty was the result of the natural progression of his degenerative changes. (Ex. 11-2, 11A). On July 26, 1990, Dr. Stanford, orthopedist, performed a record review for the SAIF Corporation. (Ex. 14). He agreed with Dr. Struckman and opined that the cause of claimant's left knee condition was his degenerative arthritis and not the 1987 industrial injury.

We do not find these opinions persuasive. Dr. Struckman finds that claimant was asymptomatic before the industrial injury. In addition, the record establishes that claimant sought no medical treatment for his left knee until after his industrial injury. Furthermore, both Drs. Struckman and Stanford agree that prior to the industrial injury claimant had degenerative arthritis in both knees. However, they do not address the difference in claimant's current symptoms in his left and right knees. Since the injury and resultant surgery, claimant's left knee has progressively worsened to the point that total knee arthroplasty is now required; however, his right knee, although somewhat painful, has required no treatment at all. Because of this significant omission regarding the issue of causation, we decline to rely on these opinions.

We are instead persuaded by the opinion of Dr. Blake, claimant's treating orthopedist. Dr. Blake has a long treating history with claimant and performed the surgery to repair the left knee medial meniscus tear caused by the injury. In a July 26, 1990 report, Dr. Blake opined that the injury and the resultant surgery was a material contributing cause to the further degeneration of the left knee. (Ex. 13C). We agree with SAIF that this report by itself is not sufficient to meet claimant's burden of proof. However, in a later report, Dr. Blake further explains the relationship between the injury and claimant's current left knee condition and establishes that the major contributing cause of that condition is the injury. (Ex. 15).

Dr. Blake opined that, although claimant had degenerative arthritis in both knees prior to the injury, both knees were essentially asymptomatic before

the injury. In comparing the right and left knees after the injury, he further opined that "the injury caused more internal damage to the left knee, resulting in a more rapid deterioration" of that knee. (Ex. 15). He based this opinion on claimant's increased symptoms in his left knee and an evaluation of the severity of pain in the left knee as compared to the right.

SAIF argues that Dr. Blake's opinions are not persuasive because claimant was not asymptomatic before the injury. However, Blake found that claimant's degenerative arthritis was essentially asymptomatic prior to the injury. (Ex. 15). Furthermore, we find that the record supports that conclusion. The only evidence of any medical treatment regarding claimant's knees is a notation of "a mild strain of the medial collateral ligament of the right knee" which occurred on September 12, 1979. (Ex. 13A (emphasis added)). Claimant required no medical treatment for his left knee prior to the injury.

SAIF also argues that Dr. Blake's opinions are not persuasive because he was apparently not immediately aware of the industrial injury when he began treating claimant in July 1987, a few weeks after that injury. We do not find that this detracts from the persuasiveness of his opinions because, at the time he gave his opinions regarding the causation of the aggravation, he knew about the industrial injury. More importantly, there is no dispute that claimant was injured while working, the industrial injury was accepted, and the compensability of that injury is now the law of the case.

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). Here, there are no persuasive reasons not to defer to Dr. Blake. Accordingly, we are persuaded that claimant's industrial injury is and remains the major cause of claimant's disability and need for surgery.

Aggravation

In order to establish a compensable aggravation of a scheduled condition, claimant must prove, by medical evidence supported by objective findings, a worsened condition resulting from the compensable condition. ORS 656.273(1) and (3); Perry v. SAIF, 307 Or 654 (1989). To prove a worsening of a scheduled body part, claimant must show that he is more disabled, i.e., has sustained an increased loss of use or function of that body part, either temporarily or permanently, since the last arrangement of compensation. International Paper Co. v. Turner, 304 Or 354 (1987, on rem 91 Or App 91 (1988).

Claimant's claim was closed by Determination Order on March 1, 1988. (Ex. 8). At that time, he continued to have pain in his left knee but his range of motion was from 0 to 120 degrees. (Ex. 1-3). He was able to tolerate his work as a truck driver about 40 hours per week. Claimant returned to Dr. Blake on November 2, 1989. Dr. Blake noted that: (1) claimant's condition had markedly deteriorated since he was last seen in April 1988; and (2) he was markedly disabled with symptoms. (Ex. 1-4). Claimant's range of motion had decreased to 15 to 90 degrees with pain at the extremes of motion. (Ex. 1-3). In comparing x-rays, Dr. Blake found "a genu varum measuring 5 degrees with diminished medial joint space as compared to the previous examination of 7-15-87." (Ex. 1-4). As a result of these findings and his evaluation of claimant's report of increased pain, Dr. Blake requested authorization to perform a total left knee replacement arthroplasty. Claimant has thus shown a worsening of his condition by medical evidence supported by objective findings. See Suzanne Robertson, 43 Van Natta 1505 (1991). As noted above, Dr. Blake's reports establish that this worsening results from the compensable injury.

Although claimant has established a worsening, he must also establish that this worsening has resulted in an increased loss of the use or function of his left knee. Dr. Blake noted that, by November 1989, claimant had a walking tolerance of only four blocks with pain with each step. (Ex. 1-3). Dr. Blake also found that claimant had lost motion in his knee and had difficulty in squatting, kneeling, climbing stairs, and climbing into his cab. (Ex. 1-3). Given Dr. Blake's long treatment history, which extends back to the initial work injury, we find his findings of increased difficulties in claimant's use of his left knee persuasive. Claimant also testified that after his claim closed in March 1988, his left knee began to worsen. (Tr. 9). As a result, he was having a lot of pain and difficulty in walking. (Tr. 9). We conclude that Dr. Blake's findings and claimant's testimony establish that claimant has experienced an increased loss of the use or function of his left knee as a result of his worsened condition.

Finally, as claimant has previously been awarded scheduled permanent disability, he 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).

The last arrangement of compensation was the March 1, 1988 Determination Order which awarded 30 percent scheduled permanent disability for the loss of use or function of the left leg. There is no indication that this order comtemplated future waxing and waning of symptoms. Furthermore, prior to this Determination Order, there is no medical evidence predicting future periods of waxing and waning of claimant's left knee condition. Therefore, we find that the Determination Order award did not contemplate any future waxing and waning of claimant's left knee condition.

For the sake of argument it could be contended that Dr. Blake's pre-Determination Order prediction that claimant would likely require a total knee replacement in 5 to 10 years constituted a contemplation of future waxing and waning of symptoms. Even if such an assumption was made, we would find that claimant's need for replacement surgery witin 2 years represented a worsening of his symptoms beyond that contemplated by the Determination Order.

Under these circumstances, we conclude that claimant has established a compensable aggravation.

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 assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability and aggravation issues is $3,500, to be paid by the SAIF Corporation. ORS 656.386(1). In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by appellant's brief and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 29, 1991 is reversed. The SAIF Corporation's aggravation denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review concerning the compensability and aggravation issues, claimant's attorney is awarded an assessed fee of $3,500, payable by SAIF.

In the Matter of the Compensation of
HELEN SHURTZ, Claimant
WCB Case No. 91-02163
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Peterson's order that dismissed her request for hearing as barred under the doctrine of res judicata. On review, the issue is whether claimant's claims for temporary disability benefits and penalties for alleged unreasonable resistance to payment of temporary disability are barred by the doctrine of res judicata.

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

There is no dispute that the question of whether claimant was entitled to further time loss compensation beyond that awarded by the Determination Orders was one of the issues claimant raised in her requests for hearing, which came before Referee Leahy on October 17, 1990. Referee Leahy's order did not address the issue of further time loss compensation, thereby allowing the Determination Orders to stand. Although Referee Leahy's failure to address the subject may have been a meritorious ground for appeal, no appeal was filed from the Referee's order which became final. Thus, we agree with Referee Peterson that the Determination Orders are now the law of the case on the question of time loss, and relitigation of that question was precluded by the principles of res judicata.

ORDER

The Referee's order dated June 5, 1991 is affirmed.

In the Matter of the Compensation of
HARIBU R. STEWARD, Claimant
WCB Case Nos. 90-18780 & 90-14632
ORDER ON REVIEW
John M. Pitcher, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant, pro se, requests review of that portion of Referee Mongrain's order that upheld the self-insured employer's denial of claimant's left shoulder injury claim. The employer has moved to strike claimant's appellant's brief, contending that claimant failed to timely provide it with a copy of the brief. Alternatively, the employer asks that the brief be stricken because the brief addresses matters that are "outside of the official record." On review, the issues are whether claimant's appellant's brief should be stricken and compensability.

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

Notwithstanding claimant's failure to submit a copy of his appellant's brief to the employer, the employer did timely file a respondent's brief. Inasmuch as the employer was not aggrieved by claimant's omission, claimant's appellant's brief shall not be stricken from the record. See David F. Weich, 39 Van

Natta 468 (1987). Finally, in conducting our review, we have fully considered claimant's briefs insofar as they address the issue of whether claimant injured his left shoulder while performing his work activities for the employer.

ORDER

The Referee's order dated August 14, 1991 is affirmed.

April 6, 1992 Cite as 44 Van Natta 669 (1992)

In the Matter of the Compensation of
DEBORAH K. BRICKLEY, Claimant
WCB Case No. 91-01242
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
David Schieber (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of Referee Brown's order that: (1) set aside its partial denial of claimant's claim for a low back condition; and (2) assessed penalties for an unreasonable denial. On review, the issues are res judicata, compensability, and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

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

Claimant first began treating with Dr. Dunn, neurosurgeon, in December 1984 and has continued to treat with him intermittently since that time. (Ex. 29).

A December 1984 CT scan revealed a "slight bulge at the left side at L5-S1 disc." (Ex. 29-1). After treatment, a CT scan in May 1985 showed no definite protrusion. (Exs. 6-3, 29).

In April 1985, SAIF denied claimant's aggravation claim. On November 29, 1985, Referee Howell set aside SAIF's denial. (Ex. 6). Referee Howell based his decision primarily on this disc bulge at L5-S1 and Dr. Dunn's opinion that the worsening was caused by the 1979 injury. This order was not appealed.

On October 7, 1987, a Determination Order issued which awarded temporary disability and 25 percent unscheduled permanent partial disability. (Ex. 14).

Claimant treated with Dr. Maukonen, neurologist, for chronic low back pain from 1986 through most of 1990. (Exs. 7, 16, 17, 18, 24, 25). On July 2, 1990, Dr. Maukonen ordered an MRI which revealed degenerative desiccation of the L5-S1 disc "with moderate disc bulge which effaces the subarachnoid space and touches the thecal sac centrally and eccentrically to the right." (Ex. 19). Dr. Maukonen referred claimant back to Dr. Dunn who recommended surgery (percutaneous automated lumbar diskectomy). (Exs. 23, 24).

On January 9, 1991, Dr. Kho, neurologist, performed an independent medical examination. (Ex. 27). On January 24, 1991, SAIF denied that claimant's current condition was related to her accepted August 1979 lumbar strain. (Ex. 28).

In a report dated April 12, 1991, Dr. Dunn stated that claimant was last seen in December 1990 and that he could not determine whether claimant still needed surgery without reexamining her. (Ex. 29-2).

At hearing, the parties stipulated that: (1) there was no current claim for surgery; and (2) the issues before the Referee were the compensability of the L5-S1 disc and the alleged unreasonableness of SAIF's denial.

CONCLUSIONS OF LAW AND OPINION

Because claimant requested a hearing after May 1, 1990 and 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).

Res Judicata

Citing Carol D. Goss, 43 Van Natta 821 (1991), aff'd mem 110 Or App 151 (1991), the Referee found that the compensability of claimant's L5-S1 disc was decided by the prior referee's order and was, therefore, the "law of the case." In effect, the Referee concluded that the doctrine of res judicata barred SAIF from contesting the compensability of that condition. SAIF argues that the doctrine of res judicata is not applicable here because claimant's condition has changed in the interim and thereby presents facts that could not have been previously litigated. We agree with SAIF's argument.

Res judicata is a doctrine of rules and principles governing the binding effect on a subsequent proceeding of a final judgment previously entered in a claim. Drews v. EBI Companies, 310 Or 134, 139 (1990). Under the res judicata doctrine of "claim preclusion," if a claim is prosecuted to final judgment, the judgment precludes a subsequent action between the same parties on the same claim or any part thereof. Restatement (Second) of Judgments, 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). Claim preclusion does not require actual litigation. A claim is a transaction or series of transactions arising from the same set of operative facts. Carr v. Allied Plating Co., supra at 310. Under the res judicata doctrine of "issue preclusion," if an issue of fact or law is actually litigated and determined by a valid and final judgment, and the determination is essential to the judgment, the determination is conclusive in a subsequent action between the parties, whether on the same or a different claim. North Clackamas School District v. White, 305 Or 48, 53, modified, 305 Or 468 (1988).

The present litigation is not barred by "claim preclusion" because the claim for the current L5-S1 disc rupture is not the same as the claim for the 1984 L5-S1 disc bulge. The current claim involves the same disc as the earlier claim, but it has now ruptured in a different area. Thus, the current condition presents a separate cause of action.

As for "issue preclusion," the same parties actually litigated the issue of the causation of claimant's L5-S1 disc bulge which was necessary to the determination of the final judgment that claimant's aggravation claim was compensable. Thus, SAIF is barred from litigating the compensability of the L5-S1 disc bulge unless claimant's current condition is different from the condition found compensable in the earlier litigation involving the aggravation claim. North Clackamas School District v. White, supra.

We find that claimant's condition is different from the condition involved in the earlier litigation. Although the prior referee's order did not describe the 1984 L5-S1 disc bulge, the record indicates that it was "a slight bulge at the left side at L5-S1." (Ex. 29-1). With treatment, by May 1985, there was no definite protrusion of the L5-S1 disc. (Ex. 29-1). On the other hand, a July 1990 MRI revealed a moderate bulge centrally and to the right at L5-S1. (Exs.

19, 29-1). Dr. Dunn, treating neurosurgeon, indicated that this was a ruptured disc. We find that this 1990 ruptured disc, which is in a different area than the 1984 disc bulge, establishes that claimant's current condition has changed so as to create a new set of operative facts that previously could not have been litigated. See Carol D. Goss, supra. Thus, SAIF is not barred by the doctrine of res judicata from litigating the compensability of claimant's current L5-S1 disc condition. Therefore, we proceed to the merits.

Compensability

As an alternative to his res judicata holding, the Referee found claimant's current L5-S1 disc condition compensable on the merits. We agree.

SAIF argues that the L5-S1 ruptured disc is a consequential condition and, therefore, claimant must establish that the injury is the major contributing cause of that condition pursuant to ORS 656.005(7)(a). In Julie K. Gasperino, 43 Van Natta 1151 (1991), we construed the phrase "consequential condition" to include only conditions 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. Such conditions remain subject to the material contributing cause test for compensability.

Here, Dr. Dunn establishes a direct link between the 1979 injury, an injury to the L5-S1 disc at that time resulting in a weakening of the annulus, and the current L5-S1 ruptured disc. (Ex. 29). Therefore, under the Gasperino analysis, only a material contributing cause standard need be established. Nevertheless, Dr. Dunn opined that the injury was the major contributing cause of the ruptured disc. (Ex. 29).

We find Dr. Dunn's opinion persuasive. He has a long treatment history with claimant and was aware of her weight problem. He acknowledged that excess weight can cause disc changes even in young people, but concluded that the injury was the major contributing cause of her condition. 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 is no persuasive reason not to defer to Dr. Dunn.

SAIF argues that Dr. Dunn's report is based on an inaccurate history in that he was not aware of an automobile accident in December 1990 which possibly resulted in low back injuries. Even if Dr. Dunn was unaware of the December 1990 accident, that does not negate his opinion as to the cause of the L5-S1 ruptured disc that was first diagnosed in July 1990, more than five months before the automobile accident.

The only other medical opinion regarding causation is provided by Dr. Kho, examining neurologist. (Ex. 27). Dr. Kho opines that claimant's L5-S1 ruptured disc is caused by degenerative disc disease. We do not find this conclusory statement persuasive. Furthermore, he denies that there was any indication of a disc bulge in the 1984 CT scan. (Ex. 27-7). This is contrary to the law of the case. This 1984 disc bulge was found to be related to the injury and was one of the bases of the prior referee's finding that the aggravation claim was compensable. See Edgar Kinnett, 43 Van Natta 1240 (1991). For these reasons, we do not find Dr. Kho's opinion persuasive. Accordingly, on the basis of Dr. Dunn's opinion, we find that claimant has established that the L5-S1 ruptured disc is compensable.

Alleged Unreasonable Denial

The Referee found that SAIF's denial was unreasonable because SAIF was barred by res judicata from contesting the compensability of claimant's disc bulge. He assessed a 25 percent penalty. We disagree.

As discussed above, SAIF was not barred by res judicata. The standard for determining an unreasonable denial is whether the carrier has a legitimate doubt as to its liability. Unreasonableness and "legitimate doubt" are to be considered in the light of all the evidence available at the time. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988), citing Norgard v. Rawlinsons, 30 Or App 999, 1003 (1977).

At the time of the denial, SAIF had received Dr. Kho's report which indicated that claimant's condition was not related to the injury. This report was sufficient to create a legitimate doubt as to SAIF's liability. Thus, the denial was not unreasonable.

Attorney Fees on Review

Claimant is entitled to an assessed attorney fee for services on review concerning SAIF's request for review. 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 attorney's services on review concerning the compensability issue is $800, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee on review for services devoted to the penalty issue.

ORDER

The Referee's order dated May 16, 1991 is reversed in part and affirmed in part. That portion of the order which assessed a penalty for an allegedly unreasonable denial is reversed. The remainder of the order is affirmed. For services on review concerning the compensability issue, claimant's attorney is awarded an assessed fee of $800.

April 6, 1992 Cite as 44 Van Natta 672 (1992)

In the Matter of the Compensation of
VELMA B. DEWEY, Claimant
WCB Case No. 91-00663
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Harri's order which: (1) set aside its partial denial of claimant's current right arm condition; and (2) assessed a penalty and related fee under ORS 656.262(10) for the insurer's allegedly unreasonable denial. On review, the issues are compensability, penalties and attorney fees.

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

Because claimant requested a hearing after May 1, 1990 and the hearing was convened after July 1, 1990, we analyze this matter under the workers' compensation law as amended by Oregon Laws 1990 (Special Session) effective July 1,

1990. See 1990 Oregon Laws, ch. 2, Senate Bill 1197, Sec 54 (2); Ida M. Walker, 43 Van Natta 1402 (1991).

As to the medical services issue, the Referee correctly found that the parties' dispute concerned the causal relationship between claimant's 1968 compensable right hand injury and her current condition. Subsequent to the Referee's order, we held in Michael A. Jaquay, 44 Van Natta 173 (1992) that the Hearings Division is the appropriate forum for resolution for such causal relationship disputes. Consequently, we conclude this matter is not within the exclusive jurisdiction of the Director. See ORS 656.704(3); Stanley Meyers, 43 Van Natta 2643 (1991). Accordingly, we hold that the Board, and thus the Referee, has jurisdiction to decide this matter. Jaquay, supra.

Additionally, with regard to the penalty and related attorney fee issue, the Referee concluded that the insurer's denial was unreasonable because it was prospective. While we agree that the portion of the denial which denied responsibility for "any future medical treatment" was prospective, the portion denying claimant's current right arm condition as not related to her accepted condition was not prospective. See Boise Cascade Corp. v. Hasslen, 108 Or App 605 (1991). However, notwithstanding our disagreement with the Referee's rationale, we continue to find the insurer's denial unreasonable.

In determining if a denial is unreasonable, the question is whether the insurer had a legitimate doubt as to its liability at the time of its denial. If the insurer based its denial upon a legitimate doubt, the denial is not unreasonable. Brown v. Argonaut Co., 93 Or App 588 (1988). The insurer's "reasonableness" and "legitimate doubt" must be evaluated in light of the information available to it at the time of the denial. Id. A reasonable doubt does not exist where a decision is made quickly which prejudges the medical information available on the question of material contributing causation without any independent investigation. Kenneth A. Foster, 44 Van Natta 148 (1992).

Here, Dr. Connor indicated in a November 6, 1990 letter to the insurer that he had no knowledge of claimant's medical history before 1988 and, therefore, declined to offer an opinion concerning the etiology of claimant's current condition. However, the medical record from 1974 to 1982 regarding claimant's compensable right hand osteoarthritis establishes, consistent with the permanent disability award, that this condition was chronic and permanent. (Exs. 10, 11, 15 and 16). Moreover, that record also indicates that Dr. Kovachevich, claimant's treating physician since 1978, prescribed the same anti-inflamatory medication at issue here to treat claimant's compensable condition and that this medication was also helpful in treating claimant's noncompensable osteoarthritis in other parts of her body. (Exs. 15, 16 and 16A). The record also establishes that the issue of whether this anti-inflamatory medication was related to claimant's compensable condition had been clarified in the past through correspondence between the insurer and Dr. Kovachevich. (Id). Consequently, while Dr. Connor's letter to the insurer focused only on the treatment of claimant's noncompensable osteoarthritis, the record as a whole, which was available to the insurer prior to its denial, indicated that the current anti-inflamatory medication treatment was related to claimant's compensable osteoarthritis condition as it had been since 1978.

Under these circumstances, we conclude that the insurer did not have a legitimate doubt as to its liability for the claim, and we find its denial unreasonable. Accordingly, we affirm the Referee's penalty assessment.

Because the insurer initiated the request for 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), we find that a reasonable assessed attorney fee for claimant's counsel's services on review concerning the compensability issue is $1,000. 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 further note that claimant's counsel is not entitled to an attorney fee for defending on the penalty and attorney fee issue. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated July 3, 1991 is affirmed. For services rendered on review concerning the compensability issue, claimant's counsel is awarded $1,000, to be paid by the insurer.

April 6, 1992 Cite as 44 Van Natta 674 (1992)

In the Matter of the Compensation of
WANDA N. HAINEY, Claimant
WCB Case No. 90-07706
ORDER ON REVIEW
Ainsworth, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of those portions of Referee Michael Johnson's order which: (1) set aside its denial of claimant's aggravation claim for a neck and shoulder condition; and (2) increased claimant's unscheduled permanent disability award from 17 percent (54.4 degrees), as awarded by Determination Order, to 20 percent (64 degrees). On review, the issues are aggravation and extent of unscheduled permanent disability. We affirm in part and vacate in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact and "Findings of Ultimate Fact," except for the first finding of ultimate fact, with the following supplementation.

Prior to claimant's last award of compensation, a March 21, 1990 Determination Order, Dr. Vranna, claimant's treating physician, anticipated that claimant would be able to work 40 hours a week with little or no medication.

Claimant's compensable condition worsened since the March 21, 1990 Determination Order, the last award of compensation.

CONCLUSIONS OF LAW AND OPINION

Aggravation Claim

The Referee found that claimant established by medical evidence a worsened condition supported by objective findings and that the major contributing cause of the worsening was her compensable injury and its sequela. Therefore, the Referee concluded that claimant had established a compensable aggravation claim. While we agree with the Referee's conclusion, we substitute our own analysis for that of the Referee's.

As a preliminary matter, we note that claimant requested a hearing after May 1, 1990 and the hearing was convened after July 1, 1990. Accordingly, we

analyze this matter under the Workers' Compensation Act effective July 1, 1990. See Or Laws 1990 (Special Session), ch. 2, 54(2). Ida M. Walker, 43 Van Natta 1402 (1991).

To establish an aggravation claim, claimant must prove by a preponderance of the evidence that: (1) since the last arrangement of compensation, she has suffered a symptomatic or pathological worsening, established by medical evidence supported by objective findings, resulting from the original injury; (2) such worsening resulted in diminished earning capacity below the level fixed at the time of the last arrangement of compensation; and (3) if the last arrangement of compensation contemplated future periods of increased symptoms and diminished earning capacity, claimant's diminished earning capacity exceeded that contemplated. ORS 656.273(1) and (8); Perry v. SAIF, 307 Or 654 (1989); Gwynn v. SAIF, 304 Or 345 (1987); Smith v. SAIF, 302 Or 396 (1986); John E. Means, 43 Van Natta 2331 (1991). If there is an off-work injury which is the major contributing cause of the worsened condition, the worsening is not compensable. ORS 656.273(1); Elizabeth A. Bonar-Hanson, 43 Van Natta 2578 (1991).

Here, prior to the March 21, 1990 Determination Order, Dr. Vranna released claimant to modified work and anticipated that she would be able to work 40 hours per week with little or no medication. (Ex. 23-2). After the March 21, 1990 Determination Order, claimant developed severe upper thoracic pain and sought emergency room treatment, where Dr. Minser noted muscle spasm, tenderness and loss of range of motion in claimant's neck. (Ex. 30-A-3). Minser prescribed medication and took claimant off work for two days. (Id). Additionally, Dr. Vranna subsequently confirmed claimant's worsened condition with a multitude of objective findings (Ex. 31-1) and opined that claimant's work injury, exacerbated by on-the-job stress, caused a symptomatic worsening of her condition since she was declared medically stationary on January 25, 1990. (Exs. 33 and 34). Dr. Vranna took claimant off work. (Ex. 37A). We find this evidence sufficient to establish that, since claimant's last arrangement for compensation, she experienced a symptomatic worsening (established by medical evidence supported by objective findings), resulting from her original injury, and that, as a consequence of this worsened condition, her earning capacity was diminished below the level of the March 21, 1990 Determination Order.

As claimant has previously been awarded unscheduled permanent disability by the Determination Order, she must also establish that the worsening is more than waxing and waning of symptoms contemplated by the previous permanent partial disability (PPD) award. ORS 656.273(8). Here, the Determination Order made no reference to the fact that a waxing and waning of symptoms was contemplated. However, Dr. Vranna's opinion suggests that claimant would be able to work 40 hours per week with little or no medication. (Ex. 23-2). Such an opinion suggests that, at most, minimal future symptoms were contemplated. In view of claimant's severe symptomatic flare-up on June 11, 1990 and her resulting inability to work after July 15, 1990, we conclude that claimant's symptomatic worsening is more than waxing and waning of symptoms contemplated by the previous 17 percent permanent disability award.

On review, the employer contends that Dr. Vranna's opinion should be given little weight because he was unaware that claimant also had significant stressors in her personal life, arguing that these personal stressors were the cause of claimant's symptomatic flare-up and not her work stress. We do not find the employer's argument persuasive because our review of the record indicates that Vranna was aware of claimant's personal problems and it did not alter his opinion that claimant's compensable injury was the major contributing cause of claimant's worsened condition. (See Ex. 37A). Accordingly, claimant has established a compensable aggravation.

Extent of Permanent Disability

With regard to the Referee's extent rating, the employer argues that the Referee should not have rated claimant's permanent disability because claimant was not medically stationary at the time of hearing. We agree.

A Referee should not rate permanent disability if the claimant is not medically stationary at the time of the hearing or the claim is in open status. ORS 655.268(1); Kociemba v. SAIF, 63 Or App 557 (1981); Glean A. Finley, 43 Van Natta 1442 (1991). The Board has followed this rule where the claimant was medically stationary when the claim was initially closed but, at the time of hearing, the claim was in open status or the claimant was not medically stationary because of a subsequent aggravation. See Glean A. Finley, supra; Raymond E. Pardee, 41 Van Natta 548 (1989).

In this case, as a result of the Referee's decision that claimant had established a compensable aggravation claim, claimant's claim was in open status. Moreover, the medical record does not establish that claimant's compensable condition was medically stationary at the time of hearing. Consequently, we conclude that it was premature for the Referee to rate claimant's permanent disability. Therefore, we vacate the Referee's extent ruling.

The Referee should have deferred action on the extent of permanent disability. Specifically, the Referee should have directed the Central Files Section of the Hearings Division to assign a new WCB case number to the extent issue. To rectify this oversight, this issue is now referred to Central Files with instructions to assign this issue a new WCB case number. Litigation of this new case shall then be deferred pending closure of the aggravation claim. The parties are requested to keep the Hearings Division apprised of further developments regarding closure of claimant's aggravation claim.

In the event that the closure of claimant's aggravation claim results in another hearing request, that request shall be consolidated with the new WCB case number created by Central Files concerning claimant's hearing request regarding the March 21, 1990 Determination Order. Should no subsequent hearing request be filed after the closure of claimant's aggravation claim, the parties shall proceed to a determination of the extent of claimant's permanent disability based on claimant's hearing request filed on the March 21, 1990 Determination Order.

Because the employer initiated the request for 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), we find that a reasonable assessed attorney fee for claimant's counsel's services on review concerning the aggravation issue is $750. 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 July 17, 1991 is affirmed in part and vacated in part. That portion of the Referee's order which rated the extent of claimant's permanent disability awarded by the March 21, 1990 Determination Order is vacated. The Central Files Section of the Hearings Division is directed to assign this issue a new WCB case number with further action on the case to be deferred pending closure of claimant's aggravation claim. The remainder of the order is affirmed. For services on Board review concerning the aggravation issue, claimant's counsel is awarded $750, to be paid by the self-insured employer.

In the Matter of the Compensation of
LONNIE SANDERS, Claimant
WCB Case No. 90-08030
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Lipton's order that upheld the insurer's denial of claimant's neck injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant failed to establish the compensability of his neck strain injury claim. We agree with the Referee's ultimate conclusion, but offer the following analysis.

As a preliminary matter, we note that claimant requested a hearing on April 13, 1990, and the hearing was convened on June 6, 1991. Accordingly, we analyzed this matter under the Workers' Compensation Act effective July 1, 1990. See Or Laws 1990 (Special Session), ch. 2, Section 54(2); Ida M. Walker, 43 Van Natta 1402 (1991).

Under amended ORS 656.005(7)(a), claimant bears the burden of proving that a work injury is a material contributing cause of his disability or need for treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991). In view of claimant's 1987 motor vehicle accident injury, we find that the cause of claimant's current disability is a complex medical question requiring expert medical opinion for its resolution. See Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985). In addition, where we find that there is a dispute between medical experts, as there is this case, we tend to give greater weight to the conclusion of the treating physician unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). We also defer to those opinions that are thorough and well-reasoned. Somers v. SAIF, 77 Or App 259 (1986).

Claimant's treating physician is Dr. Reynolds. On review, claimant argues that the Referee should have relied on Dr. Reynolds' opinion because, as treating physician, Reynolds was in the "best position" to give an opinion and because Reynolds examined claimant closest to the onset of claimant's pain. We are not persuaded by Dr. Reynolds' opinion because, first, it is conclusory. He states only that "[i]t is felt that [claimant's] work were the major contributing factor as listed in both the history and physical evaluation." (Ex. 10-1). We find this unpersuasive because Dr. Reynolds does not explain the basis of his opinion. Moe v. Ceiling Systems, 44 Or App 429 (1980). Furthermore Dr. Reynolds' opinion is based on inaccurate information. In his February 6, 1990 report, Reynolds notes that claimant experienced a gradual onset of neck pain due to repetitive lifting of ingots at work. (Ex. 3). This statement is not supported by the rest of the record which indicates that claimant had no neck pain until the day after his strenuous work activity. (Tr. 33-34). Because Dr. Reynolds' opinion is based on this inaccurate information, we give it little weight. See Somers v. SAIF, supra; Miller v. Granite Construction Co., 28 Or App 470 (1977).

On the other hand, we find the independent medical examiner's opinion of First Northwest Health's physicians, Dr. Peterson and Dr. Fuller, the most persuasive. Their examination revealed only subjective unverifiable complaints of neck pain and concluded that claimant's current symptoms were not work-related. (Ex. 5-3). We find their opinion persuasive because it is well-reasoned and based on an accurate history of the sudden onset of claimant's neck pain the day after the alleged work incident. See Somers v. SAIF, supra. Moreover, we also find Dr. Peterson's opinion particularly persuasive because she examined claimant both before and after the alleged January 15, 1990 incident. (See Exs. K-2 and 5-3). See Kienow Food Stores v. Lyster, 79 Or App 416 (1986).

Consequently, inasmuch as Dr. Reynolds was the only expert that opined that claimant's neck condition was work-related and we find the First Northwest Health physicians' opinions most persuasive, we conclude that claimant failed to establish the compensability of his claim.

ORDER

The Referee's order dated June 27, 1991 is affirmed.

In the Matter of the Compensation of
VIRGIL W. SCHMIT, Claimant
WCB Case No. 90-06284
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Pamela Schultz, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of that portion of Referee Otto's order that awarded claimant 17 percent (54.4 degrees) unscheduled permanent disability for a low back injury whereas a Determination Order did not award any unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

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

FINDINGS OF ULTIMATE FACT

Claimant's compensable low back strain resolved shortly after the initial injury.

Claimant's chronic low back condition and decreased lumbar ranges of motion are attributable to his degenerative lumbar disc disease.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the May 1988 injury permanently aggravated claimant's underlying degenerative condition and awarded him 17 percent unscheduled permanent disability. We disagree.

The issue of whether claimant's industrial injury rendered his preexisting degenerative condition permanently symptomatic is a complex medical question. Thus, although claimant's testimony is probative, the resolution of this issue

turns largely on an analysis of the medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

The only medical opinion comes from Dr. Hazel, claimant's treating physician. Dr. Hazel reported that the May 1988 injury did not cause or worsen claimant's underlying degenerative condition. Dr. Hazel opined that the compensable injury rendered claimant's degenerative condition symptomatic on a temporary basis, but did not accelerate the course of the progressive degenerative disease. Finally, Dr. Hazel opined that claimant's low back symptoms and decreased ranges of motion could not be attributed to the compensable injury, but rather were related to the progressive degenerative condition.

Although Dr. Hazel acknowledged that the industrial injury temporarily exacerbated claimant's degenerative condition, his opinion does not support a finding that the compensable injury rendered these symptoms permanent. Furthermore, Dr. Hazel specifically attributes all permanent impairment to the underlying degenerative condition. Under these circumstances, claimant has not established that his industrial injury rendered his degenerative condition permanently symptomatic. See Barrett v. D & H Drywall, 300 Or 325, on recon 300 Or 553 (1985). Therefore, we conclude that claimant has not established that he sustained any permanent impairment as a result of his compensable injury. Accordingly, claimant is not entitled to an award of unscheduled permanent disability. ORS 656.214(5).

ORDER

The Referee's order dated June 10, 1991 is reversed. The Determination Order is reinstated and affirmed.

April 6, 1992 Cite as 44 Van Natta 679 (1992)

In the Matter of the Compensation of
HENRY K. SCHWANE, Claimant
WCB Case No. 91-03765
ORDER ON RECONSIDERATION
Black, et al., Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our March 10, 1992 Order on Review which affirmed the Referee's order that directed SAIF to pay claimant's scheduled permanent disability award at a rate of $305 per degree. Citing Michael E. Morrison, 44 Van Natta 372 (1992), SAIF contends that claimant is precluded from challenging the $145 rate at which claimant's permanent disability award was paid pursuant to a June 14, 1990 Determination Order. We disagree.

We find the facts of this case distinguishable from those in Morrison. In Morrison, the claimant's injury claim was closed by a Determination Order that awarded a specified dollar amount of compensation for 40 percent scheduled permanent disability. The total award corresponded to a rate of $145 per degree of disability. The claimant requested a hearing regarding that award. By stipulation, the award was increased by a specified dollar amount of compensation for an additional 10 percent scheduled permanent disability. Again, the additional award corresponded to a rate of $145 per degree of disability. In exchange for the increased award, the claimant's request for hearing was dismissed with prejudice as to all issues raised or raisable, and the permanent disability awards became final by operation of law. After the self-insured employer paid the

claimant the awards, the claimant requested a hearing asserting that the awards should have been paid at the rate of $305 per degree.

We held in Morrison that, because the Determination Order was final and the claimant had stipulated to the payment of the additional award at a specific amount which corresponded to a rate of $145 per degree, the claimant was precluded from asserting that his award should be paid at a higher rate.

In this case, contrary to SAIF's contention, the June 14, 1990 Determination Order did not become final by operation of law. Although the June 14, 1990 Determination Order did award a specific dollar amount, the earlier Referee's order replaced the award given by the Determination Order by awarding a total of 11 percent (16.5 degrees). Furthermore, the earlier Referee's order did not award a specific dollar amount. Finally, and more importantly, claimant did not stipulate to any amount or rate of scheduled permanent disability. Accordingly, Morrison does not apply here, and claimant is not precluded from challenging the rate of compensation awarded for his compensable injury.

Accordingly, our March 10, 1992 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our March 10, 1992 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

April 6, 1992 Cite as 44 Van Natta 680 (1992)

In the Matter of the Compensation of
IVORY X. WHITE, Claimant
WCB Case No. 91-01045
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Mills' order which upheld the insurer's denial of certain chiropractic bills. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW

We agree with the Referee's conclusion that the Hearings Division has jurisdiction to resolve the dispute. However, we base our conclusion on the following reasoning.

Subsequent to the Referee's order, we held that there is no other procedure provided by ORS Chapter 656 for resolving disputes concerning the causal relationship between an injury and a need for medical services. Michael A. Jaquay, 44 Van Natta 173 (1992). Accordingly, where a denial is based on the ground that the need for medical services is not causally related to the compensable injury, the Board has jurisdiction. Jaquay, supra.

We find that the key question in this case is whether the medical services at issue were causally related to claimant's compensable 1986 injury. Accordingly, the Referee had jurisdiction to decide the matter.

The Referee also found, as a preliminary matter, that the claim is not barred by principles of res judicata. We agree that this claim is not precluded by the previous litigation because this claim is not based on the same factual transaction that was at issue in the earlier action between these parties. Drews v. EBI Companies, 310 Or 134, 140 (1990). In the earlier hearing, claimant contended the medical services were related to either a new occupational disease claim or to a 1987 foot condition claim, while in the instant case, claimant contends the medical services were related to a 1986 low back injury claim. (See Ex. 16A-88 to -97; Ex. 18). Moreover, claimant did not have a prior opportunity to litigate this claim, due to the insurer's objections at the previous hearing. (Ex. 16A-94). Accordingly, we find that this claim was not precluded by the previous litigation. See Calkins v. Westcraft Chair, Inc., 84 Or App 320 (1987).

With respect to the merits of claimant's claim, we adopt the Referee's conclusion that the services were unrelated to claimant's 1986 compensable low back injury.

ORDER

The Referee's order dated June 17, 1991 is affirmed.

In the Matter of the Compensation of
MILDRED J. ZOWIE, Claimant
WCB Case No. 91-03455
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
John Motley (Saif), Defense Attorney

Reviewed by Board Members Westerband, Moller and Gunn.

The SAIF Corporation requests review of Referee Michael Johnson's order that set aside its denial of claimant's low back injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

Following her 1987 low back injury, claimant experienced radicular symptoms extending to her left heel. Claimant also experienced radicular symptoms following the onset of her low back pain in February 1991.

Claimant suffers from a degenerative condition at the L4-5 level of her spine.

CONCLUSIONS OF LAW AND OPINION

We note, preliminarily, that SAIF denied claimant's claim "for an industrial injury" on the basis that claimant's work employment with its insured did not cause "the worsening of [claimant's] lumbar strain." At hearing, SAIF's counsel noted that claimant "had a prior condition that is a work claim." However, SAIF's counsel went on to state: "This is not an aggravation. This is a new injury." (Tr. 2). Claimant's counsel agreed that SAIF's denial was of a "new injury" not an aggravation, and that claimant had not made a claim for aggravation. (Tr. 8-9). Accordingly, the Referee analyzed the claim solely as

one for a "new injury." We, too, restrict our review to the issue as framed and litigated by the parties, i.e., whether claimant established compensability of a "new injury" claim arising on or about February 27, 1991.

The Referee found claimant credible based on her attitude and demeanor. He also concluded that claimant told Dr. Stevens, her treating orthopedist, about both the rose tending activities and the safe activities. On the basis of this conclusion, the Referee found that Dr. Stevens had a complete history upon which to base his opinion that the work activities in the safe were the major contributing cause of her disability and need for treatment. (Ex. 9).

An injury is compensable if it arises out of and in the course of employment and results in disability or the need for medical services. Accordingly, an injured worker establishes a compensable claim if she proves that the work activity is a material contributing cause of disability or need for treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991).

Because claimant's disability and need for medical services could have been caused by either work activities in the safe, activities tending roses at home, or, perhaps, her degenerative low back condition, the resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

We defer to the Referee's credibility finding. However, we disagree that the record shows that claimant informed Dr. Stevens about the rose tending activities. Dr. Stevens was out of town when claimant called for an appointment. As a result, she went to the Emergency Room on February 28, 1991 and then saw Dr. Becker, Dr. Stevens' partner, on March 7, 1991. Although claimant testified that she told Dr. Becker about both the rose and safe activities, she did not say that she told Dr. Stevens about these incidents. (Tr. 29, 30, 31, 32, 34, 45). Furthermore, claimant's attorney's letter to Dr. Stevens addressed only the safe incident. (Ex. 6A). Therefore, on this record, we do not find that Dr. Stevens had a complete history upon which to base his opinion.

Furthermore, the only other medical evidence in the record relating to causation is Dr. Becker's opinion that the work activity is not the major contributing cause. (Ex. 11).

Although no "magic words" are needed, and the doctors' phrased their reports in terms of "major contributing cause," because Dr. Stevens had an inaccurate history, we cannot assume that he would have found that the work activities would have been a material contributing cause if he had understood that the onset of severe pain began on the day after the alleged injury, while claimant was tending her roses in the "cold and damp." Accordingly, we conclude that claimant has not established that the work activities are a material contributing cause of her disability and need for medical services.

Citing ORS 656.005(7)(a)(B), SAIF argues that claimant must establish that any work injury is the major contributing cause of the disability or need for treatment, given her preexisting low back condition. Claimant's preexisting low back condition was the result of prior injuries with SAIF's insured. Because we find that the medical evidence does not establish that the work incident was a material cause of claimant's disability or need for treatment, we do not address whether a prior work injury may be a preexisting condition pursuant to ORS 656.005(7)(a)(B).

ORDER

The Referee's order dated July 17, 1991 is reversed. The SAIF Corporation's denial of claimant's lumbar strain is reinstated and upheld. The Referee's $2,000 assessed attorney fee award is also reversed.

Board Member Gunn, dissenting.

The majority concludes that claimant has not established a compensable injury on the basis that her treating physician did not have an accurate history. Specifically, the majority finds no "evidence" that Dr. Stevens, claimant's treating physician, was aware of claimant's off-work rose-tending activities before forming his medical opinion on causation. See (Ex. 9). I conclude, as did the Referee, that Dr. Stevens was aware of both claimant's work and off-work activities and used this information in reaching his medical opinion. See (Tr. 32, 34, 45). Furthermore, I do not believe that claimant's rose-tending activities were significant to the issue of causation. Therefore, I dissent.

When medical evidence is divided, we have tended to give greater weight to the conclusion of a claimant's treating physician, absent persuasive reasons not to do so. Abbott v. SAIF, 45 Or App 657 (1980); Hamlin v. Roseburg Lumber, 30 Or App 615 (1977). The reasons for deferring to the opinion of a treating physician make sense. A treating physician generally has observed and evaluated a claimant for a protracted time period and thus is in a better position to offer an opinion than a physician who has only once or twice. See Weiland v. SAIF, 64 Or App 810 (1983). Moreover, a treating physician is also a custodian of a claimant's medical records, history, and background and as such will have a greater knowledge of claimant's compensable condition as well as other maladies.

The reasons for deferring to the treating physician are illustrated in the present case. Dr. Stevens' opinion was formed by actually examining, observing and speaking with claimant. He also reviewed chartnotes which contain references to claimant's "rose-tending" activities. It is not unwarranted to assume that his examination, records and discussions with claimant gave Dr. Stevens sufficient information on which to base his opinion. The majority, however, negates Dr. Stevens' opinion by making the unwarranted assumption that he was unaware of claimant off-work activities.

Finally, the majority also assumes that claimant's off-work activities were significant to the issue of causation. The only support for this assumption was supplied by Dr. Becker. (Ex. 4). However, Dr. Becker's opinion is based on an emergency room report which is inconsistent with claimant's credible testimony regarding the extent of her rose-tending activities. (Tr. 28). By relying on Dr. Becker, the majority appears to require claimant to eliminate the alternative argument that the rose-tending activities were the cause of her injury. This is contrary to the recent holding in Magana v. Wilbanks International, 112 Or App 334 (1992), in which the court stated that under ORS 656.266, "claimant need not eliminate all other possible explanations of causation."

In conclusion, I would defer to Dr. Stevens' opinion and find claimant's injury compensable. Absent deference to Dr. Stevens, I would conclude that claimant's off-work activities were not a causal factor of claimant's injury. In this regard, it is clear from claimant's credible testimony that her rose-tending activities did not involve the body mechanics that would cause the type of injury she sustained. Accordingly, for these reasons, I dissent.

In the Matter of the Compensation of
JOHN M. AMES, Claimant
WCB Case No. 90-17571
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by the Board en banc.

The insurer requests, and claimant cross-requests, review of Referee Brown's order that increased claimant's scheduled permanent disability award for a right wrist injury from 14 percent (21 degrees), as awarded by a Determination Order, to 59 percent (88.5 degrees). On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant injured his right wrist in April 1989, while operating a jackhammer for the insured. He subsequently filed a claim for tenosynovitis of the right forearm, which the insurer accepted on May 16, 1989.

During his course of treatment, claimant underwent two surgeries: a radial and median decompression of the right wrist and an exploratory surgery of the radial nerve at the right elbow. Dr. Grant, the treating physician, declared claimant medically stationary on May 30, 1990.

On June 22, 1990, Dr. Gambee, M.D., examined claimant at the offices of the Medical Consultants Northwest. Dr. Gambee found claimant medically stationary with no objective evidence of impairment. (Ex. 36). Sarada, a physical therapist, performed a physical capacity evaluation on July 24, 1990. Sarada found decreased sensation in claimant's right hand with an apparent loss of grip strength. (Ex. 40).

Claimant's claim was closed by a July 27, 1990 Determination Order, which awarded 14 percent scheduled permanent disability for radial and median sensory loss in the right forearm. (Ex. 42). Claimant subsequently requested a hearing on the extent of his disability.

CONCLUSIONS OF LAW AND OPINION

On January 18, 1991, the Referee convened a hearing in this matter and admitted evidence concerning the extent of claimant's disability. Both parties rested their case and the record was closed. After a subsequent review of that evidence, however, the Referee noticed that the medical reports provided by Dr. Grant failed to contain range of motion findings or detailed sensory or motor studies. He also noticed that the functional limitations were given by a physical therapist and could not, therefore, be used to rate impairment under the standards. Based on those observations, he decided that the Determination Order had been improperly issued and, consequently, found that the medical record was incompletely developed.

In an effort to correct the situation, the Referee issued an Interim Order dated February 15, 1991, ordering Dr. Grant to reexamine claimant and submit additional findings for purposes of rating claimant's permanent disability. Dr. Grant complied with the order and submitted an additional medical report. The Referee admitted the report as Exhibit 49 and, based on the findings contained therein, increased claimant's scheduled permanent disability award to 59 percent.

On review, the insurer challenges the legality of the Referee's conduct.[1] It acknowledges that a referee has some authority to obtain additional medical evidence under OAR 438-07-005(5), which provides:

> "The referee may appoint a medical or vocational expert to examine the claimant and to file a report with the referee. The parties may also agree in advance to be bound by such expert's findings. The cost of examination and reports under this rule shall be paid by the insurer."

It argues, however, that the rule only allows a referee to solicit an objective third party opinion as an aid to interpreting other evidence contained in the record, and that the Referee's use of the rule in this case to obtain a definitive medical report from claimant's treating physician was improper. It further argues that Dr. Grant's opinion regarding the extent of claimant's disability had been adequately, and consistently, expressed in his numerous earlier reports and that, therefore, Exhibit 49 should not be considered in the rating of claimant's permanent disability.

We do not necessarily agree with the insurer that the rule may be used only to solicit an "objective third party opinion." Under certain circumstances, the solicitation of additional evidence from a treating or examining physician may be proper. Nonetheless, for the reasons that follow, we agree that the Referee's use of the rule to supplement the record in this case was improper.

The appropriate role of the hearings referee in supplementing the record is not free from debate. Because a complete record is an essential element of a sound decision, few would dispute that a referee has the responsibility to develop a record that will fully reveal the facts necessary for consideration of all issues properly before him or her. This responsibility is especially important whenever a claimant is unrepresented by counsel at hearing. See Dennis v. Employment Div., 302 Or 160 (1986). As a result of that obligation, a referee may be required to ask witnesses questions or to include documentary evidence in the record not offered by one of the parties. See generally 2 Davis, Administrative Law Treatise, 10.02 (1958).

The referee's obligation to develop a complete record is not without limits, however. While not bound by technical or formal rules of procedure, a referee must conduct the hearing in a manner that will achieve substantial justice. ORS 656.283(7). Accordingly, in fulfilling the duty to ensure that the facts are fully developed, a referee should avoid encroaching on the domain of counsel. As stated by Professor Davis:

> "If a trial examiner will only permit each of the parties to the proceeding before him to prove his own case, in his own way, by his own counsel, he will save himself from criticism. Excessive or improper participation may, of course, amount to a denial of fair hearing." 2 Davis, Administrative Law Treatise at 9.

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[1] The dissent contends that the issue of the Referee's solicitation of evidence has not been properly raised. We disagree. The insurer requested Board review of the Referee's April 17, 1991 Amended Opinion and Order. Reference in that order was made to the Referee's February 14, 1991 Interim Order, which reopened the record for solicitation and submission of additional medical evidence. In light of such circumstances, the issue of the Referee's solicitation of additional evidence is squarely before us on review.

In this case, the Referee supplemented the record with a post-hearing medical report from Dr. Grant, claimant's treating physician. The Referee solicited the report based on his conclusion that the medical record developed at hearing was incomplete, in that the admitted reports from Dr. Grant had failed to contain range of motion findings or detailed sensory and motor studies. The Referee was also concerned with the fact that a report listing functional limitations could not be used to assign impairment values under the standards because they were measured by a physical therapist.

After our review of the existing record at that time, we agree that Dr. Grant's reports lacked precision in stating the nature and extent of claimant's disability. We also agree that the reports did not provide range of motion findings, and that the physical limitations measured by the physical therapist may not be used to rate claimant's disability. See former OAR 436-35-005(1). Nonetheless, because claimant was represented by counsel throughout this process, and because the parties had ample opportunity to prepare their cases, we believe that any effort by the Referee to cure those shortcomings was improper. Furthermore, we find that the medical record was adequate for the purposes of rating the extent of claimant's permanent disability. Therefore, the Referee's obligation to develop a complete record had been satisfied, although it resulted in a failure of proof. It is claimant's responsibility, under ORS 656.266, to establish the extent and nature of any permanent disability. Consequently, we conclude that a referee should not exercise his or her discretion to cure a basic failure of proof, given the adversary nature of this system.[2]

Accordingly, we exclude Exhibit 49 and, on de novo review, rate the extent of claimant's disability.

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

Because claimant's condition became medically stationary on June 4, 1990, and his claim was closed by Determination Order on July 27, 1990, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-010 through 436-35-260 apply to the rating of claimant's scheduled permanent disability.

Surgical Procedures: Former OAR 436-35-110(4) allows for an award of permanent disability for various surgical procedures on the arm or forearm. As a result of his compensable injury, claimant underwent a radial and median surgical decompression of the right wrist and an exploratory surgery of the radial nerve at the right elbow. The surgeries were not excisional, however, and are not ratable under the standards.

Decreased Range of Motion: Former OAR 436-35-080 allows for an award of permanent disability for decreased range of motion in the wrist joint. Disability awards are based on degrees of motion retained. In this case, however, there is no evidence in the record that claimant has decreased range of motion

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[2] To hold otherwise could well result in inconsistent treatment of litigants by differing referees which would not provide a "fair and just administrative system" as mandated by the legislature. ORS 656.012(2)(b).

in his wrist. In fact, neither of the two examining physicians, nor Dr. Grant in his reports, indicate anything but full range of motion. Accordingly, this record does not provide a basis for determining any permanently decreased range of motion due to claimant's compensable injury.

Nerve Impairment: Under former OAR 436-35-110(3)(a), nerve impairment in the arm or forearm is rated as a loss of sensory ability and/or grip strength resulting in a loss of functional ability. In this case, Dr. Grant diagnosed a "right radial neuropathy and distal arm/proximal area" and "right distal median nerve conduction slowing - minimal and residual." (Ex. 47). Dr. Grant did not precisely quantify the extent of the loss, but did add "sensory loss in the median greater than radial distribution of the right hand." Id.

The maximum disability rating for median nerve sensory loss is 44 percent, while the maximum sensory impairment due to radial nerve damage is 5 percent. Former OAR 436-35-110(3)(a). For the "minimal" median nerve damage, which we conclude approximates a 15 percent disabling effect, claimant is entitled to a median rating of sensory loss of 7 percent. For the radial nerve damage, which is even less than in the median distribution, claimant is entitled to radial nerve rating of 1 percent.

These sensory loss ratings are combined with objective findings of functional loss due to loss of strength to determine a final impairment rating for residual nerve damage. Dr. Grant does not provide any findings of loss of strength. Sarada, a physical therapist, reported lost grip strength in her physical capacity evaluation report of July 24, 1990. However, in addition to the fact that Sarada questioned the objective validity of the findings, a physical therapist's measurements may not be used to assign impairment values under the standards. Former OAR 436-35-005(1); Linda F. Wright, 42 Van Natta 2570 (1990).

We note that Dr. Button, an independent medical examiner, included voluntary grip measurements in his report dated March 26, 1990. (Ex. 29). Those measurements, however, do not provide any means for determining any permanent loss of grip strength due to claimant's compensable injury. We also note that, at hearing, claimant estimated that he had lost about 70 percent of his grip strength. (Tr. 8) However, absent corroborating medical evidence, claimant's opinion is not persuasive evidence as to the extent of his permanent disability.

After our review of this record, we conclude that claimant had failed to establish a permanent loss of function due to loss of strength. Accordingly, for his residual median and radial nerve damage, claimant is entitled to an award of 8 percent scheduled disability.

Total Impairment: On this record, we conclude that claimant's total permanent disability is equal to 8 percent. We note that the July 27, 1990 Determination Order awarded claimant 14 percent scheduled permanent disability. However, we will not reduce claimant's award as the insurer has not requested a reduction. See Daniel M. Alire, 41 Van Natta 752 (1989).

ORDER

The Referee's order dated April 5, 1991, as amended April 17, 1991, is reversed, The July 27, 1990 Determination Order award of 14 percent (21 degrees) scheduled permanent disability is reinstated and affirmed.

Board Member Gunn dissenting.

While composing this dissent, I recalled an anecdote about a trial attorney. At the conclusion of a witness' testimony, the judge directed a question to the witness. The attorney leaped to his feet stating: "If you are asking that question on behalf of my opponent, I object, if your question is on my behalf, I withdraw it!" As a former advocate, nothing can be more irritating than the trier of fact assuming the role of advocate for either party in a dispute. Also, nothing is more damaging to the validity of the dispute resolution process. However, for the reasons stated below, I must ignore my instincts to adopt the majority's conclusion, and dissent.

My first objection is purely procedural. Not until Board review did the insurer raise the issue that the Referee erred in admitting certain documents into the record or by issuing an interim order. The record contains no objections to or requests for reconsideration of the interim order, or the final amended order. Even the insurer's request for Board review only states: "Review is requested because the Referee erred in his calculations of permanent partial disability" and that review is only requested on the amended Opinion and Order.

On this basis, I would hold that the Board is prohibited from addressing the question of the referee's authority as the issue has not been raised before review. When an issue is not raised at hearing and the record is closed, that issue will not subsequently be considered. Mavis v. SAIF, 45 Or App 1059 (1980); Richard C. Centeno, 41 Van Natta 617 (1989); Randy D. Johnson, 39 Van Natta 463 (1987). We have reasoned that to address an issue that was not raised at hearing would be fundamentally unfair. Gunther H. Jacobi, 41 Van Natta 1031 (1989).

Turning to the question of the Referee's actions and authority, I am compelled to conclude that his actions did not exceed his authority. ORS 656.283(7) governs how a referee may conduct a hearing. It provides:

> "Except as otherwise provided in this section and rules of procedure established by the board, the referee is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice. Evaluation of the worker's disability by the referee shall be as of the date of issuance of the reconsideration order pursuant to ORS.268. Any finding of fact regarding the worker's impairment must be established by medical evidence that is supported by objective findings. The referee shall apply to the hearing of the claim such standards for evaluation of disability as may be adopted by the director pursuant to ORS 656.726." ORS 656.283(7).

To sustain the insurer's objections to the Referee's actions or to support the majority conclusion that the action was improper compels the Board to reach a finding that the Referee acted outside the provisions or scope of ORS 656.283 or the Board's rules. The majority makes no such finding. In fact, it even fails to adopt the insurer's argument that the referee acted beyond the scope of OAR 438-07-005(5) in soliciting the additional medical evidence. The history of the rule (438-07-005(5)) dates back to 1966. The rule originally provided:

> "The hearing officer may appoint a physician to examine the injured workman and to file a report with he hearing officer. The parties may also agree in advance to be bound by the medical findings of the physician appointed by the hearing officer with approval of the parties. The cost of examinations and reports under this

rule shall be paid by the Board out of the Administrative Fund." Rule 5.05(E) (WCB Admin. Order 5-1966).

The rule was briefly suspended due to budgetary problems and in a memo from the WCB Director, dated January 15, 1971, it was proposed to rescind the rule because, "If a claimant appeals from that determination, it is up to him to prove by a preponderance of evidence that the determination is incorrect and it is up to him, not the hearing officer, to prove his case. For this reason and in light of our present budget, I feel that this provision should be rescinded." The Board declined to rescind the rule.

The rule has been reconstituted and renumbered to its present form. The only major change is to have the cost burden shifted from the Board to the insurers. The rule arose and exists without any legislative history or statutory authority. If only because of its application in this case, the Board should in the future review the rule to determine its continuation or modification.

Absent a showing that the Referee acted beyond the scope of rule or law, the Board cannot reach the conclusion that the action was improper.

The Board's ability to void a referee's actions for erroneous exercise of authority may be limited. In SAIF v. Roles, 111 Or App 597 (1992), the court held: "A judgment is void only when the tribunal sending it has no jurisdiction of the parties or the subject matter." In that case, the court held that the referee "may have erroneously exercised his authority when he denied SAIF's motion to dismiss, his erroneous exercise of that authority did not deprive him of subject matter jurisdiction." Id.

In the case before us, there is no question the Referee had subject matter jurisdiction. He also had authority and jurisdiction under the rule to reopen the record to obtain additional medical information.

The insurer, under the Board's rules, could have requested to cross-examine the attending physician to cure any "prejudice" that might have arisen from the Referee's interim order for medical information. The medical evidence (Ex. 49) only cured any procedural defects. The order did not introduce new substantive evidence into the record.

The only "prejudice" to the employer is that the evidence supports the Referee's amended Opinion and Order and claimant's extent of disability. Moreover, current Department rules pertaining to the reconsideration process would have allowed the submission of additional information to clarify or correct a medical record based on physical examinations at or prior to closure. See OAR 436-30-050(4)(e) and (f). Denying claimant compensation for his disability because of a failure to jump through a procedural hoop does not constitute substantial justice. Deeming the actions of a referee to be improper, when he is operating under a valid Board rule, likewise does not constitute substantial justice.

The Board is ultimately responsible to set forth the standards for the way referees conduct hearings. This case certainly proves that we should pay closer attention to those responsibilities.

For the reasons stated above, I respectfully dissent.

In the Matter of the Compensation of
MARK L. HADLEY, Claimant
WCB Case No. 90-18036
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members en banc.

The self-insured employer requests review of those portions of Referee Harri's order that: (1) found that the Hearings Division has original jurisdiction to consider claimant's medical services claim for use of a vehicle equipped with automatic transmission; and (2) set aside its denial of the same claim. On review, the issues are jurisdiction and medical services. We vacate.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 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., 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 Law as amended, effective July 1, 1990.

The Board, and thus the Hearings Division, generally has original jurisdiction of matters concerning a claim. See ORS 656.283(1). However, the 1990 Legislature restricted the Board's jurisdiction by amending ORS 656.704(3) to provide that "matters [concerning a claim] do not include any proceeding for resolving a dispute regarding medical treatment or fees for which a procedure is otherwise provided in [ORS Chapter 656]."

The employer contends that claimant's claim for a vehicle equipped with automatic transmission is a matter for which a resolution procedure is already provided in ORS 656.327. ORS 656.327(1) provides:

> "If an injured worker, an insurer or self-insured employer or the director believes that an injured worker is receiving medical treatment that is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services and wishes review of the treatment by the director, the injured worker, insurer, self-insured employer shall so notify the parties and the director."

Consequently, the employer contends that, under ORS 656.704(3), this dispute is not a "matter concerning a claim" over which the Hearings Division has original jurisdiction. The Referee disagreed, concluding that ORS 656.327 did not apply to this case because the employer did not provide the requested service and because the employer issued a denial of the claim. We disagree with the Referee.

We recently held in Stanley Meyers, 43 Van Natta 2463 (1991), that under ORS 656.704(3) "matters concerning a claim," over which the Hearings Division

has original jurisdiction, do not include any dispute regarding medical treatment that is challenged on one of the grounds listed in ORS 656.327(1), i.e., "excessive, inappropriate, ineffectual, or in violation of rules regarding the performance of medical services."

Here, the employer is challenging claimant's claim as inappropriate. (Tr. 5). Although the employer did not provide claimant the use of a vehicle equipped with automatic transmission, that is not a necessary prerequisite for application of ORS 656.327. See Kevin S. Keller, 44 Van Natta 225 (1992). It is enough that claimant purchased the vehicle and is seeking partial reimbursement as a claimed medical service.[1]

We do not agree with the Referee's suggestion that the employer's denial precludes application of ORS 656.327. In Stanley Meyers, supra, we held that, until the Director issues an order after conducting his review, the insurer may not issue a denial of medical services on any of the grounds listed in ORS 656.327(1). Any such denial is null and void as a matter of law. See ORS 656.327(1)(c).

Accordingly, the employer's denial of claimant's medical services claim is null and void as a matter of law, and the Referee lacked jurisdiction to consider this matter.

ORDER

The Referee's order dated February 15, 1991, is vacated. Claimant's hearing request is dismissed for lack of jurisdiction.

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[1] Although ORS 656.327(1) and 656.704(3) expressly refer to "medical treatment" rather than "medical services," we find no statutory basis for distinguishing the two terms. "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); see OAR 436-10-005(24). We have interpreted "medical services" to include vehicle modifications. See, e.g., Benita C. McGowan, 41 Van Natta 1448 (1989); Verlin A. Belcher, 35 Van Natta 1401 (1983). "Medical treatment," on the other hand, is not defined separately either in the statutes or the administrative rules. That omission supports our view that the legislature did not intend a distinction between those terms. Indeed, it appears the two terms are used interchangeably. See generally ORS 656.245, 656.327. Therefore, we conclude they have identical meanings for purposes of applying ORS 656.327(1) and 656.704(3). In this case, our conclusion is further supported by the fact that claimant's doctor wrote a prescription for the automatic transmission in much the same way that a doctor would prescribe other types of treatment, such as medication.

Board members Kinsley and Tenenbaum dissenting.

The majority concludes that vehicle modifications for the benefit of an injured worker are "medical treatment" and that disputes regarding the appropriateness of such modifications are no longer matters within the jurisdiction of the Hearings Division of the Board pursuant to ORS 656.283, but are matters exclusively within the Director's medical review jurisdiction under ORS 656.327 and 656.704(3). We believe that interpretation expands the jurisdiction of the Director to matters not contemplated by the legislature. We therefore dissent.

The central issue is whether ORS 656.327 provides a procedure for resolving this dispute. If so, jurisdiction lies with the Director; if not, jurisdiction lies with the Board.

A prerequisite for application of ORS 656.327 is that "an injured worker is receiving medical treatment." (Emphasis added). The majority steers around this obstacle by defining "medical treatment" to include all medical services, including vehicle modifications. See infra n.1. We are not so persuaded. If the legislature had intended those terms to have identical meanings, then the legislature would have used identical terms. The legislature's decision not to do so is a statutory basis for distinguishing those terms, and we are required to give meaningful effect to that distinction. See Emerald PUD v. PP&L, 76 Or App 583 (1985), aff'd 302 Or 256 (1986) (When the legislature uses different terms in related statutes, it is presumed that different meanings were intended).

We are persuaded that the term "medical treatment" has a more restrictive meaning than "medical services." "Medical services" is defined as "any medical, surgical, chiropractic, dental, hospital, nursing, ambulance, or other related services; also any drugs, medicines, crutch, prosthesis, brace, support or physical restorative device." OAR 436-10-005(24) (Emphasis added).

"Medical treatment," on the other hand, is not defined by statute or rule. However, Dorland's Medical Dictionary (26th ed. 1981) defines "treatment" as the "management and care of a patient for the purpose of combating disease or disorder." Whereas vehicle modifications may be viewed as "other related services" within the definition of "medical services," such modifications generally are not directed toward combating a disease or disorder in a patient and, therefore, do not qualify as "medical treatment" within the meaning of ORS 656.327.

Here, the automatic transmission vehicle assisted claimant in obtaining medical treatment and performing his job; however, it was not directed toward combating a disease or disorder in claimant. Therefore, the use of the automatic transmission vehicle was not "medical treatment" and did not trigger application of ORS 656.327.

Inasmuch as there is no other procedure for resolving this dispute, we conclude it is a matter concerning a claim. See ORS 656.704(3). Accordingly, we would conclude that the Board properly has jurisdiction of this matter.

In the Matter of the Compensation of
KENNETH W. McDONALD, Claimant
WCB Case No. 90-08924
ORDER ON REVIEW
Roger D. Wallingford, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

The insurer requests review of those portions of Referee Crumme's order that: (1) concluded that the Hearings Division lacked jurisdiction over the medical services dispute regarding claimant's proposed back surgery; (2) overruled the insurer's objection to the admission of psychological reports and depositional testimony of Dr. Roundtree; and (3) set aside the insurer's denial of claimant's mental disorder claim. On review, the issues are medical services, admissibility of evidence and compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Medical Services

The insurer seeks review of the Referee's conclusion that the Hearings Division lacked jurisdiction to resolve the dispute concerning claimant's proposed back surgery. We reverse.

Pursuant to ORS 656.704(3), the Board's authority to conduct hearings is limited to "matters concerning a claim," which do not include any dispute regarding medical treatment for which a resolution procedure is otherwise provided in ORS Chapter 656. In this regard, ORS 656.327 provides, in part:

> "(1)(a) 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, self-insured employer shall so notify the parties and the director."

We have interpreted ORS 656.327 as providing a resolution procedure for disputes regarding the reasonableness and necessity of proposed medical treatment. Kevin S. Keller, 44 Van Natta 225 (1992). Accordingly, such disputes are excluded by the terms of ORS 656.704(3) from the jurisdiction of the Hearings Division.

In this case, however, the insurer contends that claimant's medical service claim for low back surgery is barred by principles of res judicata. Thus, the sole issue presented is whether claimant is entitled to make the request for surgery as a matter of law. Inasmuch as there is no other procedure provided by ORS Chapter 656 for resolving this issue, we conclude that this dispute is a "matter concerning claim" over which the Hearings Division has original jurisdiction. ORS 656.704(3); Michael A. Jaquay, 44 Van Natta 173 (1992).

Turning to the merits, we agree with the insurer that claimant's request for surgery is barred by res judicata. As stated by the court in Liberty Northwest Ins. Co. v. Bird, 99 Or App 560, 563 (1989):

> "In workers' compensation cases, when a claim for medical services is reasserted after being once denied, the question is whether the claimant's condition has changed so as to have created a new set of operative facts that previously could not have been litigated."

After our review of the record, we conclude that claimant's condition has not changed since Referee Neal denied his earlier request. We rely on the opinion of Dr. Rosenbaum, who examined claimant on September 13, 1990 and found no significant objective or subjective changes in claimant's condition since his prior evaluation on September 18, 1989. We are not persuaded by the opinion of Dr. Misko, who, after examining claimant in March 1990, concurred in the need for surgery. "A claimant is not entitled to relitigate the issue just because he finds new evidence in support of his claim." Liberty Northwest Ins. Co, v. Bird, supra, 99 Or App at 564. Accordingly, the insurer's "de facto" denial of claimant's medical services claim for low back surgery is upheld.

Admissibility of Evidence

At hearing, the insurer objected to the admission of all medical reports prepared by Dr. Roundtree, as well as his depositional testimony, on the grounds that he was not qualified to provide an expert opinion at the time the reports were prepared and his deposition was taken. The Referee overruled the insurer's

objection, concluding that Dr. Roundtree's training and experience in psychology was sufficient to qualify him as an expert.

Oregon Rule of Evidence 702 provides:

> "If scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training or education may testify thereto in the form of an opinion or otherwise."

Although a hearings referee is not bound by rules of evidence pursuant to ORS 656.283(7), we find the rationale and authority for the use of expert witnesses provided by OEC 702 useful in reviewing the Referee's evidentiary ruling. We also note that a Referee has a broad latitude of discretion with respect to the ruling, and a decision will not be disturbed if the question of admissibility reasonably could be decided either way. James A. Cross, 43 Van Natta 2475, on recon 43 Van Natta 2630 (1991).

Here, Dr. Roundtree holds both a Master's Degree and a Ph.D. in psychology. Although he was not yet a licensed psychologist at the time of his deposition, he testified that he had completed a clinical internship in psychology and, while treating claimant, was a psychology resident working under a supervising psychologist. Given Dr. Roundtree's experience and training, the Referee did not err in finding him qualified to testify as an expert with regard to claimant's condition. Accordingly, we do not believe that the Referee erred in admitting his reports and depositional testimony.

Compensability

We adopt the conclusions and reasoning concerning the compensability of claimant's psychological condition as set forth in the Referee's order.

Attorney Fee on Review

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review concerning the compensability of claimant's psychological 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 attorney's services on review is $1,000, 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 May 16, 1991, as amended May 21, 1991, is affirmed in part and reversed in part. That portion of the Referee's order that concluded that the Hearings Division lacked jurisdiction to resolve the dispute over claimant's proposed back surgery is reversed. The insurer's denial of low back surgery is upheld. The remainder of the order is affirmed. For services on Board review concerning the compensability issue, claimant's attorney is awarded an assessed attorney fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
MICHELLE R. MOREHOUSE, Claimant
WCB Case Nos. 90-17771 & 90-17770
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Wallace & Klor, Defense Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

Claimant requests review of that portion of Referee Otto's order which declined to assess a penalty for American International Adjustment Company's (AIAC) or GAB Business Services' (GAB) allegedly unreasonable denials. AIAC cross-requests review of those portions of Referee Otto's order that: (1) set aside its denial, on behalf of Vehicle Processors, of claimant's aggravation claim for a current right shoulder condition; and (2) upheld GAB Business Services' (GAB) denial, on behalf of the same employer, of claimant's new occupational disease claim for the same condition. On review, the issues are responsibility and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except that we replace his second "Finding of Ultimate Fact," on page three with:

Claimant's work activities after October 1, 1989 caused increased right shoulder symptoms, but she did not suffer a new occupational disease after that date.

CONCLUSIONS OF LAW AND OPINION

The Referee apparently applied the Workers' Compensation Law in effect prior to the 1990 amendments.[1]

However, because claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990, this matter is properly analyzed under the 1990 amendments to the Workers' Compensation Law. See Or Laws 1990 (Special Session), ch. 2, 54(2); Ida Walker, 43 Van Natta 1402 (1991).

Responsibility

The Referee decided that responsibility for claimant's current right shoulder condition did not shift from AIAC to GAB, because claimant's work exposure during GAB's coverage did not independently contribute to a pathological worsening of that condition.

We agree that responsibility does not shift to GAB. However, in reaching this conclusion, we apply Section 49(1) of Oregon Laws 1990 (Special Session), chapter 2, which provides in relevant part:

> "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."

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[1] We reach this conclusion based on the Referee's statement that AIAC had 60 days, not 90 days, to accept or deny claimant's aggravation claim. Compare former and current ORS 656.262(6).

We have interpreted Section 49(1) to mean 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. Ricardo Vasquez, 43 Van Natta 1678 (1991). Thus, in this case, AIAC, as the last insured against whom claimant had an accepted right shoulder claim, remains presumptively responsible. In order to shift responsibility, AIAC has the burden of establishing that claimant sustained a new compensable injury or new occupational disease involving the same condition while working under GAB's coverage. Or Laws 1990 (Special Session), ch. 2 49(1); see Donald C. Moon, 43 Van Natta 2595, 2596 n.1 (1991) (Section 49 applies to occupational disease claims as well as to injury claims.); Rodney H. Gabel, 43 Van Natta 2662, 2664 (1991) (The last insurer against whom claimant had an accepted occupational disease claim remains responsible unless it establishes that work activities with the later insurer were the major contributing cause of an occupational disease involving the same condition).

Dr. Browning, claimant's attending physician, first saw claimant on June 26, 1990. Because Dr. Browning did not examine claimant before October 1, 1989, she was unable to form an opinion regarding the the relative effects of claimant's work exposures before and after that date. (See Ex. 22-18). Dr. Fuller, on the other hand, examined claimant, reviewed her history and opined that claimant had suffered an exacerbation of her 1988 symptomatology, which did not represent a new injury to her right shoulder. (Ex. 19-4). Based on this evidence, we conclude that claimant's work exposure during GAB's coverage was not the major cause of her right shoulder condition. Accordingly, AIAC has not established that claimant suffered a "new" occupational disease pursuant to her later work activities. See Rodney H. Gabel, supra. Therefore, AIAC remains responsible for medical services and disability related to claimant's compensable right shoulder condition.

Penalties and attorney fees

The Referee found AIAC's denial of claimant's aggravation claim to be unreasonable. On that basis, the Referee assessed a penalty of 25 percent of the $654.20 in unpaid medical bills. However, after reconsideration, the Referee denied claimant's request for a penalty, stating that there were no amounts then due for penalty purposes, because payment of medical benefits is stayed pending acceptance or denial of the claim.

We agree that AIAC had no legitimate doubt concerning the compensability of claimant's condition at the time of the denial. Therefore, AIAC's refusal to concede compensability of the claim before hearing, and to agree to the designation of a paying agent pursuant to ORS 656.307, constituted an unreasonable resistance to the payment of compensation. See D Maintenance Company v. Mischke, 84 Or App 218, 224-25 (1987).

Although there is evidence claimant paid certain medical bills, there is no evidence those bills were submitted to AIAC. Absent proof the bills were received by AIAC, its obligation to process those bills within the statutory 90-day claim processing period was not triggered.

However, claimant is entitled to an assessed attorney fee for AIAC's unreasonable resistance to compensation. ORS 656.382(1); see Nicolasa Martinez, 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 assessed attorney fee for claimant's counsel's services concerning the unreasonable denial issue is $400, to be paid by AIAC. 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.

Compensability was not litigated at hearing. There is no evidence that claimant's compensation would have been reduced if responsibility had shifted to GAB. Because there is no evidence that claimant's compensation was at risk, claimant's attorney is not entitled to an attorney fee for services on review. See ORS 656.382(2); Riley E. Lott, 43 Van Natta 209, 212 (1991).

ORDER

The Referee's order dated April 3, 1990, as reconsidered on April 19, 1990, is reversed in part and affirmed in part. Claimant's attorney is awarded an insurer-paid attorney fee of $400, to be paid by AIAC, for its unreasonable resistance to the payment of compensation. The remainder of the order is affirmed.

April 7, 1992 Cite as 44 Van Natta 697 (1992)

In the Matter of the Compensation of
OLGA I. SOTO, Claimant
WCB Case No. 91-12369
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Lester Huntsinger (Saif), Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of that portion of Referee Myers' order that: (1) dismissed claimant's request for hearing; (2) set aside an Order on Reconsideration because it was invalidly issued; and (3) found that jurisdiction over this matter remained with the Appellate Unit of the Workers' Compensation Division (WCD). On review, the issue is the validity of the WCD's Order on Reconsideration. We affirm.

FINDINGS OF FACT

On November 8, 1989, claimant sustained a compensable injury to her to right wrist, arm, shoulder and buttocks. Her claim was closed by a February 5, 1991 Determination Order that awarded temporary disability benefits, but did not award any permanent disability.

On July 9, 1991, claimant requested reconsideration of the Determination Order. Her request for reconsideration was made on a form provided by the Department of Insurance and Finance. On the form, claimant checked the box indicating that she disagreed with the impairment findings made by her attending physician at the time of claim closure.

On August 29, 1991, an Order on Reconsideration issued which affirmed the Determination Order in all aspects. The order acknowledged that claimant was entitled to a medical arbiter as there was a dispute over the impairment findings. However, the order explained that the Director was required by a circuit court judge's injunction to issue a reconsideration order "regardless of whether the reconsideration process has been completed." Despite the issuance of the reconsideration order, the parties were further advised that claimant would still be scheduled for a medical arbiter review.

At hearing, claimant contended that the Order on Reconsideration was invalid on the basis that the Director failed to appoint a medical arbiter and consider a medical arbiter's findings prior to the issuance of the reconsideration order.

CONCLUSIONS OF LAW AND OPINION

Validity of Department's Order

The Referee found that the Order on Reconsideration was not valid. Therefore, he dismissed claimant's request for hearing, set aside the Order on Reconsideration and found that jurisdiction remained with the WCD Appellate Unit. We agree.

Claimant became medically stationary after July 1, 1990. Therefore, the 1990 amendments to the Workers' Compensation Act apply to this case. See Oregon Laws 1990 (Special Session), 54(3). The Director's rules in effect at the time of the August 29, 1991 Order on Reconsideration are applicable. Former OAR 436-30-003(4)(WCD Admin. Order 7-1990, effective July 1, 1990).

As amended, ORS 656.268(4)(e) provides that: "If a worker objects to the notice of closure, the worker must first request reconsideration by the department under this section." In conjunction with this section, amended ORS 656.268(5) provides that: "If a worker, the insurer or self-insured employer objects to a determination order issued by the department, the objecting party must first request reconsideration of the order." Amended ORS 656.268(6)(b) then provides that:

> "If any party objects to the reconsideration order, the party may request a hearing under ORS 656.283 within 180 days after the copies of the notice of closure or the determination order are mailed, whichever is applicable. The time from the request for reconsideration until the reconsideration is made shall not be counted in any limitation on the time allowed for the request for hearing."

Read together, it is clear from ORS 656.268(4)(e), 656.268(5) and 656.268(6)(b) that claimant or the objecting party must not only request reconsideration from a Notice of Closure or Determination Order before requesting a hearing pursuant to ORS 656.283, but the reconsideration process established by ORS 656.268(5)-(7) must be completed before a hearing may be requested. See Lorna D. Hilderbrand, 43 Van Natta 2721 (1991).

ORS 656.268(7) provides, in part:

> "If the basis for objection to a notice of closure or determination order issued under this section is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter appointed by the director. . . . The findings of the medical arbiter shall be submitted to the department for reconsideration of the determination order or notice of closure. . . ." (Emphasis supplied).

The Director adopted former OAR 436-30-050(9), following the statute.

Here, claimant requested reconsideration of the Determination Order on the basis that she did not agree with the impairment findings made by her attending physician at the time of claim closure. The Director did not refer this claim to a medical arbiter or obtain and consider findings from a medical arbiter prior to the issuance of the reconsideration of the Determination Order. Therefore, the issue becomes whether the Director's noncompliance with the provisions of ORS 656.268(7) and OAR 436-30-050(9) renders the August 29, 1991 Order on Reconsideration invalid.

In Anaconda v. Dept of Rev., 278 Or 723 (1977), the tax department had failed to comply with a statute allowing a taxpayer to confer with the

department before a final assessment was made. The issue was whether the assessment was invalid because of the agency's noncompliance with the statutory requirement.

The Court observed that no single, general rule could be formulated to determine when noncompliance with an obligatory statutory procedure would or would not invalidate agency action. The Court reasoned that the issue is one of interpreting the consequence more probably intended by the legislature which enacted the particular provision in question. Id. at 727-728. The Court then stated:

> "Thus procedures designed to protect individuals dealing with an agency more likely are meant to be 'mandatory' than provisions equally obligatory, that are designed to assure legally and fiscally correct public administration in general, though the text or background of a particular enactment may show otherwise. Similarly the nature and extent of the disadvantage sought to be avoided by the procedure can bear on the probable intent with respect to the noncompliance." Id. at 728.

In the present case, the language in question - "the director shall refer the claim to a medical arbiter" - is unambiguous and clearly mandatory. See Benzinger v. Or. Dept. of Ins. & Finance, 107 Or App 449 (1991) (The word "shall," as used in the same section of Workers' Compensation law as in issue in this case, ORS 656.268(6)(a), is mandatory).

The requirement that a claim be referred to a medical arbiter and that the arbiter's findings be submitted to the Director for reconsideration altered the prior evaluation and review process in which the adjudicator was often required to choose between medical experts who were hired by the opposing parties to render opinions. The use of a non-aligned medical arbiter is further designed to assist the Director in resolving the complex medical issues concerning permanent impairment which frequently arise when determining a worker's disability. Finally, the implementation of the medical arbiter as part of a reconsideration process is in keeping with the policy 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).

Legislative history confirms that these were the purposes for which the legislature adopted ORS 656.268(7). During hearings of the Joint Interim Committee, witnesses testified that the provision later adopted (with amendments immaterial to this discussion) as ORS 656.278(7) was proposed to insure that medical professionals decide medical questions and to eliminate "dueling doctors." Hearings of the Joint Interim Committee on Workers' Compensation, May 3, 1990, Tape 9, Side B.

This is further supported by the comments of Representative Shiprack during the House floor debates. He indicated that the use of a medical arbiter was compulsory and intended to protect the rights of the parties, particularly the injured workers. He stated:

> "If there is a disagreement related to the impairment of your disability, then what we're going to have from now on, and should this bill pass, is what's known as a medical arbiter. One of the biggest single complaints that injured workers have today about the Workers' Comp [sic] system is when there's a dispute about extent of disability both sides go out and hire their own hired guns. We've

talked about it on the floor. I recently talked to a carpenter in my district just this weekend who had had eight separate independent medical examinations on this one claim related to his knee. This would be cut off. There would be no more IME's on extent cases. And the medical arbiter's opinion would be binding." House Floor Debates on SB 1197, May 7, 1990.

Considering the clear and imperative language of ORS 656.268(7), as well as the aforementioned legislative history, there can be little doubt that the legislature intended referral to a medical arbiter as a condition precedent to reconsideration where the party requesting reconsideration disagrees with the impairment used in rating the worker's disability.

Where, as here, the Director does not comply with that mandatory procedure, and one of the parties objects to the order issued, the Order on Reconsideration is invalid. Here, claimant challenged impairment, the Director did not appoint a medical arbiter or consider a medical arbiter's findings prior to the issuance of an Order on Reconsideration. Based on the foregoing discussion, we agree with the Referee that the order is invalid.

ORDER

The Referee's order dated November 29, 1991, as amended December 6, 1991, is affirmed.

Board Members Kinsley and Tenenbaum dissenting.

We agree with the majority that, because the party requesting reconsideration of the February 5, 1991 Determination Order disagreed with the impairment used in rating the worker's disability, ORS 656.268(7) required the Director to refer the claim to a medical arbiter. However, we disagree with the majority's analysis of this case under Anaconda v. Dept. of Rev., 278 Or 723 (1977) and the majority's conclusion that the Appellate Unit's July 8, 1991 Order on Reconsideration should be set aside as invalid. We believe that the medical arbiter process does not necessarily operate to "protect individuals dealing with an agency." Since this is the standard required to invalidate or "erase" an order, we would not invalidate the order. Rather, we would remand the case to the Hearings Division to admit evidence on the issue of the extent of the worker's permanent disability so that a referee could issue an order resolving the case.

The problem in Anaconda was what to do with a Department of Revenue order assessing a tax where Revenue had failed to hold a conference with the taxpayer prior to the issuance of the final tax assessment. The conference was mandated by statute. The court held that, if a mandatory statute that is "designed to protect individuals dealing with an agency" is not followed, the ensuing order may be set aside or invalidated. Id. at 728. This means that the state agency would start over from scratch as if no order ever issued. We gather that if the court had not found the mandatory statute to be one that is "designed to protect individuals dealing with an agency," then they would have gone on with their usual procedure to review Revenue's order on the merits pursuant to the applicable standard of review and affirm, modify or reverse the order to reach the correct result.

The conference that Revenue did not hold would have entitled the taxpayer to participate more fully in the process leading to the tax assessment against it. (The taxpayer was a corporation.) The court held that the failure to hold the conference caused harm to the taxpayer. In this case, however, avoidance of the medical arbiter procedure would allow the parties an improved opportunity to participate in the procedure leading to the award of benefits for permanent

disability. The amendments to ORS 656.268(7) that set up the medical arbiter procedure took away the parties' long-standing right to fully present evidence at hearing on the issue of permanent disability. The last sentence of the new statute reads:

> "The findings of the medical arbiter or panel of medical arbiters shall be submitted to the department for reconsideration of the determination order or notice of closure, and no subsequent medical evidence of the worker's impairment is admissible before the department, the board or the courts for purposes of making findings of impairment on the claim closure." (Emphasis added.)

Here, where there has been no medical arbiter report, the prohibition against submission of additional medical evidence does not "kick in." Legislative history supports the premise that the prohibition is applicable where the medical arbiter procedure is used. Hearings on Senate Bill 1197 before the Joint Interim Special Committee on Workers' Compensation, (May 4, 1990, Tape 11, Side A, in responding to the question of whether further medical evaluations would be allowed: "[M]y impression was that after reconsideration had been requested and an extent of disability and impairment had been determined by a panel of medical arbiters, there would be no further evaluation for or against the disability award." (Emphasis added.) Statement of Jim Edmunson, State Representative; (Id., May 4, 1990, Tape 17, Side B: "After the panel [of medical arbiters] has come to their conclusion, there can't be additional information or evidence." (Emphasis added.) Statement of Gene Derfler, State Representative.)

A review of the legislative history reveals that a key purpose of the medical arbiter procedure was to cut down on the costs of litigation in these cases. (Id., May 3, 1990, Tape 2, Side B: "So we think this [medical arbiter procedure] will save the system a good deal of money on hearings." Testimony of Cecil Tibbetts, witness; Id., May 4, 1990, Tape 15, Side B, after discussing a worker who had eight independent medical examinations: "That would quit. We wouldn't have to put people through that situation and the needless litigation that exists. And not to mention the expense." Statement of Bob Shiprack, State Representative.)

Witnesses at the hearings believed that the Legislature's method of cutting the cost of litigation through the medical arbiter procedure meant that a party has less of an opportunity to participate in the procedure leading to the award. Lawyers experienced in representing the interests of parties in workers' compensation proceedings had concerns regarding the exclusion of evidence in the medical arbiter procedure. Hearings on Senate Bill 1197 before the Joint Interim Special Committee on Workers' Compensation (May 3, 1990, Tape 9, Side A: "The last part of that last sentence referring to the consequences of the arbiter, the medical panel appointed by the director to make the final decisions on permanent disability, says no new medical evidence of the worker's impairment is admissible in the record of the claim. I simply want to suggest to you people that no matter what the purpose of this bill is in terms of reducing costs for employers, reducing litigation, any of those things, I don't think you're going to find that purpose served ever by excluding evidence of facts that have happened in the real world." Testimony of David Force, witness; Id., Tape 10, Side A: "The provision that workers cannot put any new evidence in the record after the appeal to the medical arbiter really makes the hearings process almost worthless. . . . [I]f he [the party] can come up with some evidence for the hearings officer, let him present it. Why do you want to keep that out?" Testimony of Charles Williamson, witness; Id.: "If you're demanding they [the party] go back to another governmental agency and then their right to present more evidence is frozen, they are not going to feel like they've had their opportunity to present their case. . . . You can have a medical arbiter and

that's the last time you get to present medical or meaningful testimony. . . . I submit to you that the individuals who are coming through this system are going to be leaving it with one very clear thought in mind. And that is simply I did not have a very fair shot. Nobody listened to me. Nobody wanted to hear from me. They wouldn't even listen to the evidence I wanted to put on." Testimony of David Hittle, witness; May 4, 1990, Tape 17, Side B: "If you say that you cannot introduce evidence that you generate once you acquire the responsibility for representing a client at a hearing, then what you tend to do is to magnify the cynicism that many workers now have about a system that makes its final decisions at the level of bureaucracy and does not present the opportunity for a decision maker like a referee or some other independent process." Testimony of Brian Welch, witness.)

Further, the submission of a medical arbiter's report does not necessarily protect the parties, when one considers that they have no opportunity to supply the arbiter with the correct history of the case (outside of an oral history given by the worker at the time of the examination, if there is an examination) or to ask the specific questions that need to be answered in a particular case. Neither are they supplied with a copy of the history or the questions given to the arbiter by the Department. Further, given the complete prohibition against subsequent medical evidence, the parties apparently have no opportunity to cross-examine the medical arbiter at hearing to determine the arbiter's qualifications, to determine if the arbiter had the correct and complete history of the case, or to determine even if the arbiter focused on the correct body part and compensable condition. ORS 656.310(2) regarding the right to cross-examine a doctor whose report has been admitted into evidence is not applicable since the report is offered by the State and not by a party. In essence, the medical arbiter is a witness who has been inserted into the case by the State and who gives evidence, but unlike any other medical evidence that is admitted, the parties are unable to establish the basis for the opinion or to establish whether the opinion is reliable.

In conclusion, we find that the medical arbiter procedure in ORS 656.268(7) does not necessarily operate "to protect individuals dealing with an agency," but was enacted to cut down on the costs of litigation. The failure of the Department to follow that procedure actually allowed the parties an improved opportunity to submit medical evidence at hearing on the issue of permanent disability, since the prohibition against submission of further evidence is not applicable. We would remand the case to the Hearings Division to conduct a de novo hearing on the matter and to issue an order on the merits which affirms, modifies or reverses the award made in the August 29, 1991 Order on Reconsideration.

April 7, 1992 Cite as 44 Van Natta 702 (1992)

In the Matter of the Compensation of
GARY L. WALDRUPE, Claimant
WCB Case Nos. 90-17608 & 90-13576
ORDER ON RECONSIDERATION
Welch, et al., Claimant Attorneys
Roderick D. Peters, Defense Attorney
Vavrosky, et al., Defense Attorneys

On January 7, 1992 and January 10, 1992, we withdrew our December 13, 1992 Order on Review for reconsideration. This action was taken to consider claimant's motion for reconsideration of our order which had held that the Hearings Division lacked jurisdiction to consider claimant's hearing request concerning the self-insured employer's denial of claimant's surgery claim.

Contending that the employer's denial also raised the issues of aggravation, as well as a causal relationship between the surgery and claimant's compensable injury, claimant asserted that the Referee was authorized to consider the matter. In withdrawing our order, we granted the employer an opportunity to respond. Having received that response, we proceed with our reconsideration.

As a preliminary matter, we note that SAIF has also submitted a response to claimant's motion for reconsideration. SAIF's prior participation in this matter has consisted of its request that the Board affirm that portion of the Referee's order that dismissed claimant's hearing request from SAIF's denial of claimant's "new injury" claim. The aforementioned portion of the Referee's order was not contested on Board review. Moreover, our abatement orders granted the self-insured employer (the party which had appealed the Referee's order) the opportunity to respond to claimant's motion for reconsideration. Inasmuch as SAIF was neither requested to respond to claimant's motion nor are its interests in this case impacted by the issues raised by claimant's motion, SAIF's response has not been considered.

To begin, we amend our prior "Findings of Fact." Specifically, we adopt the Referee's "Findings of Fact" with the following supplementation. Dr. Puziss has not performed the denied surgery. Furthermore, Dr. Nathan's status in this case is not as an independent medical examiner, but rather as a surgeon who has performed two surgeries on claimant.

We turn to the merits of claimant's contentions. In reaching our conclusion that the Hearings Division lacked jurisdiction to consider claimant's hearing request we relied on Tracy Johnson, 43 Van Natta 2546 (1991). We reasoned that since the employer's denial was based on a contention that claimant had exceeded the number of attending physicians of his choice pursuant to ORS 656.245(3)(a), the Referee was without authority to address the dispute.

Claimant neither contests our determination that the employer's denial was based on ORS 656.245(3)(a) nor our reliance on the Johnson holding. Instead, he argues that we retain jurisdiction over this matter because the employer's denial also raised the issue of aggravation, as well as a causal relationship between the surgery and claimant's compensable injury. We shall respond to each contention separately.

Claimant contends that we retain jurisdiction over this case because the employer denied the existence of a causal relationship between the proposed surgery and claimant's compensable injury.

We have recently held that the Board has jurisdiction to consider disputes concerning whether medical treatment is causally related to the compensable injury. Michael A. Jaquay, 44 Van Natta 173 (1992). We have further reasoned that disputes regarding proposed medical treatment, as well as those regarding current medical treatment, are within the Director's original jurisdiction in accordance with ORS 656.327. Kevin S. Keller, 44 Van Natta 225 (1992).

Here, the Referee identified one of the issues for resolution to be whether claimant's surgery was "connected" to claimant's 1985 claim with the employer. Furthermore, at the conclusion of his order, the Referee stated as follows: "Since the issues seem to have narrowed to claimant's having had too many treating doctors, rather than was the surgery necessary and connected to the December 2, 1985 injury, I find in claimant's favor."

On review, neither party contested the Referee's identification of the salient issue nor his conclusion that the surgery was related to claimant's 1985 claim with the employer. Rather, the employer primarily focused its attention

on the persuasiveness of Dr. Puziss' opinion in light of its contention that the surgeon had not attained the level of claimant's "attending physician" under the appropriate statutory and administrative requirements. Moreover, claimant responded that the Referee did not err in finding that Dr. Puziss was claimant's treating physician and that Dr. Puziss' opinion concerning the proposed surgery was persuasive.

Notwithstanding the employer's apparent concession of a causal relationship between the surgery and claimant's compensable injury, the fact remains that a dispute regarding this causal relationship question existed at the time of hearing and was resolved by the Referee's order. Under such circumstances, the Board and its Hearings Division have jurisdiction to consider such disputes. Michael A. Jaquay, supra. Consequently, we affirm the Referee's order insofar as he found claimant's surgery to be causally related to claimant's 1985 claim with the employer.

Although we have found the condition for which Dr. Puziss proposes surgery to be causally related to claimant's 1985 injury, disputes continue to remain concerning whether Dr. Puziss is an attending physician and whether the proposed surgery is reasonable and necessary. As previously discussed, the dispute regarding the status of Dr. Puziss as an attending physician is subject to the Director's jurisdiction under ORS 656.245(3)(a). Tracy Johnson, supra. Moreover, the dispute concerning whether the proposed surgery is reasonable and necessary treatment is likewise under the Director's jurisdiction pursuant to ORS 656.327(1). Kevin S. Keller, supra. Inasmuch as the Board and Hearings Division lack jurisdiction to consider the aforementioned medical treatment disputes, we vacate the Referee's order insofar as he found that Dr. Puziss was claimant's attending physician and that the proposed surgery was reasonable and necessary. The resolution of those disputes is subject to the jurisdiction of the Director.

Finally, we turn to claimant's contention that we retain jurisdiction to consider the aggravation issue.

In addition to objecting to the number of claimant's attending physicians, the employer's denial also refused claimant's attorney's June 6, 1990 request that the claim be reopened. This request for claim reopening was apparently based on Dr. Puziss' June 1, 1990 report seeking authorization for surgery. Furthermore, no basis, other than the performance of the proposed surgery, has been advanced in support of claimant's request for claim reopening.

Without question, a refusal to reopen a claim for aggravation raises a "question concerning a claim," thereby entitling a worker to request a hearing. See ORS 656.283(1). Moreover, since a worker's right to receive compensation is directly in issue, the appropriate litigation forum for such a dispute is the Hearings Division. See ORS 656.704(3).

Nevertheless, in the present case, claimant's reopening request was contingent on whether Dr. Puziss' surgery request should be authorized. Since elective surgery requests can only be made by an attending surgeon (OAR 436-10-070(1)), the viability of Dr. Puziss' request is dependent on whether he is an attending physician under ORS 656.245(3)(a). Consequently, it follows that consideration of any claim reopening issue must await the Director's determination as to whether claimant may change his attending physician to Dr. Puziss.

Therefore, litigation of that portion of the employer's denial which pertained to an aggravation claim based on the proposed surgery must be deferred pending Director resolution of the "attending physician" dispute. As an administrative matter, when, as here, a Referee is required to consider issues that

are encompassed within one WCB Case Number in a manner that will finally resolve some issues and defer others for resolution at a future date, the following procedure is recommended. The Referee should direct the Central Files Section of the Hearings Division to create a new WCB Case Number to which the Referee will then assign the deferred issue(s).

This recommended administrative procedure is designed to permit the Referee to issue a final, appealable order resolving the issues which are presently viable under a specific WCB Case Number, while also retaining another WCB Case Number deferring action on the issues which must await resolution. In this manner, the "finally resolved" issues can be separated from the "deferred" issues, thereby avoiding potential confusions which would inevitably result if one WCB Case Number involved both types of issues. For example, if only one WCB Case Number was used in case such as this, the case administratively could be in two locations at the same time; on Board review of an appealed Referee's order and also in deferred status awaiting a Director's decision.

To return the "aggravation/surgery" issue to its appropriate status of "deferral" and to avoid any potential administrative confusion, the Central Files Section of the Hearings Division is directed to assign a new WCB Case Number to the aggravation/surgery issue. Litigation of this new case will then be deferred pending the Director's decision concerning the proposed surgery. The parties are requested to keep the Docketing Section fully apprised of further developments regarding the aggravation/surgery issue.

In reaching this conclusion, we wish to emphasize that a Referee may proceed to consider an aggravation issue based on a theory that a claimant's current condition (irrespective of a proposed surgery) constitutes a worsening of a compensable injury since the last award or arrangement of compensation. Should such a theory be advanced, it would be unnecessary for a Referee to have a new WCB Case Number created for deferral. Yet, as previously noted, no basis other than claimant's surgery request was asserted as a ground for his aggravation claim.

In conclusion, we hold that the Hearings Division lacked jurisdiction to consider claimant's hearing request insofar as it pertained to the issues of whether Dr. Puziss was an attending physician and whether the proposed surgery was reasonable and necessary. Since such disputes are subject to the jurisdiction of the Director, those portions of the Referee's order which pertained to those issues must be vacated and those portions of claimant's hearing request regarding those issues shall be dismissed.

We further conclude that, since the employer's aggravation denial was based on the proposed surgery, it would be premature for us to consider claimant's denied aggravation claim because the claim is contingent on whether the Director determines that the proposed surgery should be performed. Inasmuch as litigation of this matter should be deferred, we direct the Central Files Section of the Hearings Division to assign a new WCB Case Number to this issue. Litigation of this aggravation/surgery issue will be deferred pending the Director's decision concerning the proposed surgery. The parties are requested to keep the Hearings Division fully apprised of future developments concerning this matter.

Finally, we affirm the Referee's order insofar as the Referee found claimant's current condition and proposed surgery causally related to claimant's 1985 injury claim.

In light of our conclusions, we modify the Referee's $2,750 attorney fee award for totally prevailing against the employer's denial. As a result of our

decision, claimant is entitled to an attorney fee for prevailing against the employer's denial of a causal relationship between the current condition/proposed surgery and claimant's compensable injury. ORS 656.386(1). In addition, claimant is entitled to an attorney fee for services on Board review concerning his successful defense of that portion of the Referee's order.

After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable attorney fee for claimant's counsel's services at the hearing level and on Board review concerning the "causal relationship" issue is $1,500, to be paid by the self-insured employer. This fee is in lieu of, rather than in addition to, the Referee's $2,750 attorney fee award. In reaching this conclusion, we have considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, and the value of the interest involved. We further note that the primary focus of this dispute at both the hearings level and on Board review were the "attending physician" and "reasonable and necessary" issues, matters which we have determined are not subject to our jurisdiction.

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our December 13, 1991 order effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Member Gunn, specially concurring.

This decision is in accordance with the Board's holding in Tracy Johnson, 43 Van Natta 2546 (1991). Inasmuch as Johnson is existing case precedent, I am constrained to follow it under the doctrine of stare decisis. Nevertheless, I write this special concurrence to reiterate the reasoning expressed in my dissenting opinion in Johnson.

Board Member Kinsley, specially concurring.

This decision is in accordance with the Board's holding in Kevin S. Keller, 44 Van Natta 225 (1992), and Tracy Johnson, 43 Van Natta 2546 (1991). Inasmuch as Keller and Johnson are existing case precedent, I am constrained to follow them under the doctrine of stare decisis. Nevertheless, I write this special concurrence to reiterate the reasoning expressed in my dissenting opinions in Keller and Johnson. I further note that had my reasoning prevailed, all issues in this matter could have been heard, resulting in a final disposition of the case. Finally, this method of requiring the parties to sequentially appear before separate administrative forums to resolve their disputes increases the costs to the parties, as well as to the system, and delays resolution of the case.

Board Member Tenenbaum, specially concurring.

I join in Member Kinsley's special concurrence with respect to her observations concerning the Keller decision and the costly delays resulting from this resolution process.

In the Matter of the Compensation of
PATRICIA M. DEMETRAKOS, Claimant
WCB Case Nos. 89-23972, 89-19849, 89-17230 & 89-23971
CORRECTED ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
H. Thomas Anderson (Saif), Defense Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Westerband and Moller.

Claimant requests review of that portion of Referee Black's order which found that claimant was not entitled to temporary total disability benefits because she had voluntarily withdrawn from the work force at the time of her disability for a compensable bilateral hand/wrist condition. Liberty Northwest Insurance Corporation filed a cross-request for review, but has withdrawn that request in its respondent's brief. On review, the issue is claimant's entitlement to temporary total disability benefits under her claim with Liberty Northwest. We affirm.

FINDINGS OF FACT

Claimant gave her two week notice of retirement to her employer on August 3, 1989. (Tr. 81; Ex. 33). The personnel action form that claimant originally submitted listed the reason for her termination as "retirement." (Ex. 33).

Claimant's last day of work was scheduled to be August 18, 1989. However, claimant's actual last day of work was August 11, 1989. She took "personal leave" days on the 14th, 15th and 16th of August 1989, because she would have lost her "personal leave" days had she not taken them. Claimant took sick leave on the 17th and the 18th of August 1989. (Tr. 82). In September 1989, claimant contacted her supervisor and asked that the personnel action form be changed to indicate that her termination was due to disability rather than retirement. (Tr. 65-66).

Claimant had been talking to orthopedic surgeon, Dr. Robertson, about retiring at age 62 since at least 1986. (Ex. 53-12). Claimant told Dr. Schachner on April 3, 1989 that she planned to work through her 62nd birthday and then apply for retirement. (Ex. 26). Claimant had told Alice Johnson, her supervisor, that she was looking forward to retirement. Johnson stated that claimant wished to retire at the earliest possible time. At claimant's employer, the earliest retirement age is 62. (Tr. 63).

Claimant was examined by Dr. Jewell, a hand surgeon, on June 26, 1989. This was Dr. Jewell's only examination of claimant. On August 1, 1989, Dr. Jewell reported that "I don't see how this woman can keep working much longer with these problems referable to her hands." (Ex. 32). Dr. Jewell added that the optimal situation would be for claimant to seek employment where there were no requirements for repetitious hand and arm motions.

On September 22, 1989, Dr. Jewell signed a check-the-box form prepared by claimant's attorney indicating that, based on his June 26, 1989 examination, claimant was "permanently disabled from performing her regular work as a typist due to her industrially related bilateral hand and wrist conditions." (Ex. 36).

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had voluntarily withdrawn from the work force at the time of her disability. Consequently, the Referee reasoned that claimant was not entitled to temporary total disability benefits. We agree.

To receive temporary disability, claimant must be in the work force at the time of her disability. A worker who has voluntarily withdrawn from the work force is not entitled to such compensation. Cutright v. Weyerhaeuser, 299 Or 290 (1985).

The critical time for determining whether claimant has withdrawn from the work force is at the time of her disability. Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989). In Weyerhaeuser Co. v. Kepford, 100 Or app 410, 414 (1990), the court held that entitlement to temporary disability benefits is not dependent upon whether or not a claimant had retired or had withdrawn from the work force if the claimant's disability arose before the worker's withdrawal from the work force. Kepford, supra at 414.

Here, claimant did not become disabled until after she withdrew from the work force. Dr. Jewell saw claimant once on June 26, 1989. In his August 1, 1989 report, Dr. Jewell expressed concern regarding claimant's capacity to continue her current work activities. He also noted that an optimal situation would be employment where there were no requirements for repetitious hand and arm motions. Nevertheless, Dr. Jewell did not indicate that claimant was disabled from performing her current work activities or any other work activity.

It was not until approximately one month after claimant's retirement that Dr. Jewell appeared to modify his initial opinion. Specifically, Jewell signed a "check-the-box" response from claimant's attorney agreeing to the statement that as of her June 26, 1989 examination, claimant was "permanently disabled from performing her regular work as a typist due to her industrially related bilateral hand and wrist conditions."

We do not consider this response to be persuasive evidence that claimant was disabled prior to her withdrawal from the work force. To begin, Jewell does not provide any explanation for why he neither stated that claimant was disabled following his June 1989 examination nor resticted her from returning to her work activities. Considering this unexplained apparent change of opinion, we decline to accord it weight. Kelso v. City of Salem, 87 Or App 630 (1987). Moreover, in light of the lack of reasoning provided in this check-the-box response, we do not find this conclusory response persuasive. Moe v. Ceiling Systems, 44 Or App 429 (1980). Finally, inasmuch as the response is primarily directed to claimant's permanent capacity to use her hands repetitively, it may be of more assistance in evaluating claimant's permanent disability, which will occur at claim closure.

In conclusion, we find that claimant retired effective August 18, 1989. The record indicates that claimant had been anticipating her retirement at age 62 since 1986. Claimant retired two days before her 62nd birthday, indicating (before consultation with her attorney) on her personnel action form that her termination was due to retirement.

Based on this record, we agree with the Referee that claimant had withdrawn from the work force prior to the onset of disability due to her compensable condition. Consequently, we hold that claimant is not entitled to temporary disability benefits.

ORDER

The Referee's order dated February 5, 1991, as reconsidered July 9, 1991, is affirmed.

In the Matter of the Compensation of
DEBRA L. ENDICOTT, Claimant
WCB Case No. 90-22506
ORDER ON REVIEW
Phillip G. Henderson, Claimant Attorney
Brian Pocock, Defense Attorney

Reviewed by Board Members Moller and Neidig.

The self-insured employer requests review of those portions of Referee McWilliams' order which: (1) awarded claimant 30 percent (96 degrees) unscheduled permanent partial disability, whereas a Determination Order previously provided for an award of 31 percent (99.2 degrees) unscheduled permanent disability for claimant's low back condition; and (2) awarded penalties and an assessed attorney fee for unreasonable resistance to the payment of compensation. Claimant cross-requests review of those portions of the Referee's order that: (1) reduced the Determination Order award of unscheduled permanent disability for her low back condition; and (2) declined to award scheduled permanent disability for her left leg. On review, the issues are extent of unscheduled permanent disability, scheduled permanent disability, and penalties and attorney fees. We modify in part, affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for the third sentence of the "Findings of Ultimate Fact."

Claimant has sustained a 33 percent loss of earning capacity as a result of her compensable injury.

CONCLUSION OF LAW AND OPINION

We agree with the Referee that the "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability.

Unscheduled Permanent Partial Disability

The determination of permanent partial disability under the "standards" is made by determining the appropriate values assigned by the "standards" to 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 39 years is 0. Former OAR 436-35-290(3).

Formal education

The appropriate value for claimant's GED is 0. Former OAR 436-35-300(3).

Skills

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor.

The highest SVP level demonstrated by a claimant during the ten years prior to the date of hearing is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of hearing was 4 based upon her work as a nurse's aide and salesperson. DOT 355.674-014 and 279.357-054. We therefore agree with the Referee that the appropriate value for skills is 3. Former OAR 436-35-300(4).

Training

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

The Referee concluded that despite claimant's having participated in truck driving and computer operations training programs, claimant does not possess the ability to obtain and maintain employment in that field beyond an entry-level position. We agree. However, we find that claimant's work as a certified nurse's aid in 1986 provides her with training beyond an entry-level position. (Ex. 3). Moreover, in assigning a value for training, claimant's physical capabilities to do the job in question are not taken into account. Roger F. Slade, 43 Van Natta 631, 633 (1991); Jimmie L. Wilson, 42 Van Natta 2526, 2528 (1990). Accordingly, the appropriate value for training is 0.

Adaptability

Claimant contends that her adaptability factor should be determined under former OAR 436-35-310(4), rather than former OAR 436-35-310(2) or (3). We agree.

Claimant's work at injury was medium. She is now limited to light to moderate work. Further, we agree with the Referee that " . . . Dr. Kendrick's statement that claimant was medically able to drive a truck under unspecified conditions negates his precise specification of limitations set forth in the physical capacities exam and his chart notes."

The record has established that truck driving is medium work, (DOT # 902.683-010) which requires maximum lifting of 50 pounds with frequent or constant jolting, jarring, twisting and prolonged sitting. (Ex. 8). However, Dr. Kendrick, claimant's treating physician reported:

> "I think the patient has reached a permanent and stationary state. She has been left with a mildly moderate disability which would preclude heavy lifting, heavy manual labor, heavy pushing or pulling, or a job which requires frequent bending or twisting at the waist. She should not lift more than 30 pounds and should not lift more than 20 pounds repetitively. I would say her work capacity involves light to moderate work." (Ex. 4A; Tr. 22).

Accordingly, claimant cannot perform the modified work for which she is trained. On this basis, we conclude that claimant is not working for reasons related to her compensable injury. See Almer R. English, 43 Van Natta 438 (1991).

The adaptability value for a claimant who is not working as a result of her compensable injury is determined by the claimant's residual physical

capacity, without regard to that claimant's physical capacity prior to the injury. Former OAR 436-35-310(4); Donna Bartruff, 42 Van Natta 2784, 2786 (1990).

Based on the above stated restrictions placed upon claimant by her treating physician, we conclude that her residual physical capacity is "light to moderate." The proper adaptability factor is 2. Former OAR 436-35-310(4).

Impairment

In rating claimant's impairment, we find that the values under the "standards" are not contested for claimant's reduced ranges of motion (8.5), fusion surgery at L4-5 (5), and fusion surgery at L5-S1 (5). Furthermore, we agree that the Referee properly analyzed those values. Therefore, we adopt those values assigned by the Referee.

The employer contests, however, the 10 percent value assigned by the Referee for claimant's Gill procedure at L5 and a 5 percent value assigned to a chronic condition precluding repetitive use. Additionally, claimant contests the Referee's conclusion that no value should be assigned to claimant's disc derangement and disc bulge at L4-5.

a. Gill procedure

The Referee concluded that claimant was entitled to a 10 percent value for the Gill procedure surgery performed at L5. We agree and adopt her conclusions of law and opinion on this matter. See former OAR 436-35-340; Robert W. McDonald, supra.

b. Chronic condition precluding repetitive use

The Referee concluded that claimant was entitled to a 5 percent value for a chronic condition precluding repetitive use. We agree. The record supports this finding. Therefore, we adopt the Referee's conclusions of law and opinion on this matter.

c. Disc derangement and disc bulge at L4-5

Claimant contends that she is entitled to a value for her disc derangement and disc bulge at L4-5. Claimant asserts that: "No issue was raised at Hearing with regard to whether the bulging disc had been caused by the injury so that issue is now moot." (Resp. Br. at 4). Further, claimant maintains that since the bulging disc was identified in an early CT of the lumbar spine, she has met the requirement of causation. We disagree.

Any injury-related unoperated rupture bulge or other disc derangement is entitled to a value of 4 percent. Former OAR 436-35-350(2). However, claimant must establish a causal relationship between her disc bulge and her compensable injury. Daniel G. Huff, 42 Van Natta 2805, 2806 (1991). That is, she must show that disability resulting from impairment presumed by the "standards" to result from her disc bulge is "due to" the compensable injury. ORS 656.214(5); Daniel G. Huff, supra. We conclude that claimant has not established the requisite causal relationship. While an early CT of the lumbar spine may have identified her disc bulge, no medical report attributes that disc bulge to the compensable injury. Therefore, we conclude that claimant has failed to establish entitlement to an impairment value for her bulging disc at L4-5.

Claimant's impairment values of 8.5 for lost range of motion, 5 for fusion surgery at L4-5, 5 for fusion surgery at L5-S1, 10 for the Gill procedure at L5,

and 5 for limited repetitive use, are combined for a total impairment value of 26.9.

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/skills/training value, 3, the sum is 3. Former OAR 436-35-280(4). When that value is multiplied by claimant's adaptability value, 2, the product is 6. Former OAR 436-35-280(6). When that value is added to claimant's impairment value, 26.9, the result is 32.9. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Id. Claimant's unscheduled permanent disability under the "standards" is, therefore, 33 percent.

Scheduled Permanent Partial Disability

The Referee found that neither the medical record nor claimant's testimony establish that her asserted leg condition resulted in a measurable impairment. Therefore, the Referee declined to grant claimant an award for loss of use or function of the left leg. We agree.

Disability is rated on the permanent loss of use or function of a body part due to an on-the-job injury. Former OAR 436-35-010(2)(a). Pain is considered to the extent that it results in measurable impairment. Former OAR 436-35-010(2)(b). If there is no measurable impairment, no award of permanent impairment shall be allowed. See Susan L. Ferguson, 42 Van Natta 2382 (1990). "Impairment" means a decrease in the function of a body part or system as measured by a physician according to the methods described in the American Medical Association Guides to the Rating of Permanent Impairment, 2nd Edition, copyright 1984. Former OAR 436-35-005(1).

Here, on June 26, and September 4, 1990, claimant reported to Dr. Kendrick that she still had some residual left leg pain. (Exs. 4A, 4B). However, a complete review of the record establishes that Dr. Kendrick's medical reports only refer to limitations placed on claimant's low back. Dr. Kendrick reported no objective findings of a measurable impairment in relation to her left leg.

Inasmuch as the record lacks medical evidence that claimant's compensable injury has resulted in measurable impairment to her left leg, we conclude that she is not entitled to an award of scheduled permanent disability. Accordingly, we affirm the Referee's order award of no scheduled permanent disability.

Penalties and Attorney Fees

The employer contends that the Referee should not have awarded penalties and attorney fees in this case. We agree that a penalty and related fee is appropriate and we adopt the Referee's reasoning in that regard.

Pursuant to ORS 656.262(10)(a), claimant is entitled to a penalty equal to 25 percent of the amount of permanent disability benefits payable to claimant, with one half of the penalty to be paid to claimant and one half to her attorney. Here, however, the Referee held that the insurer's failure to pay permanent disability benefits amounted to unreasonable resistance to compensation to justify a separate fee pursuant to ORS 656.382(1). We modify and reverse.

In deciding this matter, the Referee applied the law as amended by Oregon 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 polices of the workers' compensation law. Bryan L. Dunn, 43 Van Natta 1673 (1991); Ida M. Walker, 43 Van Natta 1402 (1991). Accordingly, we too analyze this issue under the Workers' Compensation Act as amended, effective July 1, 1990.

The legislature amended ORS 656.262(10)(a) to provide that, if the worker is represented by an attorney, the attorney shall receive one-half the penalty "in lieu of an attorney fee." Moreover, in this case, there are amounts "then due" upon which to assess a penalty under ORS 656.262(10). Subsequent to the Referee's order, we held that 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. Forester, 43 Van Natta 1480 (1991). Accordingly, claimant is not entitled to a separate fee under ORS 656.382(1). We, therefore, reverse the Referee's assessed attorney fee award of $500. We further modify the Referee's 25 percent penalty assessment so that the penalty is equally shared by claimant and her attorney. See ORS 656.262(10)(a)

Inasmuch as the employer has requested review and claimant's compensation has not been disallowed or reduced, claimant is entitled to a reasonable attorney fee award. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services on Board review concerning the unscheduled permanent disability issue is $800, 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 issues, and the value of the interest involved.

ORDER

The Referee's order dated April 17, 1991 is affirmed in part, modified in part and reversed in part. In lieu of the Referee's award and in addition to the 31 percent (99.2 degrees) Determination Order award, claimant is awarded 2 percent (6.4 degrees) unscheduled permanent disability giving her a total unscheduled permanent disability to date of 33 percent (105.60 degrees). Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. The Referee's assessed attorney fee award of $500 is reversed. The Referee's penalty assessment is modified. The 25 percent penalty shall be shared equally by claimant and her attorney. The remainder of the Referee's order is affirmed. For services on Board review concerning the issue of extent of unscheduled permanent partial disability, claimant's attorney is awarded $800, to be paid by the self-insured employer.

April 8, 1992 Cite as 44 Van Natta 713 (1992)

In the Matter of the Compensation of
ROGER L. GREENMAN, Claimant
WCB Case No. 89-05156
ORDER ON REMAND
Francesconi & Associates, Claimant Attorneys
Schwabe, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. The court reversed our prior order, Roger L. Greenman, 42 Van Natta 2080 (1990), which set aside the self-insured employer's denial of claimant's occupational disease claim for degenerative joint disease of the low back because he had

established that his work activities were a material contributing cause of his disability and need for medical services. Citing Aetna Casualty Co. v. Aschbacher, 107 Or App 494, rev den 312 Or 150 (1991), the court has remanded for reconsideration.

FINDINGS OF FACT

We republish the "Findings of Fact" contained in our September 27, 1990 order with the following supplementation. Claimant's work activities as a produce manager for a grocery store constituted a series of traumatic events which were the major contributing cause of his low back degenerative joint disease or its worsening.

CONCLUSIONS OF LAW AND OPINION

In our prior order, we reversed the Referee's order which had upheld the employer's denial of claimant's occupational disease claim for a low back degenerative joint disease condition. We found that claimant's work activities as a produce manager were a material contributing cause of his low back condition. Relying on Donna E. Aschbacher, 41 Van Natta 1242 (1989), we concluded that such a finding established the compensability of his occupational disease claim. Consequently, we set aside the employer's denial.

Subsequent to our order, the court has held that to establish the compensability of an occupational disease under former ORS 656.802, a claimant must prove that his work activities were the major contributing cause of his condition or the worsening of his underlying condition. Aetna Casualty co. v. Aschbacher, supra. Citing Aschbacher, the court has reversed our prior order and remanded for reconsideration.

Major cause means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening of her condition than all other conditions, explanations, or exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); David K. Boyer, 43 Van Natta 561 (1991), aff'd mem Boyer v. Multnomah County School District No. 1, 111 Or App 666 (1992). When there is a dispute between medical experts, we generally give greater weight to the conclusion of the treating physician unless there is a persuasive reason not to do so or we find another opinion is more thorough and well-reasoned. See Taylor v. SAIF, 75 Or App 583 (1985); Somers v. SAIF, 77 Or App 259 (1986).

Here, the medical evidence is divided concerning whether claimant's low back degenerative condition was caused or worsened by his work activities. Dr. Cannard, claimant's treating chiropractor, concluded that claimant's 35 years of heavy lifting while performing his work activities for the employer caused a "severe degenerated L5 disc." This opinion was shared by Dr. Brett, a consulting neurosurgeon. Dr. Brett agreed that claimant's work activities over the last 35 years had been "a major contributing factor to the development of his underlying degenerative disc disease."

On the other hand, Dr. Simpson, an independent examining chiropractor, opined that claimant had a preexisting degenerative condition which was symptomatically increased by heavy physical work. The Western Medical Consultants and Dr. Kho, neurosurgeon, also agreed that claimant had a degenerative condition. However, they concluded that claimant's employment did not independently contribute to a pathological or objective change of his condition. Rather, the Consultants and Dr. Kho related claimant's work activities to a symptomatic change in his underlying and preexisting degenerative condition.

After conducting our review of the aforementioned medical opinions, we find no persuasive reason not to defer to Dr. Cannard's opinion as treating

physician. Taylor v. SAIF, supra. Familiar with claimant's work activities and his complaints, Dr. Cannard persuasively concluded that claimant's 35 years of heavy manual labor had caused his degenerative low back condition. This causal relationship was further supported by consulting neurosurgeon Dr. Brett, who opined that claimant's work activities had been "a major contributing factor to the development of his underlying degenerative disc disease."

Although Dr. Brett used the phrase "a major contributing factor" rather than "the major contributing factor" when describing the causal relationship between claimant's work and his degenerative condition, medical evidence is not required to consist of a specific incantation or to mimic the statutory language. Liberty Northwest v. Cross, 109 Or App 109 (1991); McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986) ("Magic words" not required). Inasmuch as Dr. Brett demonstrated an understanding of claimant's low back degenerative condition and his medical/work history, we find that his observations lend further persuasive evidence to support the compensability of claimant's occupational disease claim under former ORS 656.802.

In reaching this conclusion, we acknowledge that Dr. Simpson, the Western Medical Consultants, and Dr. Kho attributed only a symptomatic increase in claimant's underlying degenerative low back condition to his work activities. However, none of these physicians provided a persuasive explanation rebutting the opinion advanced by Drs. Cannard and Brett that claimant's extensive work history of heavy manual labor was responsible for his current low back degenerative condition. Lacking such an explanation, we do not consider their opinions to be persuasive.

Consequently, we find that claimant's work activities were the major contributing cause of his degenerative low back condition or its worsening. Therefore, we adhere to our prior decision that set aside the employer's denial of claimant's occupational disease claim.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our September 27, 1990 order.

IT IS SO ORDERED.

April 8, 1992 Cite as 44 Van Natta 715 (1992)

In the Matter of the Compensation of
TERESA PRESLAR, Claimant
WCB Case No. n/a
ORDER DENYING RECONSIDERATION
Pozzi, Wilson, et al., Claimant Attorneys
Gatti, Gatti, et al., Attorneys

Reviewed by Board Members Neidig and Moller.

On December 31, 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 released certain rights to future workers' compensation benefits, except medical services, for the compensable injury. As the disposition complied with statutory requirements and applicable administrative rules, we approved the agreement on February 3, 1992. Claimant has moved that we reconsider our order of approval.

Pursuant to OAR 438-09-035, we may reconsider final orders under ORS 656.236, provided that the motion for reconsideration: (1) is filed within 10

days of mailing of the final order; and (2) states specifically the reason reconsideration is requested. OAR 438-09-035(1) and (2). Moreover, reconsideration 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. OAR 438-09-035(3).

Here, the approved agreement was mailed on February 3, 1992, and claimant's request for reconsideration was filed on April 1, 1992. Accordingly, we find that claimant has failed to file her reconsideration request within 10 days of mailing of our final order.

In her memorandum in support of her reconsideration request, claimant contends that, because an addendum was required before the agreement could be signed, she was entitled to an additional 30-day "cooling off" period following the submission of the addendum. We do not agree with claimant that an additional 30-day period is required by ORS 656.236 any time that further information is requested on a proposed agreement. Moreover, in this case, the addendum was filed with the Board on January 30, 1992. Accordingly, even if we had granted claimant an additional 30 days beyond the time the addendum was filed, claimant's reconsideration request would, nevertheless, have been untimely. Under the circumstances, we deny claimant's motion for reconsideration.

Further, we note that claimant's reconsideration request is premised primarily upon a dissatisfaction with her former counsel's legal representation leading to submission and approval of the agreement. Such concerns are more properly addressed to another forum.

IT IS SO ORDERED.

In the Matter of the Compensation of
BUDDY J. WILLIS, JR. , Claimant
WCB Case No. 90-16494
ORDER ON REVIEW
Popick & Merkel, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of that portion of Referee Crumme's order which upheld the insurer's denial of his aggravation claim for his current thoracic and lumbar back condition. Claimant also contends that the Referee should have applied the law in effect prior to July 1, 1990. In the alternative, claimant asserts that, if he has not established an aggravation, he is entitled to an award for permanent partial disability. In its respondent's brief, the insurer contends that its denial was not a prospective denial of medical services. On review, the issues are applicable law, aggravation, permanent disability, and propriety of denial. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee "Findings of Fact."

CONCLUSION OF LAW AND OPINION

Applicable Law

The Referee correctly applied the Workers' Compensation Act as amended by Oregon Laws 1990 (Special Session). Claimant requested a hearing after May 1, 1990; therefore, the "litigation savings clause" contained in Oregon Laws 1990, Chapter 2, Section 54(2) does not apply. Furthermore, the matter at issue here

is not subject to a special exception to the Act's general application provision. See Oregon Laws 1990, Chapter 2 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. See Ida M. Walker, 43 Van Natta 1402 (1991).

Aggravation

Under the current version of ORS 656.273, an injured worker is still entitled to compensation for a "worsened condition" resulting from the compensable injury since the last arrangement or award of compensation. The worsened condition, however, must be established by medical evidence supported by objective findings. ORS 656.273(1).

In Suzanne Robertson, 43 Van Natta 1505 (1991), we construed that statutory definition to require a determination by a physician, based on an examination of the injured worker, that the worker has a disability or need for medical services. Such a finding may be based on a physician's evaluation of the worker's description of the pain that he is experiencing. Jacqualyn L. Hetrick, 43 Van Natta 2357 (1991).

Here, claimant's treating physician, Dr. Browning's initial report recites: "History of recurrent thoracic and lumbar strain with near normal orthopedic and neurological examinations." (Ex. 26-1). On July 5, 1990, Dr. Browning reported: "History of thoracolumbar strain on 10-31-89 with ongoing pain of undetermined etiology." (Ex. 35). On July 10, 1990, Dr. Browning reported: "I recommend [claimant] have an outside independent medical evaluation. If that physician or panel finds the patient to be medically stationary without permanent impairment, I would agree. . ." (Ex. 38). On July 17, 1990, Dr. Browning reported: "History of of thoracic strain in motor vehicle accident on 10-31-89 with chronic pain syndrome. No objective Orthopedic findings. . ." (Ex. 39).

Moreover, on November 19, 1990, Dr. Browning reported that:

> "His industrial claim was closed by [de]termination order in early June, 1990 with no permanent disability. I did not learn of this until August 2, 1990. The patient filed an aggravation injury through his personal attorney, but the aggravation claim was denied because there was no orthopedic abnormality on medical examination (I would concur with this decision)." (Ex. 46-1).

In addition, she stated that:

> " . . . On one office visit some time in the late spring or summer of 1990, I asked the patient "How do you maintain such a muscular torso in spite of your back pain?" I recall he answered that he was going to a local gym and doing recreational weight lifting. I did not obtain from him, just exactly how much he was lifting, or which muscles he was strengthening. I am aware that weight lifting within reason can be a form of back therapy and rehabilitation for past strains. However, he repeatedly insisted his back pain interfered with regular duties, but (given his persistent muscular torso) did not prohibit recreational weight lifting-I find this behavior somewhat incongruent." (Ex. 51-2).

Finally, Dr. Browning expressly reported that in none of claimant's visits in June, July or August of 1990 did she find any objective findings of a worsening since February 1, 1990. (Ex. 51-1).

Under these circumstances, we agree with the Referee that there are no objective findings to support claimant's contention that his accepted condition worsened after May 23, 1990. Accordingly, we conclude that claimant has failed to carry his burden of proving that he suffered a compensable aggravation.

Permanent Disability

We adopt the Referee's "Conclusions of Law" on the issue of permanent disability.

Propriety of Denial

The Referee found that the insurer's July 5, 1990 letter was a prospective denial of future medical services. We disagree.

An employer has authority to deny a current claimed need for medical services or specific claims as the claimant presents them, if the medical services are not reasonable and necessary or attributable to the compensable injury. ORS 656.245(1); Evanite Fiber Corporation v. Striplin, 99 Or App 353, 356-7 (1989). However, an employer may not deny its future responsibility for payment of benefits relating to a previous accepted claim unless it follows the statutory procedure for claim closure. Evanite, supra at 357.

Here, the insurer's denial recites that: "We feel there is insufficient evidence to prove a material worsening of your underlying condition or is there objective evidence of an aggravation. Thus we are respectfully denying your claim of aggravation for your back." (Ex. 37).

Inasmuch as the insurer denied claimant's claim that he suffered a worsening of his compensable injury, we find that it did not deny future medical benefits for the accepted condition. Rather, the insurer denied a separate noncompensable condition. Therefore, we conclude that the denial was not prospective. Accordingly, the denial is reinstated and upheld.

ORDER

The Referee's order dated February 11, 1991, as reconsidered March 5, 1991, is affirmed in part and reversed in part. That portion of the Referee's order which set aside the July 5, 1990 denial is reversed. The denial is reinstated and upheld. The Referee's #350 attorney fee award is reversed. The remainder of the Referee's order is affirmed.

April 9, 1992 Cite as 44 Van Natta 718 (1992)

In the Matter of the Compensation of
SAM L. HOOVER, Claimant
WCB Case No. 90-06155
ORDER ON RECONSIDERATION
Gatti, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Claimant requests reconsideration of our March 27, 1992 order which denied claimant's request for reconsideration of our March 16, 1992 Order on Remand that awarded claimant a $750 insurer-paid attorney fee under ORS 656.386(1) for services rendered in prompting the pre-hearing rescission of the SAIF Corporation's denial. Claimant continues to request a "substantial" (but unspecified) increase in his attorney fee award. Claimant argues that we erred by 1) taking into account the penalty related $800 attorney fee awarded to claimant's counsel

for his services at and prior to hearing on the question of SAIF's unreasonable denial; and 2) by refusing to consider any services rendered subsequent to the rescission on April 16, 1990 of SAIF's denial. On this latter point, claimant contends that he did not receive notice of the rescission until one week before the July 31, 1990 hearing. Therefore, he asserts, his attorney was required to work on the case until just before the hearing, and he should be compensated for his services.

On the latter point, claimant is mistaken on the facts. SAIF's letter of April 16, 1990 rescinding the denial is marked on its face "received" by claimant's attorney on April 17, 1990. (Ex. 15) Thus, even if claimant did not see the letter until one week before the hearing, claimant's attorney did and knew on April 17, 1990 that the denial was rescinded. Since after that date, claimant's attorney's services were obviously not devoted to prompting rescission of the denial (or preparing for hearing on the issue of compensability), we have not considered such services in determining a reasonable attorney fee pursuant to amended ORS 656.386(1).

As for claimant's first point, the $800 attorney fee award claimant's attorney has already received is a relevant consideration to the extent that by that award, claimant 's attorney has already received some compensation for his services prior to hearing. Claimant's attorney has not submitted any petition or statement of services which requests a specific amount, supported by a detailed statement of the time spent on the case, and an explanation of how all other factors set forth in OAR 438-15-010(4) substantiate the reasonableness of the requested amount. Under the circumstances, we continue to conclude, for the reasons articulated here and in our prior orders, that a reasonable attorney fee is $750.

Consequently, we withdraw our prior orders. On reconsideration, as supplemented and modified herein, we adhere to and republish our prior orders. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
CAROL J. KNAPP, Claimant
WCB Case No. 90-01628
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

The self-insured employer requests review of that portion of Referee Harri's order that granted claimant permanent total disability, whereas a Determination Order had awarded 54 percent (172.80 degrees) unscheduled permanent disability for a low back condition. On review, the issue is extent of permanent disability, including permanent total disability. We affirm.

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

One essential element to an award of permanent total disability is that claimant must establish that even though not working, she is willing to seek work and has made reasonable efforts to obtain work unless it is shown that such

efforts would be futile. Even if a work search would be futile, claimant must establish that but for the compensable injury, she would have been willing to seek regular gainful employment. ORS 656.206(3); SAIF v. Stephen, 303 Or 41 (1989).

We agree with the Referee's finding that it would be futile for claimant to seek employment. In addition, we find that the record as a whole establishes that, but for the compensable condition, claimant would be willing to work or to seek work.

Since 1988 claimant has done photography, primarily as a hobby. However, she has also prepared business cards for herself, was anticipating photographing two weddings at the time of the hearing, is interested in selling her photographs, and had undertaken certain marketing steps (a showing at the local public library, prizes at the county fair) to promote her work. While we agree with the Referee's finding that claimant's photography activity does not constitute regular, gainful and suitable work, we nevertheless find that it is evidence of claimant's willingness to work or to seek work within the constraints of her physical limitations.

In addition, we note that, to the extent vocational services were made available to her, claimant fully cooperated and participated. Finally, there is no evidence that claimant ever voluntarily removed herself from the labor market.

Under these circumstances, we find that claimant has established that, but for her compensable injury, she would have been willing to work or to seek regular and gainful employment.

In affirming the Referee's award of permanent and total disability, we considered only the disabling effects of claimant's compensable low back injury. Although the Referee found that claimant suffered from several preexisting conditions, including a degenerative neck condition, a knee injury, bilateral wrist degeneration, carpal tunnel syndrome and hypertension (Exs. 7G-1 and 2; 29-4), there is no evidence that any of these conditions was disabling at the time of the compensable back injury in September 1983 (Ex. 30-6). Consequently, we have not considered these preexisting conditions in affirming the Referee's rating of permanent total disability. Elder v. Rosboro Lumber Co., 106 Or App 16 (1991); Alice V. Maloney, 41 Van Natta 2229 (1989).

Finally, Dr. Kiest's opinion concerning claimant's condition has been considered for its medical, rather than vocational, expertise. See Peggy S. Charpilloz, 42 Van Natta 125, 127 (1990). When Dr. Kiest examined her in 1987, he noted that claimant's lumbar x-rays revealed "very graphic demonstrations of severe pathology," that claimant presented "as someone with legitimate severe lumbar distress," and that her "complaints of difficulty moving, sitting, driving and standing are legitimate." (Ex. 7G-3). On the basis of these findings and his examination, Dr. Kiest opined that claimant was not capable of gainful work in any of her past occupations. To the extent that Dr. Kiest's opinion included vocational considerations in addition to medical considerations, we relied on the vocational evidence in the record, rather than Dr. Kiest's opinion.

Claimant's counsel is entitled to a reasonable, assessed attorney fee for his services on review, pursuant to 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 $1,200, 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 of the interest involved.

ORDER

The Referee's order dated June 28, 1991 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,200, to be paid by the self-insured employer.

April 9, 1992 Cite as 44 Van Natta 721 (1992)

In the Matter of the Compensation of
RICHARD D. OLSON, Claimant
WCB Case No. 89-14741
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Phillip L. Nyburg, Defense Attorney

Claimant requests reconsideration of that portion of our March 2, 1992 Order on Review that affirmed a Referee's order that had, in turn, affirmed the Workers' Compensation Division Order of Dismissal dated February 8, 1991. Specifically, claimant requests that we reconsider our conclusions regarding his eligibility for vocational services.

We withdraw our March 12, 1992 order for reconsideration. After review of claimant's motion, as well as the insurer's response, we adhere to the conclusions in our prior order. Accordingly, on reconsideration, we adhere to and republish our March 12, 1992 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Member Kinsley, dissenting.

Pursuant to ORS 656.283(1), I would set aside the February 8, 1991 Order of Dismissal regarding claimant's vocational rights for the reason that the Rehabilitation Review Section (RRS) did not notify claimant's legal representative of the settlement offer it made to claimant prior to issuing its Order.

By a letter to RRS dated November 14, 1990, claimant, through his attorney, notified RRS of his legal representation, requested review of the October 17, 1990 notice of the end of his eligibility for vocational assistance, and gave his permission for claimant to be contacted directly. (Ex. 47). By letter of November 29, 1990, a representative of RRS asked claimant's attorney to contact him if "you wish to be personally involved in meetings and/or conferences connected with this review. If I do not hear from you, I will proceed to meet directly with Mr. Olson." (Ex. 49). It appears from the record that claimant's attorney did not contact RRS. In its prior order, the majority concludes from those facts that RRS was justified in proceeding to negotiate a settlement and dismissal of the case without the involvement of claimant's attorney. I disagree. At no time did claimant or his attorney notify RRS that claimant was no longer represented by his attorney. At no time did the RRS representative inform claimant's attorney that RRS was planning on settling the case without involvement of claimant's attorney. In my view, it makes no sense to interpret claimant's November 14, 1990 letter as simultaneously asserting his right to be represented by counsel and giving up his right to be represented by counsel, especially as to the final settlement of the case. I believe a more reasonable interpretation of the situation is that offered by claimant in his Motion for Abatement and Reconsideration:

"It is the practice of the Rehabilitation Review Section to investigate requests for review made to it prior to an issuance of an order or resolution of the claim. This procedure involves contact with the claimant, as well as the employer. Attorneys for claimant sought to facilitate review by the Rehabilitation Review Section by permitting contact with the claimant at a time and in a manner convenient to the Rehabilitation Review Section for the purposes of conducting this investigation and discussing with Mr. Olson their findings.

"Resolving the claim, however, involves consideration and representation which exceed the mere investigation of the underlying facts. The consent to contact claimant given by claimant's attorney to the Department of Insurance and Finance should not be read so broadly as to permit entering into settlement negotiations or establishing and adopting a final settlement without first obtaining the approval of claimant's attorney."

Based on the above, I respectfully dissent.

In the Matter of the Compensation of
SANDRA L. SCHUCHERT, Claimant
WCB Case Nos. 90-21590 & 90-07843
ORDER ON REVIEW
Aspell, et al., Claimant Attorneys
David Schieber (Saif), Defense Attorney
David O. Horne, Defense Attorney

Reviewed by Board Members Tenenbaum and Gunn.

The SAIF Corporation requests review of Referee Brown's order that: (1) set aside its denial of claimant's aggravation claim for a current low back condition; and (2) upheld Employer's Insurance of Wausau's (Wausau's) "de facto" denial of claimant's herniated disc at L5-S1. On review, the issues are aggravation and compensability. We reverse.

FINDINGS OF FACT

On July 12, 1989, claimant fell from a chair at work and sustained a lumbar strain. SAIF accepted claimant's claim as nondisabling.

On February 2, 1990, claimant again fell from a chair at work. Wausau, the carrier on the risk at that time, accepted claimant's injury claim for a "non-displaced fracture, left inferior pubic ramus."

Although prior to February 2, 1990, claimant's low back condition was improving with conservative treatment following the 1989 injury, she now requires surgery for a herniated disc at L5-S1.

ULTIMATE FINDINGS OF FACT

Claimant's February 2, 1990 fall at work is a material contributing cause of her current need for surgery for a herniated disc at L5-S1.

Claimant's July 12, 1989 fall at work is not a material contributing cause of her current need for medical services for her low back condition.

CONCLUSIONS OF LAW AND OPINION

We note at the outset that Wausau accepted claimant's February 1990 pratfall only as a "non-displaced fracture, left inferior pubic ramus." (Ex. 17C). Because Wausau did not accept or deny claimant's subsequent claims for treatment for her low back within 90 days of its notice of those claims, the Referee deemed those claims to be "de facto" denied at hearing. (Tr. 4). We agree. See Barr v. EBI Companies, 88 Or App 132 (1987).

We also note that, although the scope of Wausau's acceptance was limited to a contusion of the pubic ramus, the 1990 incident involved injury to the low back, as well as to the pubic ramus. (See Exs. 11A, 12-1, 21-1).

The parties litigated this dispute as though ORS 656.308 determines the outcome. Although we agree that the question on review is which insurer is "responsible" for claimant's need for treatment for a current L5-S1 disc herniation, we are not convinced that ORS 656.308 provides the answer.

ORS 656.308 provides in relevant part:

> "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." (Emphasis added).

In the present case, we are unable to determine whether claimant's current herniated disc involves the "same condition" as was caused by SAIF's injury. See Beverly R. Tillery, 43 Van Natta 2470, 2472 (1991) (Where the second compensable injury does not involve the same condition, but, rather, merely the same body part as the prior injury, ORS 656.308 is not applicable.) In this regard, we note that it is not clear exactly when the L5-S1 disc herniation occurred, although the first radiographic confirmation of its existence was on March 22, 1990. (See Exs. 13-1, 14-1, and 20-1). Under these circumstances, we do not apply ORS 656.308 to decide which insurer is responsible for the treatment in question. Instead, we consider the medical evidence concerning causation relative to each work injury, but without the presumption in ORS 656.308.

The Referee decided that claimant's 1989 injury was the major contributing cause of her current need for treatment for her L5-S1 disc. In reaching this conclusion, the Referee relied on the opinion of Dr. Webb, who has treated claimant since October 31, 1989. We find no reason not to rely on Webb's opinion concerning causation and agree that it is persuasive. See Weiland v. SAIF, 64 Or App 810 (1983). However, we find that Dr. Webb's opinion supports a contrary result.

Dr. Webb opined that the "initial major cause of [claimant's] disk disease" was the 1989 lumbar strain (which SAIF accepted). (Ex. 26; see Ex. 23-B-1). However, Dr. Webb concluded:

> "In my opinion, the need for back surgery is related to the second injury. I state this, again, since she was improving satisfactorily with conservative treatment just before the fall in January [sic] 1990 but then afterwards had escalating symptoms which failed to improve with any conservative treatment." (Ex. 26-1).

Considering Dr. Webb's opinion, particularly his failure to include the 1989 injury as a current causative factor, as well as the progression of claimant's low back problems, we conclude that claimant's 1990 injury is a material cause of her need for surgery for a disc herniation at L5-S1, but her 1989 injury is not a material cause of that need. Consequently, Wausau, rather than SAIF is responsible for the claimed treatment. Moreover, based on the same persuasive medical evidence, we conclude that claimant has not proven that her current condition is materially related to the 1989 condition. Accordingly, she has not established a compensable aggravation claim with SAIF. See ORS 656.273(1).

Claimant is entitled to an assessed attorney fee under ORS 656.382(2) for services 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 attorney's services on review is $800, to be paid by the Wausau. 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 June 21, 1991 is reversed. The SAIF Corporation's November 6, 1990 denial of aggravation is reinstated and upheld. Employer's Insurance of Wausau's "de facto" denial of claimant's claim for a disc herniation at L5-S1 is set aside and the claim is remanded to Wausau for processing according to law. Wausau, rather than SAIF, shall pay the assessed attorney fee of $3,170 to claimant's attorney for his services at hearing. For services on Board review, claimant's counsel is awarded an assessed attorney fee of $800, to be paid by Wausau.

April 9, 1992 Cite as 44 Van Natta 724 (1992)

In the Matter of the Compensation of
WILLIAM J. WILSON, Claimant
WCB Case No. 89-09198
ORDER ON REMAND
Jim L. Scavera, Claimant Attorney
Cowling & Heysell, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Roseburg Forest Products v. Wilson, 110 Or App 72 (1991). The court reversed our prior order, William J. Wilson, 43 Van Natta 288 (1991), which had awarded claimant benefits for temporary total disability during a labor dispute. The court concluded that the legislature's failure to include temporary total disability benefits within the protection of laws relating to labor disputes indicated that it did not intend those benefits to be available to claimants who lose wages due to an election to participate in a strike. Accordingly, it held that claimant's decision not to cross a picket line did not justify his refusal for work and reversed and remanded the matter for reconsideration.

In accordance with the court's decision, we find claimant's failure to report for available work to be a refusal of wage earning employment. Accordingly, the employer was authorized to terminate payment of temporary total disability benefits pursuant to former OAR 436-60-030(5). Furthermore, because the employer had offered modified work at claimant's pre-injury rate of pay, no temporary partial disability benefits were due. Former OAR 436-60-030(2).

Accordingly, on reconsideration, the Referee's order dated September 20, 1989 is affirmed.

IT IS SO ORDERED.

Board Member Gunn specially concurring.

I am compelled by the court's decision to provide the majority signature in this case. In some regards, the legislature has provided injured workers who participate in a labor dispute with more rights than other striking employees. For example, while a private sector employer may otherwise permanently replace striking employees,[1] an injured worker may refuse to return to work during a labor dispute "without loss of reemployment rights or any vocational assistance[.]" ORS 656.268(12). (Emphasis supplied.) As noted by the court, however, the legislature has not included the right to temporary total disability benefits within the protection of laws relating to labor disputes. I agree with the legislature's apparent conclusion that an injured worker's decision to return to work offered by an employer or lose benefits for temporary total disability is no different from the decision other striking employees make to forego their wages and participate in a labor dispute.

I write separately to address two aspects of this case not discussed by the court, but which I find disturbing. The first issue, which was mentioned by Board Member Crider in her concurrence to the Board's original order, is whether there was a bona fide offer of employment. There was some evidence in the record that the work offered to claimant was beyond his physical limitations. There is also evidence that the employer's mill was not operating at the time the work offer was made. Nonetheless, claimant carries the burden of proving such an assertion. I do not believe claimant has met that burden.

The second issue is that the record suggests that the employer made the job offer with knowledge that claimant's position as a union official would compel his refusal. If true, I believe the employer's actions would more appropriately be addressed in a discrimination claim with either the National Labor Relations Board or Oregon's Employment Relations Board. For our purposes, however, claimant again would bear the burden to sustain such an allegation, which, in my opinion, he has not met.

In short, the evidence preponderates that work was offered and available to claimant. The work may not have actually been performed due to the labor dispute, but was offered to claimant. Because claimant refused to accept that work, the employer was authorized to terminate payment of temporary total disability benefits. As a final point, I believe that this situation is distinguishable from a labor dispute where striking workers are locked out by the employer or permanently replaced where work is not available or performed.

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[1] I note that, under current public sector labor law, striking workers may have a claim of discrimination for protected activity under ORS 243.672 if permanently replaced by employers. That issue has not yet been contested or litigated through the courts.

In the Matter of the Compensation of
CHARLES E. CONDON, Claimant
WCB Case No. 91-00585
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum, Gunn and Kinsley.

Claimant requests review of Referee T. Lavere Johnson's order that: (1) declined to address the compensability of claimant's psychiatric condition; (2) declined to award claimant an attorney fee for his counsel's efforts in obtaining an acceptance of claimant's psychiatric condition at hearing; and (3) declined to assess an attorney fee for the SAIF Corporation's failure to timely accept the claim. On review, the issues are compensability and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On January 14, 1991, claimant filed a request for hearing, challenging SAIF's de facto denial of her psychiatric condition and seeking penalties and attorney fees. A hearing was convened on April 1, 1991, at which time SAIF, through its counsel, informed the Referee that it had "accepted" claimant's claim and that a formal notice of acceptance was being processed and prepared by its staff. The formal acceptance was later submitted and received into evidence as Exhibit 69.

On review, claimant first challenges the Referee's conclusion that the compensability of the psychiatric condition was no longer at issue. He contends that the Referee was obligated to make a determination on the evidence before him and erred in failing to do so. We disagree. That issue was rendered moot by virtue of SAIF's acceptance. Accordingly, there was no issue concerning compensability to be decided by the Referee. See Gene C. Dalton, 43 Van Natta 1191 (1991).

Claimant next challenges the Referee's failure to award an attorney fee for his counsel's efforts associated with the claim under former ORS 656.386(1). The Referee concluded that claimant was not entitled to the fee because claimant did not "prevail" during a hearing.

Subsequent to the Referee's order, the Governor signed into law 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." Because this matter has not become final, the recent amendment to ORS 656.386(1) is applicable. Considering claimant's counsel's efforts in submitting a hearing request and eliciting medical reports concerning claimant's psychiatric condition, we conclude that claimant's attorney was instrumental in obtaining compensation for claimant through the acceptance of his claim during 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) and applying them to this case, we find that a reasonable assessed attorney fee for the at-hearing acceptance of claimant's psychiatric condition is $1,700, to be paid by

SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue, and the value of the interest involved.

Claimant last challenges that portion of the Referee's order that concluded that his attorney was not entitled to a carrier-paid fee for SAIF's delay in accepting the psychiatric condition claim. He contends that SAIF's misconduct constituted an unreasonable resistance to the payment of compensation under ORS 656.382(1). We agree.

We have previously held that ORS 656.382(1) authorizes the assessment of an attorney fee if an insurer unreasonably resists the payment of compensation, provided that there are no amounts of compensation then due upon which to base a penalty or the unreasonable resistance is not the same conduct for which a penalty has been assessed under ORS 656.262(10). See Nicolasa Martinez, 43 Van Natta 1638 (1991). In this case, SAIF failed to accept or deny the psychiatric claim within 90 days of notice, as required by ORS 656.262(6). However, all benefits were provided to claimant, including medical services. Inasmuch as no amounts of compensation were then due as a result of SAIF's failure to timely accept or deny the claim, no penalty may be assessed under ORS 656.262(10).

However, we conclude that SAIF unreasonably resisted the payment of compensation and we assess an attorney fee under ORS 656.382(1) on that basis. See Charles W. Wilson, 43 Van Natta 2792 (1991); Tami L. Farrell, 43 Van Natta 2727 (1991). By failing to timely respond to the claim, SAIF delayed the process and the ultimate resolution as to the compensability issue. We find that its unexplained failure to respond to the claim was unreasonable and that its nonaction had the effect of delaying benefits which were eventually paid as a result of SAIF's ultimate acceptance of the claim.

Even had we found that SAIF did not actually delay the payment of benefits, we would nevertheless conclude that SAIF's conduct constituted an unreasonable resistance to compensation. The statutory scheme in ORS 656.262(6) envisions a speedy, proper and fair resolution of workers' compensation claims. Under that statutory provision, the insurer must, within 90 days after notice of knowledge of a claim, furnish written notice of claim acceptance or denial to the claimant. Such timely processing helps secure the proper determination and payment of all compensation due an injured worker, and expedites the final disposition of the claim.

More immediately, the formal notice of acceptance or denial informs the injured worker of his rights and responsibilities under the law. Timely notice allows an injured worker to act promptly in availing himself of the right to seek a hearing regarding the claim. In this case, by failing to timely respond to claimant's claim, SAIF left claimant unaware of his rights under the law. Therefore, even had we found that SAIF did not successfully delay compensation, it is clear that SAIF's conduct placed a greater burden on claimant to learn of his rights and to prove his claim. That is enough to warrant the assessment of an attorney fee under ORS 656.382(1).

SAIF contends that our decision in Buck E. Johnson, 43 Van Natta 423 (1991) is directly on point and precludes an attorney fee in this case. In that case, we declined to award an attorney fee under ORS 656.382(1) for a carrier's failure to timely provide exhibits as required by an administrative rule, noting that, even if the violation of the rule was unreasonable, no compensation was delayed by the failure to provide the exhibits. However, that rationale was effectively overruled by Aetna Casualty Co. v. Jackson, 108 Or App 253 (1991), in which the court held that the failure to comply with discovery requirements may be unreasonable resistance to the payment of compensation under ORS 656.382(1),

even when there is no evidence that the noncompliance delayed acceptance of the claim. See also Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991). Accordingly, we do not find SAIF's argument persuasive.

Having considered the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable attorney fee for claimant's counsel's services concerning the untimely acceptance is $300. In reaching this decision, 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 April 25, 1991 is affirmed in part and reversed in part. Claimant's attorney is awarded a reasonable insurer-paid fee of $1,700 for services in connection with SAIF's acceptance of claimant's psychiatric condition. For services concerning the untimely acceptance, claimant's counsel is awarded an insurer-paid fee of $300. The remainder of the order is affirmed.

Board Member Kinsley dissenting.

I agree with the majority's conclusions that the compensability of claimant's psychiatric condition was rendered moot by SAIF's acceptance of the claim at hearing, and that claimant's attorney is entitled to a fee under ORS 656.386(1) for services rendered in obtaining that acceptance. I disagree, however, with the majority's conclusion that claimant's attorney is also entitled to a fee under ORS 656.382(1) on the basis that SAIF failed to timely accept the claim.

ORS 656.262(6) requires an insurer to provide "written notice of acceptance or denial of the claim" with 90 days after "notice or knowledge of the claim." In this case, SAIF had notice of the claim in December 1989, and provided written notice of its acceptance on April 1, 1991, well after the 90 day period. The majority finds that SAIF's failure to timely accept the claim was unreasonable and that "its nonaction had the effect of delaying benefits which were eventually paid as a result of SAIF's ultimate acceptance of the claim." Based on those findings, the majority concludes that SAIF unreasonably resisted the payment of compensation and awards a carrier-paid attorney fee under ORS 656.382(1) on that basis.

In awarding the fee, however, the majority cites no evidence in the record that SAIF's delay in accepting the claim interfered with the payment of any specific compensation. To the contrary, it is undisputed that SAIF paid claimant workers' compensation benefits throughout the delay, including medical services provided by Dr. McCarthy. Absent some showing that SAIF's failure to timely provide written notice of the claim affected some obligation to pay compensation due, it cannot be said that there was an unreasonable resistance to the payment of compensation.

The majority's reliance on Aetna Casualty Co. v. Jackson, 108 Or App 253 (1991), is misplaced. In that discovery violation case, the court noted that the failure to comply with discovery requirements can interfere with the payment of compensation, thereby warranting the assessment of an attorney fee under ORS 656.382(1). On the facts of that case, however, the court noted that the employer had paid all compensation before the discovery violation and, therefore, held that it could not have resisted the payment of compensation that had been paid. The same reasoning applies here; SAIF could not have resisted the payment of compensation it had paid.

The majority also relies on Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991), in which the court held that the failure to comply with discovery requirements may be unreasonable resistance to the payment of compensation and may justify attorney fees under ORS 656.382(1), even where there is no evidence that the noncompliance delayed acceptance of the claim. The court's holding, however, was simply directed to the Board's evident misstatement that, without "evidence that the delay in production of documents delayed acceptance of the claim * * * there is no basis for an assessed attorney fee." 109 Or App at 293. The court simply overruled that statement and remanded the case to the Board to determine, under the proper standard, whether the employer's delay was unreasonable and resulted in the resistance to the payment of compensation for which attorney fees should be awarded. Contrary to the majority's assertion, that case does not support the assessment of an attorney fee in this case, where there is no evidence that SAIF's failure to timely accept the claim interfered with the payment of compensation.

In short, I agree that the failure to timely accept a claim for compensation may provide the basis for awarding an attorney fee for the unreasonable resistance to the payment of compensation. I find no basis for awarding such a fee in this case, however, because there has been no delay in the payment of any compensation. Accordingly, I respectfully dissent.

In the Matter of the Compensation of
GILBERT T. HALE, Claimant
WCB Case No. 91-01277
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Tenenbaum.

The self-insured employer requests review of Referee Livesley's order which directed it to pay claimant's scheduled permanent disability awards at the rate of $305 per degree. Claimant requests that the employer be directed to pay interest of 9 percent on all compensation stayed pending Board review. On review, the issues are the rate of scheduled permanent disability and interest on stayed compensation.

Rate of Scheduled Disability

On the rate of scheduled disability issue, we affirm and adopt the Referee's order with the following supplementation.

The Referee concluded that claimant's June 12, 1990 and March 5, 1991 awards of scheduled 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 to $305, applied to all awards of scheduled disability made on or after May 7, 1990, regardless of the date of injury.

Accordingly, because claimant's awards of scheduled 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.

Interest on Stayed Compensation

ORS 656.313(1)(B)(b) provides, in relevant part:

> "If ultimately found payable under a final order, benefits withheld under this subsection shall accrue interest at the rate provided in ORS 82.010 from the date of the order appealed from through the date of payment."

The statute addresses one of the self-insured employer's claim processing duties. When benefits withheld pending appeal are found payable under a final order, the employer is required to pay the interest that accrued on those benefits. Pending appeal, however, the employer's obligation to pay interest is not ripe for adjudication, because there is no final order.

If and when benefits are found payable under a final order, the employer's duty to process the claim according to law will include the obligation to pay any interest accrued. If a dispute arises regarding the payment of interest, the matter will then be ripe for adjudication.

Attorney Fee On Review

Claimant's attorney is entitled to an assessed attorney fee for prevailing against the self-insured employer's request for review. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the rate of permanent disability issue is $300, to be paid by the self-insured 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 to claimant of the interest involved.

ORDER

The Referee's order dated May 24, 1991 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $300, to be paid by the self-insured employer.

April 10, 1992 Cite as 44 Van Natta 730 (1992)

In the Matter of the Compensation of
JOSEPHINE LANDRISCINA, Claimant
WCB Case No. 90-15113
ORDER ON REVIEW
Dennis W. Skarstad, Claimant Attorney
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

Claimant requests review of Referee Leahy's order that: (1) refused to leave the record open for the introduction of rebuttal evidence; (2) upheld the insurer's partial denial of claimant's right carpal tunnel syndrome and ulnar and radial lesion; and (3) affirmed a Determination Order award of no permanent partial disability. On review, the issues are admissibility of evidence, compensability and extent of permanent disability. We reverse.

FINDINGS OF FACT

On December 22, 1988, claimant sustained a compensable injury when her right hand was caught in a bacon-slicing machine at work. She sought treatment from Dr. Dickson, who diagnosed a severe soft tissue injury and recommended physical therapy.

Claimant was seen by Dr. Nolan, a hand surgeon, who referred her to Dr. Amsden for electro-diagnostic testing. Dr. Amsden examined claimant on March 7, 1989, and found some conduction delay in both medial and ulnar nerves. Dr. Nolan did not believe that surgery was necessary and, on March 20, 1989, released claimant to light work.

Dr. Nolan referred claimant to Dr. Radecki for nerve conduction studies, which proved normal. At the insurer's request, claimant was examined by Dr. Nye on September 7, 1989. He diagnosed neurapraxia subsequent to a crush injury of the right hand and noted some functional overlay.

On December 19, 1989, Dr. Nolan found claimant medically stationary and released her to work with limitations on the amount of time working in the meat freezer. Her claim was closed by a February 2, 1990 Determination Order, which awarded temporary disability only.

In November 1990, claimant sought additional treatment from Dr. Long, who diagnosed a crush injury to the right hand with residual complaints and evidence of mild ulnar and radial compression lesions. Claimant was subsequently examined by Dr. Puziss, an orthopedic surgeon, who diagnosed a crush injury with right carpal tunnel syndrome.

At the request of the insurer, claimant was reexamined by Dr. Radecki, who concluded again that nerve conduction studies were normal. On November 28, 1990, the insurer issued a partial denial of claimant's carpal tunnel syndrome and ulnar and radial lesion.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant's carpal tunnel syndrome and ulnar and radial lesions were not compensably related to her 1988 compensable injury and upheld the insurer's partial denial of those conditions. We find that the evidence preponderates in favor of compensability and reverse.

Claimant seeks compensation for a disability that has allegedly resulted from a combination of her 1988 compensable injury and preexisting hand and forearm condition. Accordingly, she must prove by a preponderance of the evidence that the 1988 injury was the major contributing cause of her need for treatment and/or disability. ORS 656.005(7)(a)(B); Bahman M. Nazari, 43 Van Natta 2368 (1991). We find that the causation of her current condition is of sufficient medical complexity that we cannot decide it without expert opinion. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Two expert opinions on medical causation were submitted in this matter. Dr. Long, claimant's attending physician since November 1990, opined that claimant's current condition was directly related to her compensable injury:

> "I conclude that the incident of 12/22/88 was the major contributing cause of [claimant's] continuing right forearm and hand condition. This condition appears to include some element of median

> entrapment at the distal edge of the carpal ligament, and may include mild symptoms of ulnar irritation at the right elbow, and/or radial entrapment in the supinator area. * * * To the extent that the peripheral nerve lesions are symptomatic and are contributing to [claimant's] chronic right forearm and hand condition, it is more probable than not that the work injury of 12/22/88 was the major cause of the symptomatic peripheral nerve conditions." (Ex. 45-5).

On the other hand, Dr. Radecki, who examined claimant on two occasions, opined that, based on his testing, claimant has no objective pathology in her right hand or arm and that her condition was normal.

When there is a dispute between medical experts, we give greater weight to those opinions that are well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). After our review of both opinions, we find the opinion of Dr. Long more persuasive than that of Dr. Radecki. As noted by claimant, both doctor's opinions can be considered an ongoing debate regarding appropriate diagnostic testing procedures. Dr. Radecki favors a technique that usually employs fewer measurements over greater distances, and evidently believes that the technique used by Dr. Long, which employs more measurements over shorter distances, has caused a false positive here. However, to accept his belief that claimant has no abnormality in the right arm and hand, we must not only reject the findings of Dr. Long, but also the findings of Dr. Nolan, Dr. Amsden and Dr. Puziss, who all diagnosed ulnar and median nerve damage as a consequence of the 1988 industrial injury. In light of that contrary medical evidence, we are not persuaded by Dr. Radecki's opinion that claimant has no objective pathology in her right hand or arm.

After our review of the record, we conclude that claimant has established that her 1988 compensable injury is the major contributing cause of her carpal tunnel syndrome and ulnar and radial lesions and that, therefore, those conditions are compensable. The insurer's partial denial is set aside.

Admissibility of Evidence

Claimant contends that the Referee erred in failing to keep the record open for the admission of rebuttal evidence from Dr. Long, the attending physician. In light of our ruling in claimant's favor with regard to the compensability issue, we find that any error in refusing to admit the rebuttal evidence was harmless and, under the circumstances, conclude that we need not address claimant's contention.

Extent of Permanent Disability

In his report dated March 31, 1991, Dr. Long indicated that claimant's current condition was not yet medically stationary, in that he believed that claimant had potential for further material improvement with treatment. Accordingly, because we have determined that claimant's current condition is compensably related to her 1988 industrial injury and is not medically stationary, the Determination Order is set aside as premature. Thus, it is premature to rate the extent of her permanent disability at this time. See Kociemba v SAIF, 63 Or App 557 (1983).

Attorney Fee

Because claimant has prevailed against a denial of compensation, claimant's attorney is entitled to an assessed fee under ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's

services at hearing and on review concerning the compensability of claimant's current condition 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 hearing record and claimant's appellant's briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 8, 1991 is reversed. The insurer's partial denial is set aside, and the claim is remanded to the insurer for further processing according to law. The Determination Order is set aside as premature. For services rendered in overturning the denial, claimant's counsel is awarded as assessed fee of $2,500, to be paid by the insurer.

April 10, 1992 Cite as 44 Van Natta 733 (1992)

In the Matter of the Compensation of
STAN J. MANSER, Claimant
WCB Case No. 90-19595
ORDER ON REVIEW
Cooney, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Kinsley.

Claimant, pro se, requests review of Referee Otto's order that upheld the self-insured employer's denial of his occupational disease claim for a right inguinal hernia. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

We find that claimant gave Drs. Wojeski and Twombly essentially accurate histories regarding his off-the-job activities and the onset of his right-sided groin pain.

We do not find that claimant told Anita Wallace, employer's representative, that his hernia occurred off-the-job.

FINDING OF ULTIMATE FACT

Claimant's work exposure, specifically repetitive trauma associated with driving a forklift over potholes on or about August 20, 1990 and thereafter, was the major cause of his disability and need for treatment for a right inguinal hernia.

CONCLUSIONS OF LAW AND OPINION

On or about August 20, 1990 and thereafter, claimant's work activity of driving a forklift for the employer involved repetitive traumatic jarring of his body when the forklift regularly hit potholes. Considering this work exposure, we conclude that his claim is for a condition resulting from a "series of traumatic events or occurrences" under ORS 656.802(1)(c). In order to establish the compensability of an occupational disease under ORS 656.802(1)(c), claimant must prove that these work activities or exposures were the major contributing cause of his right inguinal hernia condition. The existence of the disease must be established by medical evidence supported by objective findings. ORS

656.802(2). Due to the number of potential causal factors in this case, the causation issue is of sufficient medical complexity that we cannot decide it without expert opinion. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986).

Credibility

On review, the insurer argues that claimant has not carried his burden, because he is not credible and, consequently, that medical opinions based on claimant's inaccurate history are unpersuasive. We disagree, because, based on the record, we find claimant to be credible. Moreover, we find no indication that the doctors' opinions concerning causation are tainted by inaccurate histories.

In reaching these conclusions, we note that the Referee's negative credibility finding is based on his review of the record, rather than claimant's demeanor. Because we are in as good a position as the Referee to evaluate the written record, we do not defer to the Referee's finding on this issue and proceed with our evaluation. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

To begin, we compare claimant's various reports regarding the onset of his symptoms and conclude that his reports to the employer and his doctors have been consistent over the course of this claim. (Compare Exs. 12A, 13, 34 & 11, 42).

In addition, we find that the doctors' recollections of claimant's reporting regarding his activities and the onset of his right groin pain are consistent with claimant's statements at hearing, with one exception. Dr. Twombly was of the opinion that claimant had lifted no weights for two months prior to the onset of his groin symptoms. Claimant, on the other hand, admitted at hearing that he had continued to do some weight lifting, though at a level much reduced from his former regimen. He stated that he lifted some weights, much lighter than usual, at home during the two months between the expiration of his health club membership and the first groin symptoms. (See Tr. 21-25).

Considering the record as a whole, we find claimant's reporting to be consistent and conclude that he is credible. Considering Dr. Twombly's awareness of claimant's work activities and off-work athletic endeavors (other than weight lifting), we find that Dr. Twombly's misapprehension concerning claimant's continuing, but reduced, weight lifting does not materially diminish the accuracy of his history or the persuasiveness of his reasoning and conclusions.

We note that the parties vigorously dispute whether claimant initially admitted or denied in his reports to the employer that his groin problem was work-related. The Referee decided that claimant's statements in this regard to Melva Holmes and Anita Wallace, employer's representatives, were inconsistent with his statements at hearing. (See O&O p. 3). We are inclined to believe claimant's recollections concerning his reporting. Moreover, even assuming that claimant voiced different opinions concerning the cause of his groin problems, we find any uncertainty claimant may have had in this regard to be reasonable, because he is not a medical expert. Viewing this record as a whole, we are persuaded that even inconsistent speculations by claimant would not negatively impact his credibility or the reliability of his reporting. For these reasons, and considering the record as a whole, we find no reason to disbelieve claimant and conclude that he is a credible witness.

Compensability

Concerning the merits of the claim, we note at the outset that claimant's conclusion as to the cause of his medical problem can be given little weight. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980). Claimant is not charged with knowing the etiology of his medical problem in this medically complex case. That is a question for medical experts. See Uris v. Compensation Department, supra and Kassahn v. Publishers Paper Co., supra.

The only medical evidence in this case supports claimant's claim. The circumstantial evidence also supports the claim and is undisputed: there is no evidence that claimant had prior hernias or groin problems; numerous potholes exist in claimant's work area; claimant's work activities at the time his groin problems began involved driving over those potholes; and the resultant jarring to his body was repetitive and traumatic. Further, Dr. Twombly's initial report clearly noted that claimant's job as a material handler required claimant to lift and carry parts from the receiving dock to various locations at the employer's assembly line. Claimant testified that he lifted five to over 100 hundred pounds in his job and frequently lifted over 50 pounds during the work day.

Although the insurer contends that other activities caused claimant's hernia, no physician doubts that the condition is work-related. Dr. Wojeski agrees with Dr. Twombly that the claim is work related. Considering the close temporal relationship between claimant's exposure and the onset of his groin problems, as well as the factual bases for the physicians' conclusions supporting this claim, we conclude that claimant has established a causal nexus between his work and his condition. See Moe v. Ceiling Systems, supra. In reaching this conclusion, we emphasize that the physicians' reports reveal that other potential causes were considered and ruled out. (See Ex. 11-1; 42-2). See Bradshaw v. SAIF, 69 Or App 587, 590 n.2 (1984). Dr. Twombly's conclusion that claimant's "job is the major contributing cause of [his groin] symptoms and need for treatment and surgery" is uncontradicted. (Ex. 11-2). Claimant's claim is supported by objective findings which verify the existence of the hernia and its work relationship. For these reasons, we conclude that claimant has carried his burden of proving that his work activities were the major contributing cause of his right inguinal hernia.

Claimant is entitled to an assessed attorney fee for his attorney's services at hearing for finally prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's former counsel's services at hearing concerning the compensability issue is $1500, 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 the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 7, 1991 is reversed. The self-insured employer's denial is set aside and the claim is remanded to it for processing according to law. Claimant's attorney is awarded an assessed fee of $1500 for his services at hearing, payable by employer.

In the Matter of the Compensation of
AMADOR MENDEZ, Claimant
WCB Case No. 90-06901
ORDER ON REMAND
Emmons, et al., Claimant Attorneys
Alan Ludwick (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Mendez v. Conifer Plywood, 110 Or App 564 (1991). The court has reversed our order which adopted a Referee's order holding that claimant was not entitled to a carrier-paid attorney fee under ORS 656.386(1) when the SAIF Corporation rescinded its compensability denial of claimant's low back condition prior to hearing. Citing Jones v. OSCI, 108 Or App 230 (1991), the court has reversed and remanded for reconsideration of an award of attorney fees.

FINDINGS OF FACT

We adopt the "Findings of Fact" contained in the Referee's order with the following supplementation. Claimant's attorney was instrumental in obtaining compensation for claimant without a hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was not entitled to an assessed attorney fee under former ORS 656.386(1). However, the Referee did award claimant's attorney a fee payable from claimant's temporary disability (not to exceed $1,050) and permanent disability (not to exceed $2,800).

In reaching his conclusion, the Referee relied on our order in Duane L. Jones, 42 Van Natta 875 (1990), which held that former ORS 656.386(1) provided no basis for an award of insurer-paid attorney fees to a claimant when a carrier withdraws its denial prior to hearing. We affirmed and adopted the order of the Referee.

Our order in Jones initially was affirmed by the Court of Appeals. Jones v. OSCI, 107 Or App 78 (1991). The court subsequently allowed reconsideration, however, and withdrew its opinion. Jones v. OSCI, 108 Or App 230, 232 (1991). The court's action was based on the 1991 amendment to ORS 656.386(1) providing 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." Id. Relying on its decision in Jones, the court has reversed and remanded for reconsideration of claimant's attorney fee award.

Claimant's attorney filed a March 27, 1990 hearing request regarding SAIF's March 7, 1990 denial and, on May 2, 1990, submitted for introduction into the record an August 1990 letter from claimant's employer regarding a work incident and a Novemer 1989 work release from claimant's physician. In light of these circumstances and the May 18, 1990 rescission of SAIF's denial prior to the August 14, 1990 scheduled hearing, we conclude that claimant's counsel was instrumental in obtaining compensation for claimant without a hearing. See Kimberly Wayne, 44 Van Natta 328 (1992). Consequently, we hold that claimant is entitled to an attorney fee award under ORS 656.386(1). Jones v. OSCI, supra.

For purposes of determining a reasonable assessed attorney fee, we consider the factors set forth in OAR 438-15-010(4). After considering those factors, we find that a reasonable attorney fee concerning the pre-hearing rescission of SAIF's denial is $1,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as

represented by the record), the value of the interest involved, and the risk that claimant's attorney's efforts might go uncompensated.

In making this determination, we have not considered any of claimant's counsel's services rendered subsequent to SAIF's May 18, 1990 rescission. We have previously held that our mandate in determining the amount of an attorney fee for services regarding a denial rescission is confined to a claimant's counsel's services prior to the rescission. Ernest C. Richter, 44 Van Natta 101 (1992), on recon 44 Van Natta 118 (1992). Thus, counsel's services pertaining to post-rescission preparation for the hearing (including procedural and jurisdictional arguments) have not been considered.

Moreover, any of claimant's counsel's efforts devoted to reversing the Referee's order and our prior decision are similarly irrelevant to a determination of a reasonable attorney fee for claimant's counsel's pre-hearing services. Id. Because attorney fees do not constitute compensation, claimant would not be entitled to an attorney fee award for services rendered before the Board and court for "finally prevailing" on this issue. See ORS 656.388(1); Ernest C. Richter, supra; Cleo I. Beswick, 43 Van Natta 1314 (1991).

Accordingly, on reconsideration, the Referee's order dated October 22, 1990 is reversed. Claimant's attorney is awarded a reasonable attorney fee of $1,500, for services concerning the rescission of SAIF's denial, to be paid by the SAIF Corporation.

We note that a portion of claimant's compensation has been held by claimant's counsel awaiting resolution of this attorney fee issue. As a result of this order, we have held that, rather than being payable from claimant's compensation, claimant's $1,500 attorney fee is payable by SAIF in addition to claimant's compensation. Therefore, in the event that claimant's attorney has already received the $1,500 fee granted by this order from claimant's compensation, SAIF shall pay claimant the $1,500 as reimbursement for the fee. If the amount held in claimant's counsel's trust account is less than $1,500, SAIF shall pay claimant the amount held in claimant's counsel's trust account as reimbursement for the fee. In addition, SAIF shall pay claimant's counsel an amount sufficient to reach the $1,500 attorney fee award. If the amount held in claimant's counsel's trust account exceeds $1,500, claimant's counsel shall return the funds in excess of $1,500 to claimant.

IT IS SO ORDERED.

In the Matter of the Compensation of
DONALD H. SMITH, Claimant
WCB Case No. 89-21043
ORDER ON REMAND
Claudette L. Yost, Claimant Attorney
Cummins, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Medford Corporation v. Smith, 110 Or App 486 (1992). The court reversed our prior order, which affirmed and adopted the Referee's order finding that claimant had established that his work activity was a material contributing cause of his left carpal tunnel syndrome condition and, therefore, had proved a compensable occupational disease claim. The court remanded for reconsideration in light of Aetna Casualty Co. v. Aschbacher, 107 Or App 494, rev den 312 Or 150 (1991), which held that a claimant must establish that his employment was the

major contributing cause of a claimed condition or its worsening in order to prove a claim for occupational disease under former ORS 656.802(1)(c).

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In Donna E. Aschbacher, 41 Van Natta 1242 (1989), we held that, under the 1987 amendments to former ORS 656.802(1), a claimant could prove a compensable claim under former ORS 656.802(1)(c) by merely showing that work was a material contributing cause of a claimed condition or a worsening of the symptoms of a preexisting disease. The Referee, relying on our order in Aschbacher, concluded that claimant proved that employment conditions were a material cause of his left carpal tunnel syndrome. The Referee further found that the self-insured employer was responsible. See Bracke v. Baza'r, 293 Or 239 (1982). We affirmed and adopted the order of the Referee.

The Court of Appeals subsequently reversed our order in Aschbacher, holding that the legislature had not intended to change the standard of proof necessary to prove a claim under former ORS 656.802(1)(c) and that a claimant was still required to show that the work activity was the major contributing cause of a claimed condition or worsening of an underlying disease. Aetna Casualty Co. v. Aschbacher, supra. Although the court here determined that the Board's findings regarding responsibility under Bracke v. Baza'r, supra, were supported by substantial evidence, the court reversed and remanded the order for reconsideration in light of its decision in Aschbacher. Medford Corporation v. Smith, supra.

The record contains two opinions regarding causation of claimant's left arm condition. Dr. Grant, who initially saw claimant on referral from the employer, diagnosed left carpal tunnel syndrome, left ulnar neuropathy at the elbow and chronic generalized peripheral neurophathy. (Ex. 49-4). Although attributing the peripheral neuropathy to alcohol intake, Grant also stated that "[w]ork undoubtedly has played a role in the causation of his above-mentioned compressive neuropathies, but the underlying generalized peripheral neuropathy has made him very susceptible to nerve compression syndromes in general." (Id).

Claimant also was evaluated by Dr. Schostal, neurologist, for an independent medical examination. Schostal agreed with Grant's diagnoses of left carpal tunnel syndrome, left ulnar neuropathy at the elbow, and an underlying polyneuropathy and also found that the last condition was caused by excessive alcohol ingestion. (Exs. 51-2, 3). He disagreed, however, that claimant's work activity was a causal factor in the other two conditions, attributing them instead to the underlying polyneuropathy. (Id. at 3). Schostal based his conclusion on his determination that claimant's work did not include the "biomechanical activities" that would "make one prone to develop such multiple compressive neuropathies." (Id).

In responding to Schostal's report, Grant stated that "the underlying peripheral neuropathy predisposes to, but does not in and of itself cause, a compressive neuropathy such as carpal tunnel syndrome. Undoubtedly[,] the 'unhealthiness' of the nerves in general due to the underlying generalized peripheral neuropathy made it somewhat easier for [claimant] to develop a carpal tunnel syndrome, but without some other causation, I do not believe a carpal tunnel syndrome of this severity would have occurred." (Ex. 54-1) (emphasis in original). Grant also found his opinion supported by literature showing that repetitive hand motions could cause carpal tunnel syndrome and that claimant's

"job as a machinist surely involves repetitive and strenuous use of his hands[.]" (Id. at 2). Grant subsequently stated that claimant's "activity or work was the most causative with regards to the left carpal tunnel syndrome and the left ulnar neuropathy at the elbow." (Ex. 57-1).

Schostal continued to disagree with Grant, stating that "Dr. Grant is overlooking one fundamental and crucial bit of information," in that claimant was experiencing "multiple compressive neuropathies of several different nerves in several different extremities." (Ex. 55).

As we concluded in our previous order, we find that Dr. Grant provides the more persuasive opinion. Schostal did not demonstrate a sufficient degree of familiarity with claimant's work activities; during his deposition, Schostal conceded that he was unaware of many of the specific activities engaged in by claimant during his 16 years working as a machinist. (See Exs. 61-23, 24). Schostal therefore did not persuasively prove that he had an adequate basis for determining that claimant's work did not include activities that could cause carpal tunnel syndrome. Grant, on the other hand, expressed a detailed knowledge of claimant's work activities. (Exs. 62-6, 7). Under such circumstances, we give Dr. Grant's opinion greater weight. Somers v. SAIF, 61 Or App 259 (1986); Givens v. SAIF, 61 Or App 490 (1983).

Having found Grant's opinion to be more persuasive, we further conclude that it satisfies claimant's burden of proving that employment conditions were the major contributing cause of his carpal tunnel syndrome. To be sufficient to establish the compensability of a claim, medical evidence is not required to consist of a specific incantation or to mimic the statutory language. Liberty Northwest v. Cross, 109 Or App 109 (1991); McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986) ("Magic words" not required). Major cause means an activity or exposure or combination of activities or exposure which contributes more to the onset or worsening of a condition than all other conditions, explanations, or exposure combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); David K. Boyer, 43 Van Natta 561 (1991), aff'd Boyer v. Multnomah County School Dist. No. 1, 111 Or 666 (1992).

Here, Grant satisfied that standard by stating that claimant's "activity or work was the most causative with regards to the left carpal tunnel syndrome and the left ulnar neuropathy at the elbow." (Ex. 57-1). Therefore, we conclude that the occupational disease claim for left carpal tunnel syndrome is compensable. Consequently, we agree with the Referee that the employer's denial must be set aside.

Accordingly, as supplemented herein, we republish our April 12, 1991 order in its entirety.

Inasmuch as claimant has finally prevailed before the Board after remand from the court, he is entitled to a reasonable attorney fee for services before every forum. See ORS 656.388(1). Since claimant's counsel provided services before the court, a reasonable fee for such efforts shall be awarded. Id. After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable fee for claimant's counsel before the court is $2,000, to be paid by the employer. This fee is in addition to claimant's prior attorney fee awards for services rendered at the hearings level and on Board review. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate brief), the complexity of the issue, the value of the issue involved, and the risk that claimant's attorney's efforts may go uncompensated.

IT IS SO ORDERED.

In the Matter of the Compensation of
KELLY L. STOCKTON, Claimant
WCB Case No. 90-19421
ORDER ON REVIEW
Bottini, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Neidig and Moller.

The insurer requests review of that portion of Referee Tenenbaum's order that set aside its denial of claimant's bilateral foot condition. On review, the issue is compensability.

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

Claimant's congenital bilateral flat feet, with bilateral accessory navicular bones, predisposed claimant to experience her bilateral foot condition requiring medical treatment. However, her employment activities were the major contributing cause of that condition. Therefore, her condition is compensable. See Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566 (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 issue of compensability is $900, 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 June 24, 1991 is affirmed. For services on review concerning the issue of compensability is $900, payable by the insurer.

In the Matter of the Compensation of
KENNETH A. TATTOO, Claimant
WCB Case No. 90-08503
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Terrall & Associates, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The self-insured employer requests review of those portions of Referee Tenenbaum's order that: (1) set aside its April 3, 1990 partial denial of claimant's alleged discitis and osteomyelitis conditions; (2) assessed penalties for its allegedly unreasonable April 3, 1990 preclosure denial; (3) awarded an assessed attorney fee for claimant's counsel's services in setting aside the April 3, 1990 denial; (4) found claimant's condition medically stationary on February 12, 1990, whereas the Determination Order found claimant's condition medically stationary on May 8, 1990; (5) did not address the employer's request for an offset of temporary disability benefits paid from January 30, 1990 through February 18, 1990; (6) set aside its May 30, 1990 denial of claimant's chiropractic treatment, finding that the denial was prospective, and that the rendered medical services were both causally related to and reasonable and necessary treatment for claimant's compensable injury; (7) assessed penalties and a

separate penalty-related attorney fee for unreasonable resistance to the payment of compensation for its refusal to pay compensation pursuant to the July 5, 1990 Determination Order; (8) increased claimant's unscheduled permanent disability award for a low back condition from 8 percent (25.6 degrees) as awarded by Determination Order, to 10 percent (32 degrees); and (9) awarded an assessed attorney fee for claimant's counsel's services in defending against the employer's cross-request for a reduction of permanent disability benefits. On review, the issues are propriety of the denials, temporary disability, compensability of medical services, medically stationary date, offset, extent of unscheduled permanent partial disability, penalties and attorney fees. We affirm in part, modify in part, vacate in part, and reverse in part.

FINDINGS OF FACT

On August 1, 1989, claimant compensably injured his low back while pulling on the green-chain. Claimant sought treatment from Dr. Zimmerman, orthopedist, who, on August 21, 1989, diagnosed a lumbosacral strain/sprain. The employer categorized claimant's injury as disabling, but deferred acceptance or denial of the claim. In September 1989, upon referral by Dr. Zimmerman, claimant underwent a work tolerance screening program at Emanuel Hospital which determined that claimant was physically able to return to light duty work. On October 11, 1989, Dr. Zimmerman released claimant for light duty work.

Dr. Danis, chiropractor, became claimant's treating physician on October 23, 1989. He diagnosed an acute lumbosacral sacroiliac strain/sprain syndrome, and claimant received conservative therapy.

Claimant continued to experience low back and left leg pain. On January 16, 1990, claimant changed treating physicians to Dr. Holman, chiropractor. Dr. Holman diagnosed acute lumbosacral subluxation and acute pelvis and left leg myalgia and neuralgia. On February 7, 1990, Dr. Holman released claimant to return to light duty work on February 12, 1990, with limitations on work requiring bending, twisting and prolonged sitting.

On January 29, 1990, claimant was examined by Dr. Dinneen, orthopedist, and Dr. Hathaway, chiropractic physician, of the Western Medical Consultants. Their examination revealed nonorganic pain responses, but no evidence of nerve root impingement. The Consultants noted no improvement with continuing chiropractic treatments. They found claimant's condition to be medically stationary and opined that he could perform at least mild physical labor.

The employer first submitted the claim to the Department of Insurance and Finance for closure on February 19, 1990. The employer had accepted claimant's low back injury claim by that date.

Dr. Holman referred claimant for an MRI which was performed on March 13, 1990. The study revealed that claimant's L5-S1 disc space was abnormal, with virtual obliteration of the disc and very irregular endplates. Additionally, a mild L4-5 bulge, narrowed L1-2 disc, and hypertrophic osteophyte formation anteriorly were noted. Dr. McAfee, radiologist, commented that the disc disease at the L5-S1 level had features suggesting inflammatory discitis with osteomyelitis.

Dr. Egener, M.D., examined claimant for Dr. Holman on March 16, 1990. Based on the March 13, 1990 MRI findings, Dr. Egener took claimant "off work completely," and referred him to Dr. Rosenbaum, neurosurgeon, for further evaluation.

On March 21, 1990, upon initial review of claimant's x-rays taken in January and March 1990, Dr. Rosenbaum noted claimant's spinal abnormalities and diagnosed claimant as having sustained only a lumbar strain. Dr. Rosenbaum obtained a white blood cell scan to determine whether an active infection was present. On April 2, 1990, Dr. Rosenbaum reported that the blood scan was negative for evidence of acute discitis or osteomyelitis. He could not state whether claimant's spinal abnormality was new or preexisted his industrial injury without reviewing claimant's initial x-rays films.

On April 3, 1990, the employer denied claimant's claim for benefits related to discitis and osteomyelitis, explaining that claimant did not have the discitis/osteomyelitis condition for which Dr. Egener had released him from work and, further, that the suspected discitis/osteomyelitis was not compensably related to claimant's industrial injury.

Claimant requested a hearing from that denial on April 18, 1990.

On May 17, 1990, after comparing claimant's x-rays taken the day of his August 1, 1989 industrial injury with the x-rays and MRI performed in March 1990, Dr. Rosenbaum stated that claimant's spinal abnormality preexisted and was not related to claimant's industrial injury.

On May 18, 1990, Dr. Egener clarified that while it was medically prudent to remove claimant from work when a severe infectious process was suspected, had he had access to claimant's prior treatment records, he would not have taken claimant off work.

On May 30, 1990, the employer denied claimant's "current" chiropractic care as neither related to claimant's compensable injury nor reasonable and necessary. At the time the denial issued, there were unpaid chiropractic bills in the employer's possession. At the time of hearing, there were chiropractic bills due and owing.

On June 19, 1990, claimant supplemented his hearing request to challenge the employer's May 30, 1990 denial of chiropractic services.

On July 5, 1990, a Determination Order issued, awarding claimant temporary disability through February 18, 1990 and 8 percent unscheduled permanent disability. Claimant was deemed medically stationary on May 8, 1990. On July 12, 1990, the employer requested reconsideration of the Determination Order. On July 23, 1990, the Evaluation Section declined to reconsider the Determination Order because a hearing request was pending.

On August 2, 1990, claimant completed a Request for Hearing form, seeking additional permanent partial disability. Claimant apparently mismailed the request to another agency. On September 24, 1990, claimant remailed his hearing request to the Board. The request was date-stamped received at the Board on September 25, 1990.

By correspondence Friday, August 3, 1990, the employer cross-requested a hearing on the Determination Order, challenging the temporary disability and permanent partial disability awards as excessive. The employer sent its cross-request by regular mail; it did not submit a certificate of service. The thirtieth day to request review of the Determination Order was Saturday, August 4, 1990. The employer's request was date-stamped received at the Board on Monday, August 6, 1990.

On August 8, 1990, claimant sought an order compelling the employer to pay the permanent partial disability benefits awarded by the July 5, 1990 Determination Order.

As of the date of hearing, the employer had not paid claimant the permanent disability compensation awarded by the July 5, 1990 Determination Order. The employer paid temporary disability benefits through February 18, 1990. At hearing, claimant conceded that he is not entitled to temporary disability benefits after February 18, 1990.

The hearing was held on October 22, 1990, and the record was closed on December 7, 1990.

FINDINGS OF ULTIMATE FACT

The insurer accepted claimant's lumbosacral sprain/strain. Its acceptance did not include claimant's possible discitis or osteomyelitis and resultant degenerative condition of the lumbosacral spine, which are separate conditions from the low back sprain/strain listed on the 801 Form submitted for this injury.

The employer's April 3, 1990 denial was not an unreasonable resistance to the payment of compensation.

As of January 29, 1990, no further material improvement could reasonably be expected for claimant's lumbosacral sprain/strain from medical treatment or the passage of time.

The insurer's May 30, 1990 denial did not prospectively deny future medical treatment for claimant's accepted condition.

Claimant's need for chiropractic medical services was causally related to his compensable low back injury.

The Hearings Division does not have jurisdiction over that portion of the insurer's May 30, 1990 denial which disputed that chiropractic medical services were reasonable and necessary treatment for claimant's compensable low back injury.

The employer's failure to pay permanent partial disability as awarded by the Determination Order was not an unreasonable resistance to the payment of compensation.

At the time of injury, claimant had preexisting degenerative changes of the lumbosacral spine, possibly due to discitis or osteomyelitis, but unrelated to the August 1, 1989 injury. Claimant's 1989 compensable low back injury did not worsen his preexisting degenerative spine condition.

CONCLUSIONS OF LAW AND OPINION

Propriety of April 3, 1990 Denial

Stating that claimant does not have either discitis or osteomyelitis and, furthermore, that such conditions are not causally related to claimant's industrial injury or employment, the employer denied benefits, including temporary disability, for these conditions. The Referee concluded that because the claim was in open status when the denial issued, the denial was impermissible and unreasonable. Therefore, she set it aside and awarded penalties and assessed an

attorney fee for claimant's counsel's services in setting aside the denial. We reverse, based on the following analysis.

Where there is an accepted claim, an employer/insurer may not issue a denial which attempts to terminate future responsibility for the accepted condition or any inseparable part of the accepted condition, where the extent of claimant's disability has not yet been determined pursuant to statutory procedures for claim closure. Roller v. Weyerhaeuser Co., 67 Or App 583 (1984). If the denial was of a separate, unaccepted condition, however, it is procedurally proper. See Roller, supra; Aquillon v. CNA Insurance, 60 Or App 231, 235 (1982). Cf. Destael v. Nicolai Co., 80 Or App 596 (1986). We find that the preclosure denial prohibition does not apply to this claim because the employer's denial was for a separate, noncompensable infectious process that it never accepted.

The employer denied temporary disability and treatment for, and the compensability of, claimant's possible discitis and osteomyelitis. Therefore, we must first determine whether the employer's acceptance included these conditions. The Form 801 submitted for the 1989 injury listed "strained back." The Form 827 diagnosed "lumbosacral sprain." The employer deferred acceptance or denial by checking the 801 Form; there is no formal acceptance in the record. The treatment claimant was receiving at the time he filed his claim and in February 1990 when the employer first submitted the claim for closure was for a lumbosacral sprain/strain. There is no evidence that the employer's eventual acceptance included claimant's degenerative spinal condition due to an infectious process. We find, therefore, that the employer's acceptance did not include those conditions. See Melvin G. Monday, 40 Van Natta 2411 (1990).

Moreover, the medical record establishes that claimant does not have an acute infection, and claimant asserts that he has never submitted a claim for discitis or osteomyelitis. We are persuaded by the medical evidence that any discitis or osteomyelitis condition claimant may have had in the past is separable from the lumbosacral sprain/strain condition listed on the 801 Form. The medical evidence conclusively establishes that claimant's possible discitis or osteomyelitis condition preexisted his compensable injuries. Although x-rays taken subsequent to the injury reveal the presence of significant degenerative changes which might be indicative of an infectious process, no physician, including Dr. Holman, attributes this condition to claimant's compensable back injury.

Finally, no physician, including Dr. Holman, has suggested that claimant's compensable injury worsened this underlying degenerative condition caused by the infectious process. Similarly, no physician, including Dr. Holman, has suggested that claimant's current need for treatment is attributable to his degenerative spinal condition.

In summary, all physicians have, without exception, diagnosed claimant's degenerative condition and possible discitis and osteomyelitis as separate noncompensable conditions. Thus, the denial at issue was of temporary disability and treatment for a separate, noncompensable condition that the insurer never accepted. As such, the denial was not an improper preclosure denial of an accepted condition. See Roller, supra; see Aquillon v. CNA, supra.

In light of our conclusion that the employer's denial did not concern an accepted condition or inseparable condition, we find that its denial was not unreasonable. Consequently, we reinstate the employer's April 3, 1990 denial, and reverse the award of a penalty for unreasonable denial and assessed attorney fee for services in setting aside the denial.

Medically Stationary Date/Offset

Claimant's claim was closed by Determination Order awarding temporary disability through February 18, 1990, and finding claimant medically stationary on May 8, 1990. The Referee concluded that claimant was entitled to temporary disability benefits until February 12, 1990, when he was released to return to light duty work. On review, the employer renews its contention that January 29, 1990, the date the Western Medical Consultants examined claimant, is the proper medically stationary date. In addition, the employer requests that the Board grant an offset for the temporary disability benefits paid from January 30, 1990, through February 18, 1990, the date that claimant concedes he was no longer eligible for temporary disability benefits.

"Medically stationary means that no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). The resolution of the medically stationary date is primarily a medical question based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1985).

Here, as the proponent of the argument, the employer has the burden of proving by a preponderance of the evidence that claimant was medically stationary on January 29, 1990. See Milford W. Hayes, 42 Van Natta 2865 (1990). We find that the employer has met its burden. In reaching this result, we give great weight to the opinions of Dr. Zimmerman, Dr. Dinneen, and Dr. Hathaway. We do not rely on the opinion of Dr. Holman, claimant's most recent treating chiropractic physician.

Claimant was examined by Dr. Dinneen and Dr. Hathaway on January 29, 1990. In a well-reasoned and complete report, they noted no improvement with continuing chiropractic treatments. They found claimant's condition to be medically stationary and opined that he could perform at least mild physical labor. Dr. Zimmerman reviewed the Consultants' report and agreed with their findings and conclusions. He indicated that claimant's condition at the time of his last appointment in October 1989 corresponded to his condition as noted by the Consultants in January 1990.

Only Dr. Holman continues to report that claimant is not medically stationary. However, his reports are primarily focused on explaining claimant's continuing need for treatment, and do not include objective evidence to refute the Consultants' findings or recommendation that claimant became medically stationary on January 29, 1990.

We accordingly conclude from the medical evidence that, as of January 29, 1990, no further material improvement could reasonably be expected for claimant's lumbosacral sprain/strain from medical treatment or the passage of time. Consequently, we find that claimant's condition was medically stationary at that time.

Offset of Temporary Disability

Insurers and self-insured employers may offset overpayments of temporary disability from future awards of permanent disability when authorized. See former ORS 656.268(4); 656.268(10). As the Board has now determined that claimant became medically stationary on January 29, 1990, the employer's request for an offset of benefits paid after that date against future permanent disability benefits is granted. See Berliner v. Weyerhaeuser Company, 92 Or App 264 (1988).

May 30, 1990 Medical Services Denial

Propriety of Denial

Although an employer may not deny its future responsibility for payment of medical services for a previously accepted claim, it may deny a request for payment of current services. Evanite Fiber Corporation v. Striplin, 99 Or App 353 (1989). To determine what a denial denies, we look to the language of the denial notice itself. Subsequent to the Referee's order, the court has held that, if an employer denies benefits for a current need but does not preclude future benefits, the denial is not impermissibly prospective. See Green Thumb Inc. v. Basl, 106 Or App 98 (1991). The May 30, 1990 denial denied "current chiropractic care" as not reasonable and necessary and not related to claimant's compensable injury. Accordingly, we conclude that the May 30, 1990 denial was not procedurally improper under existing law when the denial issued.

Jurisdiction

The Referee found that the chiropractic treatments denied by the employer were both causally related to claimant's compensable low back injury and reasonable and necessary for his low back strain. However, a threshold matter not addressed by the Referee or either party is whether we have jurisdiction to resolve the substantive issues raised by this medical services dispute under the 1990 amendments to the workers' compensation law.

The hearing in this case was convened after July 1, 1990. Therefore, the litigation "savings clause" contained in section 54(2) of Oregon Laws 1990 (Special Session), chapter 2, does not apply. Thus, the amendments to ORS Chapter 656 apply. See Ida M. Walker, 43 Van Natta 1402 (1991). Because the employer's medical services denial involves both the causal relationship and reasonableness and necessity of medical treatment, we conclude we share jurisdiction over this matter with the Director.

Causal Relationship

In Michael A. Jaquay, 44 Van Natta 173 (1992), we held that there is no procedure provided by ORS Chapter 656 for resolving disputes concerning the causal relationship between an injury and a need for medical treatment. Therefore, such disputes are "matters concerning a claim" over which we have jurisdiction. See ORS 656.704(3). Accordingly, where an insurer/employer has denied that the need for medical services is causally related to the compensable injury, the Board has jurisdiction over this aspect of the medical services dispute. Michael A. Jaquay, supra.

Having clarified our jurisdiction as it concerns the issue of causal relationship, we affirm and adopt the Referee's reasoning and conclusion that claimant's chiropractic treatments were causally related to his compensable low back injury.

Reasonableness and Necessity

However, as to the second basis for the employer's medical services denial, we no longer have jurisdiction over disputes involving medical treatment that is alleged to be excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services. Subsequent to the Referee's order, we held in Stanley Meyers, 43 Van Natta 2643 (1991), that under the amended workers' compensation law, the Director, rather than the Board, has jurisdiction to determine whether causally related medical treatments are reasonable and necessary.

Thus, the Hearings Division, including the Board, lacks jurisdiction to determine the reasonableness and necessity of claimant's chiropractic treatment. Accordingly, we vacate the Referee's decision insofar as it purports to set aside this aspect of the May 30, 1990 medical services denial, as that portion of the denial did not raise a matter concerning a claim within the jurisdiction of the Hearings Division. Stanley Meyers, supra.

In light of our conclusions, we modify the Referee's $950 attorney fee award for totally prevailing against the employer's denial. As a result of our decision, claimant is entitled to an attorney fee for prevailing only against the employer's denial of a causal relationship between the chiropractic treatments and claimant's compensable injury. ORS 656.386(1). In addition, claimant is entitled to an attorney fee for services on Board review concerning his successful defense of that portion of the Referee's order.

After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable attorney fee for claimant's counsel's services at the hearing level and on Board review concerning the "causal relationship" issue is $1,200, to be paid by the self-insured employer. This fee is in lieu of, rather than in addition to, the Referee's $950 attorney fee award. In reaching this conclusion, we have considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, and the value of the interest involved.

Failure to Pay July 5, 1990 Determination Order Award

On July 5, 1990, a Determination Order issued finding claimant medically stationary on May 8, 1990, and awarding him temporary disability benefits through February 18, 1990 and 8 percent unscheduled permanent disability. By correspondence dated Friday, August 3, 1990, the employer cross-requested a hearing on the Determination Order, challenging the temporary disability and permanent partial disability awards as excessive. The employer sent its request by regular mail; it did not submit a certificate of service. The thirtieth day to request review of the Determination Order was Saturday, August 4, 1990. The request was date-stamped received at the Board on Monday, August 6, 1990.

Amended ORS 656.313 provides for a stay of payment of compensation where an employer or insurer requests a hearing on a reconsideration order. Because no reconsideration order issued in this matter, ORS 656.313 does not provide support for the employer's failure to pay benefits pursuant to the July 5, 1990 Determination Order. Finding the employer's conduct to have been unreasonable, the Referee assessed penalties and attorney fees. We disagree.

Subsequent to the Referee's order, we have held that when a carrier requests Board review of a Referee's order awarding temporary disability within the statutory 30-day period, the carrier did not act unreasonably by failing to pay temporary disability within 14 days of the Referee's order as required by former OAR 436-60-150(3)(e). Walden J. Beebe, 43 Van Natta 2430 (1991). Furthermore, former OAR 436-60-150(6) provides that permanent disability benefits awarded pursuant to a determination order must be paid within 30 days unless the order has been appealed. Finally, former OAR 436-60-150(1) states that benefits falling due on a weekend shall be paid on a working day prior to the weekend.

Here, unlike Beebe, the stay of compensation provisions in ORS 656.313 are not applicable. Nevertheless, the fact remains that, when the carrier mailed its August 3, 1990 cross-request for hearing of the Determination Order, former OAR 436-60-150(6)(c) provided that permanent disability benefits were due no later than the thirtieth day after the date of any determination order awarding such compensation, unless the order has been appealed. In addition, section (1)

of the aforementioned rule stated that benefits falling due on the weekend were payable on a working day prior to the weekend. Inasmuch as the thirtieth day from the July 5, 1990 Determination Order was Saturday, August 4, 1990 (the day after the employer mailed its cross-request), we find that it was reasonable for the employer to conclude that it was not required to pay the permanent disability award granted by the Determination Order because it had "appealed" the order.

Since the employer's cross-request for hearing was not mailed by certified mail and was actually received by the Board on Monday, August 6, 1990, the request was not "filed" until 32 days after the Determination Order permanent disability award. See OAR 438-05-046(1)(b). However, our inquiry is not when the employer "filed" its appeal, but rather whether the employer was reasonable in concluding that it had "appealed" the Determination Order prior to the expiration of the aforementioned 30-day period.

After consideration of the aforementioned points and authorities (particularly section (6)(c)), we conclude that the employer's action, albeit incorrect, was not unreasonable. Consequently, we reverse the Referee's penalty and $350 attorney fee assessment concerning this issue.

Extent of Permanent Unscheduled Disability

The Referee increased claimant's unscheduled permanent disability award for his low back injury from 8 percent, as awarded by the July 5, 1990 Determination Order, to 10 percent. On review, the employer argues that claimant has sustained no permanent partial disability as a result of his compensable low back strain. We agree.

Unscheduled permanent disability is based on a permanent loss of earning capacity due to the compensable injury. 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 Oregon Laws 1990 (Special Session), chapter 2, section 54(3).

Where a claimant fails to establish any measurable impairment resulting from his compensable injury, no award of permanent disability is allowed. See ORS 656.214(5); former OAR 436-35-270(2); OAR 436-35-280(1). Following our de novo review of this record, we conclude that claimant has sustained no permanent impairment as a result of his compensable injury. In reaching this conclusion, we rely on the opinions of Dr. Rosenbaum, Dr. Egener, and Drs. Dinneen and Hathaway.

Dr. Rosenbaum performed a thorough examination of claimant and reviewed all relevant medical records. In a well-reasoned report, he explained that after comparing claimant's x-rays taken the day of his August 1, 1989 industrial injury with the x-rays and MRI performed in March 1990, he was able to determine that claimant's spinal abnormality preexisted and is not related to his industrial injury. Further, he opined that claimant has no work restrictions associated with his August 1990 work accident.

Following his examination of claimant, review of Dr. Rosenbaum's tests, and claimant's x-rays and MRI, Dr. Egener concurs that claimant's spinal condition is not related to his compensable injury of August 1, 1989.

Similarly, Drs. Dinneen and Hathaway report that their examination revealed nonorganic pain responses, with no valid signs of nerve root impingement, such as would occur with a low back injury. Although they suggest that claimant would not have the ability to perform heavy labor, they note that this

limitation is not due to the industrial incident, but to claimant's preexisting physiology.

We do not find the contrary opinion of Dr. Holman, claimant's latest treating chiropractic physician, to be persuasive. Although Dr. Holman indicates that he does not attribute claimant's significant degenerative changes to his compensable back injury, he nevertheless contends that claimant continues to have objective findings related to his low back strain. He does not, however, describe those "objective findings," nor has he submitted evidence to refute the reports of Drs. Rosenbaum, Egener, Dinneen or Hathaway.

Accordingly, we conclude that claimant has not established that he has any permanent impairment as a result of his industrial injury. Consequently, claimant has not shown that he has sustained a loss of earning capacity due to the compensable injury. Therefore, we reverse claimant's unscheduled permanent disability award.

Attorney Fee

Finally, the employer challenges the Referee's award of a "separate" $350 attorney fee to be paid by the employer, and not out of claimant's increased permanent partial disability award. Specifically, the employer contends that there is no authority for awarding a separate fee for obtaining increased compensation. However, because the employer cross-requested a hearing, and the Referee found that the compensation awarded to claimant should not be reduced, an attorney fee was proper under ORS 656.382(2). Nevertheless, since we have concluded that claimant's unscheduled permanent disability award should be eliminated, it follows that claimant is no longer entitled to the Referee's $350 attorney fee award.

ORDER

The Referee's order dated January 7, 1991 is affirmed in part, modified in part, vacated in part, and reversed in part. Those portions of the Referee's order that set aside the self-insured employer's April 3, 1990 denial and awarded a 25 percent penalty and assessed a $500 attorney fee for counsel's services in setting aside the denial are reversed. The employer's April 3, 1990 denial is reinstated and upheld. That portion of the Referee's order that found claimant to be medically stationary February 12, 1990, whereas the Determination Order found claimant to be medically stationary on May 8, 1990, is modified. Instead, claimant is found to be medically stationary on January 29, 1990. The employer is granted an offset of temporary disability benefits paid from January 30, 1990 through February 18, 1990, against any future permanent disability awards. That portion of the Referee's order that set aside the employer's May 30, 1990 medical services denial insofar as it denied the reasonableness and necessity of chiropractic treatment is vacated. The Referee's attorney fee award regarding the May 30, 1990 denial is modified. In lieu of the Referee's $950 assessed fee, for services at hearing and on review concerning the causal relationship issue, claimant's counsel is awarded a reasonable fee of $1,200, to be paid by the employer. That portion of the Referee's order that awarded a 25 percent penalty and a $350 attorney fee for the employer's unreasonable failure to timely pay the permanent partial disability awarded by the July 5, 1990 Determination Order is reversed. The Determination Order and Referee's unscheduled permanent disability award totalling 10 percent (32 degrees) is reversed. The Referee's $350 attorney fee award concerning the employer's cross-request of the Determination Order award is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
RACHEL E. TORGESON, Claimant
WCB Case Nos. 91-11734 & 91-09823
INTERIM ORDER (REMANDING)
Westmoreland & Shebley, Claimant Attorneys
Schwabe, et al., Defense Attorneys
Daryl Nelson, Defense Attorney

Liberty Northwest Insurance Corporation requests review of Referee Neal's order that: (1) set aside its responsibility denial of claimant's low back condition; and (2) upheld K-Mart Corporation's responsibility denial of the same condition. In its reply brief, Liberty has requested that this matter be remanded to the Referee for the taking of additional evidence.

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). Liberty has requested remand for the admission of the final signed version of an October 7, 1991 report from the Orthopedic Consultants. Liberty explains that the dictated but not read version of the report was admitted into the record as Exhibit 34. After the record was closed, however, counsel for K-Mart obtained the final signed version of the report and, with the consent of all parties involved, requested the Referee to replace Exhibit 34 with the newly signed copy. It later became apparent that the Referee evidently did not receive the signed report and, consequently, did not admit it into the record. Liberty explains that the admission of the final report is crucial, because the opinion of the Consultants changed somewhat between the dictated report and the signed version. K-Mart does not object to Liberty's request, but asks that the parties be given the opportunity to present oral argument regarding the report if the motion is granted.

Considering the aforementioned circumstances, we find that this case has been improperly, incompletely, or otherwise insufficiently developed, and conclude that remand is an appropriate action. Accordingly, this matter is remanded to Referee Neal for further proceedings. These proceedings may be conducted in any manner that will achieve substantial justice and ensure a complete and accurate record. The limited purpose of the proceedings is to replace the admitted version of Exhibit 34 with the final and signed version of the report. No additional exhibits or testimony, other than that directed towards the new report, shall be admitted into the record.

We retain jurisdiction over this matter. Within 30 days of completion of the proceedings consistent with this order, a transcript, if any of the remand proceedings, along with the newly admitted exhibit, shall be forwarded to the Board. In addition, Referee Neal shall provide an interim order on remand, explaining what effect, if any, the new exhibit had upon her prior order. Once the Board receives the Referee's interim order, a revised briefing schedule will be implemented.

IT IS SO ORDERED.

In the Matter of the Compensation of
A. V. MATTHEWS, Claimant
Own Motion No. 91-0711M
OWN MOTION ORDER

The self-insured employer submitted claimant's claim for an alleged worsening of his April 2, 1980 compensable low back injury. Claimant's aggravation rights expired on December 4, 1985. However, the employer opposes the reopening of claimant's claim for payment of temporary disability compensation, contending that claimant has removed himself from the work force. In addition, the employer has requested the Director's review of the reasonableness and necessity of proposed surgery pursuant to ORS 656.327 and OAR 436-10-046.

It is the Board's policy to postpone action regarding own motion relief until the Director's review and any subsequent litigation on related issues has been resolved. Nevertheless, postponement is not necessary where the claimant is not entitled to own motion reopening. In order to qualify for the payment of temporary disability compensation, claimant must have been in the work force at the time of the worsening. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Cutright v. Weyerhaeuser Company, 229 Or 290 (1985). The employer contends that claimant had withdrawn from the work force. Claimant has not responded to the employer's contention. Claimant has the burden of proof on this issue. Accordingly, claimant's request for temporary disability compensation is denied. See id.

Claimant's entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES O. SEIBERT, Claimant
Own Motion No. 91-0722M
OWN MOTION ORDER ON RECONSIDERATION
Emmons, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our March 11, 1992 Own Motion Order in which we denied temporary total disability compensation on the ground that claimant had not submitted evidence to substantiate that he was in the work force at the time his condition worsened.

Claimant has now submitted an affidavit wherein he contends that Dr. Golden advised him to stop his regular work in March 1989, due to his low back condition. Claimant further contends that he subsequently applied for modified work at various employers and that he received unemployment compensation in 1989 and 1990. However, he provided no documentary evidence to substantiate his work search or receipt of unemployment compensation during that time, nor did he provide medical or documentary evidence that he had been unable to work from January 1991 until his surgery in January 1992. Where claimant points to readily verifiable work force indicia, such as receipt of unemployment benefits, we expect independent documentation, rather than claimant's mere statement, to be provided. Having failed to provide proof of his receipt of unemployment benefits, or even the names of employers where he lookd for work, we conclude that claimant has failed to prove that he was in the work force at the time of his current worsening. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258

(1989). Accordingly, we continue to deny claimant's request for temporary disability compensation. See id.

Consequently, we withdraw our March 11, 1992 order. As supplemented herein, we adhere to and republish our March 11, 1992 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARY E. BIGLER, Claimant
WCB Case No. TP-91027
THIRD PARTY DISTRIBUTION ORDER
Burt, Swanson, et al., Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

The SAIF Corporation, as a paying agency, has petitioned the Board to resolve a dispute concerning whether SAIF is entitled to a share of a settlement claimant has recovered stemming from injuries she sustained as a result of a non-work-related motor vehicle accident which occurred before she was found to be medically stationary from a January 1988 compensable injury. Contending that no portion of the settlement was granted for disability or medical expenses resulting from the compensable injury, claimant asserts that SAIF is not entitled to a share of the recovery. We conclude that a distribution of settlement proceeds in accordance with ORS 656.593(1) is just and proper. See ORS 656.593(3).

FINDINGS OF FACT

In January 1988, claimant sustained a compensable back injury while working as a registered nurse. She continued to work, but was placed under a 35 pound lifting restriction. For the first week after her injury, claimant received chiropractic treatment on a daily basis. Within a month, she had reduced her treatments to one per week.

In March 1988, SAIF accepted the claim as nondisabling. SAIF identified the accepted conditions as "disorder of sacroiliac joint; sprain left hip."

In June 1988, claimant was involved in an off-the-job motor vehicle accident with another vehicle. She suffered injuries to several areas of her body, including her low back. Thereafter, claimant was taken off work and began receiving chiropractic treatments more frequently.

In August 1988, claimant returned to her nursing duties on a part-time modified basis. However, by October 1988, she was taken off work because of her inability to fully resume her duties.

As a result of the June 1988 motor vehicle accident, claimant filed an aggravation claim with SAIF for her worsened back condition. In addition, she retained counsel to seek damages from the operator of the motor vehicle involved in the June 1988 accident.

In an October 31, 1988 letter, Dr. Freeman, claimant's treating chiropractor, reported that, although claimant's past work injuries had been brought under control and claimant was able to work prior to the June 1988 motor vehicle accident, the past work injuries had weakened claimant's spinal structures.

In a December 23, 1988 letter, Dr. Freeman reported that claimant's prior work injuries had caused certain amounts of chronic instability in her back area, and the June 1988 motor vehicle accident had caused further sprains and strains in the back area.

In a December 30, 1988 letter, Dr. Poulson, claimant's treating orthopedic surgeon, stated that claimant's January 1988 compensable injury contributed about 20 percent to her back condition, and the June 1988 motor vehicle accident contributed to the rest of her condition.

In December 1988, SAIF denied claimant's aggravation claim. In September 1989, a Referee set aside the denial and remanded the aggravation claim to SAIF for processing. In so doing, the Referee found that:

> "...although claimant was doing fairly well regarding her low back prior to the June 1988 motor vehicle accident, she had not fully recovered from her January 1988 injury and although the June 1988 motor vehicle accident was the cause of her worsening at that time, the January 1988 work injury was a material contributing cause of claimant's worsened condition regarding her low back subsequent to the June 1988 motor vehicle accident."

A March 22, 1990 Determination Order closed the claim. Claimant was awarded: (1) temporary partial disability benefits for the period between January 1988 and the June 1988 motor vehicle accident; (2) temporary total disability benefits commencing after the accident and continuing until her August 1988 return to work; (3) two months of temporary partial disability during her attempted return to work; and (4) approximately 15 1/2 months of temporary total disability benefits following her unsuccessful return to work and her February 1990 medically stationary date. Claimant was also awarded 31 percent unscheduled permanent disability.

On March 23, 1990, SAIF submitted a third party election form to claimant's counsel. Claimant was requested to indicate whether she intended to proceed on her own behalf against the driver of the other motor vehicle involved in the June 1988 accident, or whether she wished to assign her cause of action to SAIF.

On March 28, 1990, claimant's counsel responded to SAIF's request for an election. After reviewing the Referee's September 1989 order, claimant's counsel stated that the June 1988 motor vehicle accident was a separate and distinct injury that was unrelated to the compensable injury. Under such circumstances, it was claimant's position that there was no need to complete the third party election form.

In November 1991, claimant notified SAIF that she had reached a settlement of $25,000 against the driver of the other vehicle involved in the June 1988 auto accident. Claimant also disputed SAIF's entitlement to a share of the settlement.

On December 26, 1991, SAIF petitioned the Board for resolution of the dispute. SAIF contended that claimant's compensable injury had been exacerbated as a result of the June 1988 motor vehicle accident.

Following the motor vehicle accident, SAIF has incurred $35,752.47 in actual claim costs attributable to claimant's compensable injury. These costs are comprised of $24,157.20 in temporary disability benefits (80 percent of the temporary disability benefits paid after the motor vehicle accident), $3,659.27 in medical bills (80 percent of the medical bills paid after the motor vehicle

accident), and $7,936 in permanent disability benefits (80 percent of the permanent disability paid on the claim).

A distribution of the third party settlement proceeds in accordance with ORS 656.593(1) is "just and proper." Such a distribution would permit SAIF to retain the balance of the proceeds remaining after the deduction of claimant's attorney fees, litigation costs, and statutory 1/3 share.

CONCLUSIONS OF LAW

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 shall elect whether to recover damages from the third person. ORS/656.578. The paying agency has a lien against the worker's cause of action as provided by ORS 656.591 to 656.593. ORS 656.580(2). An off-the-job injury that aggravates a compensable condition is a "compensable injury" within the meaning of ORS 656.578. SAIF v. Dooley, 107 Or App 287, 290 (1991).

In Dooley, the claimant was nearing a medically stationary status and still receiving temporary disability when he was involved in a motor vehicle accident unrelated to his employment. The accident resulted in new injuries and worsened the claimant's compensable condition. The claimant's physician was able to distinguish both the medical costs and the time loss attributable to the auto accident from those attributable to the original injury. As a paying agency, the insurer did not pay the medical costs resulting from the accident. However, the insurer sought reimbursement from the claimant's settlement with the third party for four months of additional temporary disability attributable to the worsened compensable condition. Reasoning that the insurer was obligated to pay the additional benefits for the aggravated compensable condition, the court held that the insurer was entitled to receive a share of the settlement proceeds. Dooley, supra.

The facts in the present case are similar to those in Dooley. Here, although claimant did not miss work following the January 1988 compensable injury, she continued to receive chiropractic care for her back condition. At the time of the June 1988 motor vehicle accident, claimant was still under lifting restrictions and she was receiving chiropractic care on a weekly basis. Moreover, as in Dooley, the auto accident worsened claimant's compensable condition, and in this case, claimant was eventually taken off work. As a result of claimant's worsened condition following the motor vehicle accident, SAIF paid temporary disability payments to claimant. SAIF also paid claimant's medical costs following the accident and paid permanent partial disability on the claim.

We also find that, as in Dooley, the present record distinguishes between disability attributable to the compensable injury and disability attributable to the motor vehicle accident. Here, claimant's treating physician, Dr. Poulson, has opined that 80 percent of claimant's condition is attributable to the motor vehicle accident, and 20 percent of her condition remains attributable to her compensable injury in January 1988.

Claimant, however, contends that the $25,000 she received in settlement for the auto accident was intended to cover only the injuries sustained in that accident. In support of her contention, claimant submits an affidavit and a letter from the third party adjustor, stating that the settlement was made for injuries solely arising from the motor vehicle accident. We are not persuaded by claimant's argument.

In September 1989, a Referee set aside SAIF's denial of claimant's aggravation claim which was filed after the motor vehicle accident. The Referee found that claimant's compensable work injury remained a material contributing cause of her worsened condition subsequent to the June 1988 motor vehicle accident. The Referee's conclusion was based, in part, upon the opinion of Dr. Poulson, who stated that claimant's work injury contributed about 20 percent to her worsened back condition.

Under the circumstances, we find that it is the law of the case that claimant's compensable injury remained a material contributing cause of her worsened condition. Accordingly, claimant is precluded from arguing that her worsened condition is solely attributable to the motor vehicle accident. Such an argument is inconsistent with her argument at hearing, and the Referee's conclusion, that her compensable injury materially contributed, in part, to her worsened condition.

Moreover, in the present case, claimant has accepted benefits as a result of prevailing upon her aggravation claim. See Verne E. Davis, 43 Van Natta 1726 (1991)(Benefits paid as a result of the reopening of a claim satisfy the definition of compensation pursuant to ORS 656.593(1)(c), and, because the insurer is statutorily obligated to provide compensation such as temporary and permanent disability benefits, it may recover such benefits from a third party settlement.)

Claimant also asserts that the statement provided by the third party adjustor establishes that the accident was the sole cause of her condition. We disagree. Here, the adjustor provided a statement that the settlement was for "injuries arising solely out of an automobile accident which occurred on June 26, 1988." We conclude that the adjustor's statement is contrary to the law of the aggravation case, which holds that claimant's worsened condition is attributable, in material part, to her compensable work injury. In addition, we note that the adjustor's statement is inconsistent with her action in issuing the settlement check (i.e., the draft was payable to claimant, her attorney, and to SAIF). Most importantly, we find the medical opinion of Dr. Poulson to be more persuasive on the causal relationship between claimant's low back condition and her work and auto accident injuries.

Finally, SAIF argues that claimant is contending that her settlement with the third party insurer consists of general damages, which should not be subject to SAIF's lien. However, we do not distinguish between general and special damages for purposes of a third party settlement. We have previously held that, where a settlement agreement expressly provides that claimant and the third party are resolving claimant's cause of action for damages arising from an event such as an auto accident, the entire settlement proceeds, regardless of how they are apportioned, are subject to the lien of the paying agency, which in this case, is SAIF. See Gale E. Charlton, 43 Van Natta 1356 (1991).

Accordingly, we conclude that the June 1988 auto accident required SAIF to provide additional compensation that it would not have otherwise paid. We find that the record establishes that 80 percent of the compensation SAIF has provided subsequent to the June 1988 motor vehicle accident is directly attributable to the motor vehicle accident. We further hold that a distribution in accordance with ORS 656.593(1) is just and proper. See ORS 656.593(3).

SAIF has calculated the total costs attributable to expenses paid upon claimant's claim following the motor vehicle accident as: (1) $30,196.50 temporary disability benefits (100 percent of which were paid after the motor vehicle accident); (2) $3,659.27 in medical bills (or 80 percent of the $4,574.09 in medical expenses paid after the motor vehicle accident); and (3) $7,396.00 in

permanent disability benefits (or 80 percent of the $9,920 in permanent disability benefits paid on the claim).

We agree with SAIF's calculations in all aspects except one. SAIF's calculations for medical expenses and permanent disability are based upon Dr. Poulson's opinion that 80 percent of claimant's condition is attributable to the motor vehicle accident. We agree. However, SAIF has attributed 100 percent of claimant's temporary disability benefits to the motor vehicle accident, presumably because claimant's injury was not disabling and she was not taken off work until after the noncompensable auto accident.

Because Dr. Poulson has attributed 20 percent of claimant's worsened condition to her compensable injury, however, we find that SAIF is only entitled to claim 80 percent of the temporary disability benefits paid after the auto accident. In other words, SAIF has not persuasively argued that 100 percent of the temporary disability was paid for the condition attributable to the auto accident. Therefore, in regard to temporary disability benefits, SAIF's actual claim cost attributable to the compensable injury is $24,157.20, or 80 percent of all temporary disability benefits paid on the claim following the auto accident.

Following the motor vehicle accident, we find that SAIF has incurred $35,752.47 in actual claim costs attributable to claimant's compensable injury. These costs are comprised of $24,157.20 in temporary disability benefits (80 percent of the temporary disability benefits paid after the motor vehicle accident), $3,659.27 in medical bills (80 percent of the medical bills paid after the motor vehicle accident), and $7,936 in permanent disability benefits (80 percent of the permanent disability paid on the claim).

As we have found that a distribution in accordance with ORS 656.593(1) is just and proper, we turn to a computation of such an allocation. Pursuant to ORS 656.593(1)(a), costs and attorney fees incurred shall be initially disbursed. Here, from the $25,000 total settlement, claimant's counsel is entitled to $8,333.33 in attorney fees and $814.65 in litigation costs. The balance remaining after such disbursement is $15,852.02.

Then, claimant shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b). Accordingly, claimant is entitled to a disbursement of $5,284.01. The balance remaining after such disbursement is $10,568.01.

Finally, SAIF 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 services. See ORS 656.593(1)(d). Here, we have found that SAIF incurred a total of $35,752.47 in actual claim costs attributable to the motor vehicle accident. Accordingly, we conclude that the remaining balance, or $10,568.01, constitutes SAIF's "just and proper" share of the third party settlement. See ORS 656.593(3). Claimant's attorney is, therefore, directed to distribute to SAIF $10,568.01 in settlement proceeds which has been held in claimant's attorney's trust account pending resolution of this dispute.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM G. CUMMINGS, Claimant
WCB Case No. TP-91024
THIRD PARTY DISTRIBUTION ORDER
Lane, et al., Claimant Attorneys
William E. Brickey (Saif), Defense Attorney

The SAIF Corporation, as a paying agency, has petitioned the Board for resolution of a dispute which concerns the "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, the dispute involves the distribution of the parties' respective shares of proceeds from a "structured settlement." We find that a distribution in accordance with ORS 656.593(1) in which SAIF recovers $72,409 of its asserted lien is "just and proper."

FINDINGS OF FACT

In October 1987, while performing his work activities, claimant sustained a compensable injury when he fell 12 feet. He suffered a severe comminuted and displaced fracture of the left heel. Surgery to repair the fracture was performed by Dr. Ellison. The SAIF Corporation, the worker's compensation insurer for claimant's employer, accepted the claim and has provided benefits.

In December 1987, osteomyelitis of the left foot and ankle was diagnosed. In September 1988, as a result of this infection, claimant's left leg below the knee was amputated. This surgery was performed by Dr. Warren.

Claimant engaged legal representation. Thereafter, claimant instituted a third party action against his surgeons for malpractice in the treatment of his osteomyelitis. Claimant did not seek damages for medical expenses or disability incurred prior to the December 1987 diagnosis of his osteomyelitis.

In January 1991, a bilateral ulnar nerve compression condition was diagnosed. Claimant reported that the numbness and tingling in his hands had arisen in approximately December 1987, while he was convalescing from his left heel and bone graft procedure. Specifically, claimant related that he had spent approximately 10 months sitting in a reclining chair and resting his arms on the armrests.

Based on this history, Dr. Nathan opined that claimant's symptoms were "associated with resting his arms on the armrests of a reclining chair following his leg surgery." Consequently, Dr. Nathan concluded that "the sequela of the industrial injury of October 29, 1987, was a major contributing cause of his present hand condition."

In April 1991, Dr. Woolpert, orthopedist, performed an independent medical examination. Claimant reported that his arm numbness arose during his approximately 10 month convalescence period prior to an August 1988 return to work. This return to work was short-lived, since he underwent the left lower leg amputation in September 1988.

Dr. Woolpert explained that it was not uncommon for patients to develop such a problem from lying in bed during post-op convalescence and while using crutches. Thus, in the absence of other documented ulnar nerve problems, it was Dr. Woolpert's impression that "it is certainly possible that the patient developed his ulnar nerve neuropathy secondary to his recumbency or use with crutches."

SAIF accepted the bilateral ulnar nerve condition. Claimant did not seek damages for this condition in his malpractice action.

An August 13, 1991 Determination Order closed claimant's October 1987 injury claim. He was awarded 100 percent scheduled permanent disability for loss of his left foot (lower leg). In addition, claimant was granted 5 percent scheduled permanent disability for loss of use or function of the left arm.

Also in August 1991, claimant and the surgeons reached a settlement. The surgeons agreed to pay claimant a lump sum payment of $95,000. In addition, claimant, then 57 years of age, would receive annual payments of $15,018 for the remainder of his life or 15 years, whichever was longer. The cost of the structured settlement was $154,375. Claimant's life expectancy was 25.93 years.

Claimant's attorney fee equals 30 percent of the gross settlement. Litigation costs total $502.

SAIF approved the gross settlement. However, it recommended a distribution of proceeds in which a portion of claimant's attorney fee, litigation costs, statutory 1/3 share, and SAIF's lien would be recovered from the $95,000 lump sum payment, as well as each annual payment. When claimant declined to distribute the settlement proceeds in the manner SAIF had proposed, SAIF petitioned the Board for resolution of the dispute.

Initially, SAIF asserted a lien of $96,436.94, which was composed of actual and projected expenses pertaining to medical benefits, vocational costs, and temporary/permanent disability for claimant's October 1987 left foot injury, December 1987 osteomyelitis, and January 1991 bilateral ulnar nerve condition.

In response, claimant challenged several portions of SAIF's lien. Specifically, claimant contended that medical expenses and temporary disability incurred prior to the December 1987 osteomyelitis diagnosis were not recoverable. Claimant also asserted that SAIF's lien for temporary disability ($10,458.62) should be reduced by 50 percent because only approximately 6 of his 12 months of lost wages was due to the malpractice. In addition, claimant opposed SAIF's request for reimbursement for any expenses attributable to his bilateral ulnar nerve condition, which he argued did not result from the malpractice. Finally, claimant objected to SAIF's claim for vocational expenses and future temporary disability compensation.

In reply, SAIF withdrew its claim for future temporary disability and vocational expenses. SAIF also agreed to remove from its lien medical expenses incurred prior to the December 1987 malpractice. In addition, SAIF reduced its claim for recovery of actual temporary disability costs. However, rather than reducing its total expenses for the approximately 1-year period of temporary disability benefits by 50 percent as proposed by claimant, SAIF argued that the last 6 months of the 1-year period (April 1988 - October 1988) should be subject to its lien. Thus, rather than a $5,229.31 lien for temporary disability as suggested by claimant, SAIF sought a $6,592.49 lien. Next, contending that claimant would require 4 to 6 revisions of his prosthetic device during his lifetime, SAIF projected future medical expenditures of $16,763. Finally, SAIF continued to seek recovery of all claim costs attributable to claimant's bilateral ulnar nerve condition.

In answer to SAIF's reply, claimant identified the following remaining disputes concerning SAIF's lien. SAIF was seeking recovery of $6,592.49 for temporary disability, while claimant was contending that $5,229.31 was recoverable. The parties also continued to disagree whether SAIF's expenses related to claimant's bilateral ulnar nerve condition were reimbursable.

FINDINGS OF ULTIMATE FACT

SAIF has incurred claim costs in the following amounts as a result of the December 1987 malpractice: (1) $33,733.61 for actual medical expenses; (2) $5,229.31 for temporary disability benefits; (3) $16,683 for permanent disability benefits; and (4) $16,763 for future medical expenses. These claim costs total $72,409 (rounded to the nearest dollar). A distribution of third party settlement proceeds in a manner in which SAIF would eventually receive $72,409 (after payment of claimant's attorney fee, litigation costs, and statutory 1/3 share) from the structured settlement would be just and proper.

CONCLUSIONS OF THE LAW AND OPINION

Pursuant to ORS 656.578, 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 the third person. The proceeds of any damages recovered from a third person by the worker or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.693(1).

If the worker or beneficiaries settle the third party claim with agency approval, the agency is authorized to accept as its share of the proceeds "an amount which is just and proper," provided the worker receives at least the amount to which he is entitled under ORS 656.593(1) and (2). ORS 656.593(3); Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). Any conflict as to what may be a "just and proper distribution" shall be resolved by the Board. ORS 656.593(3).

The statutory scheme for the allocation of damages is precise. Robert B. Williams, 38 Van Natta 119, 123 (1986), aff'd Estate of Troy Vance v. Williams, supra. ORS 656.593(1) provides in exact detail how, and in what order, the proceeds of any damages shall be distributed. Pursuant to ORS 656.593(1)(a) costs and attorney fees incurred shall be initially disbursed. Then, the worker shall receive at least 33 1/3 percent of the balance of the recovery. ORS 656.593(1)(b). However, the amount that the agency is "authorized to accept" from a third party settlement is less precise than the amount of its lien from damages recovered from a third party under ORS 656.593(1)(c): i.e., an amount which is "just and proper," as opposed to "its expenditures for compensation . . . and . . .the present value of its reasonably to be expected future expenditures of compensation." Estate of Troy Vance v. Williams, supra, 84 Or App at 620.

The aforementioned statutes do not discuss the distribution of proceeds from a third party "structured" settlement. Nevertheless, we have held that the "proceeds" of a third party settlement encompass not only immediate cash payments, but also annuity payments payable over a period of years. See Thomas T. Traver, 43 Van Natta 2295 (1991); Dick A. Cole, 40 Van Natta 1021 (1988); Ralph W. Schemmel, 40 Van Natta 951 (1988). In reaching our conclusion, we have reasoned that such annuity payments do not alter the fundamental principle that the payments are "proceeds" from a third party recovery and, as such, should be distributed in accordance with the schedule set forth in ORS 656.593(1). Id.

Here, in accordance with the aforementioned reasoning, we hold that the "total proceeds" of the structured settlement are comprised of the initial lump sum payment plus the annuity payments. We further conclude that these proceeds should be distributed in accordance with the statutory schedule. Pursuant to that schedule, incurred litigation costs and attorney fees shall initially be paid, followed by the worker's statutory one-third share of the remaining

balance. See ORS 656.593(1)(a), (b). SAIF's lien applies only after the aforementioned shares have been fully disbursed. See ORS 656.593(3); 656.593(1)(c).

SAIF recognizes the Board's longstanding holdings concerning a "just and proper" distribution of proceeds in third party structured settlements. Nevertheless, contending that under such a distribution scheme it would not begin receiving reimbursement for several years (assuming that the annuity insurer does not suffer a financial failure in the meantime), SAIF suggests an allocation of proceeds in a manner in which "claimant, claimant's attorney, [and] SAIF receive equal portions of each installment in a manner equitable and fair to all three parties." Under such a proposal, SAIF asserts that each party "should eventually receive that party's full share of the third party recovery in a reasonable manner."

In effect, SAIF is advancing a "pro-rata" proposal for distribution of the annual payments from the third party structured settlement. We have consistently rejected such an approach because the statutory distribution scheme to apportion those "total proceeds" in accordance with ORS 656.593(1) is clear and precise. Thomas T. Traver, supra; Dick A. Cole, supra; Ralph W. Schemmel, supra.

We further note that ORS 656.593(3) authorizes a paying agency to recover a "just and proper" distribution from a third party settlement, provided that the worker receives the amount to which he is entitled to recover under subsections (1) and (2). Were we to follow SAIF's proposed distribution scheme, claimant would eventually receive the amount to which he is entitled under ORS 656.593(1) and (2). Yet, neither he nor his attorney would receive their shares in the "precise" manner as set forth in ORS 656.593(1). Robert B. Williams, supra; Estate of Troy Vance v. Williams, supra. Consequently, we decline to adopt SAIF's distribution proposal.

In reaching this conclusion, we acknowledge SAIF's contention that a distribution in accordance with the Traver/Cole/Schemmel rationale would be unfair and inequitable. Nevertheless, as we stated in Traver, the Cole/Schemmel distribution scheme has remained unaltered through two legislative sessions. Considering such circumstances, we decline SAIF's invitation to disavow our previous holdings concerning the distribution of proceeds from structured settlements.

As we reasoned in Traver, our decisions regarding third party distribution disputes are designed to provide a consistent and ascertainable basis for resolving questions concerning the allocation of proceeds from a third party recovery. Such an approach is traditionally taken to avoid making "equitable distributions on an ad hoc basis and to permit the parties to generally know where they stand as they seek to settle a third party action." See Marvin Thornton, 34 Van Natta 999, 1002 (1982). We continue to adhere to that philosophy and find no persuasive reason to depart from our longstanding approach.

Accordingly, claimant's attorney is directed to distribute the "total proceeds" of the third party settlement in accordance with ORS 656.593(1)(a), (b), and (c). The "total proceeds" shall be comprised of the $95,000 initial lump sum and the $154,375 cost of the annuity; i.e., a total of $249,375.

Before proceeding to a specific distribution schedule, we must resolve the parties' remaining disputes concerning the amount of SAIF's asserted lien. To begin, SAIF seeks $6,592.49 in temporary disability reimbursement. This compensation coincides with a six month period from April 1988 through October 1988, which SAIF claims is attributable to the physicians' malpractice and, thereby, the third party recovery. Claimant acknowledges that the malpractice

contributed to his inability to work and that SAIF should be entitled to recover a portion of its temporary disability expenses from the settlement. However, since SAIF's total lien for temporary disability paid during the approximately one-year period of claimant's incapacity is $10,458.92 and because claimant is conceding that 6 months of that period would be attributable to the malpractice, claimant contends that SAIF's lien should be 50 percent of its total costs ($5,229.31).

SAIF is entitled to the recovery of its claim costs from a third party settlement for malpractice to the extent that it is receiving reimbursement for additional expenses incurred as a result of the malpractice. Diane T. Dawes, 44 Van Natta 75 (1992); John W. Kuykendall, 42 Van Natta 1886 (1990); Ray F. Littlefield, 41 Van Natta 1781 (1989). The burden of proof is upon SAIF to establish the extent of expenditures attributable to the malpractice. Id.

Here, SAIF provides no evidence to support its assertion that the temporary disability provided between April 1988 and October 1988 was incurred as a result of the December 1987 malpractice. In fact, the medical evidence is to the contrary. Dr. Ellison testified by way of deposition that "some alterations and changes in healing and function and activity could extend for up to five or six years" following the October 1987 compensable injury. (Ex. F-2). Thus, if anything, the record suggests that the temporary disability expended by SAIF was related to the October 1987 injury rather than resulting from the December 1987 malpractice.

Notwithstanding this observation, claimant has conceded that SAIF is entitled to 50 percent of its $10,458.92 lien for temporary disability. In light of claimant's concession, we conclude that SAIF is entitled to recover $5,229.46 from the third party settlement for its temporary disability expenses.

The final dispute pertains to whether SAIF may include in its lien medical expenses and permanent disability benefits provided for claimant's bilateral ulnar nerve condition. SAIF contends that these expenses were incurred as a result of the December 1987 malpractice. In support of this contention, SAIF relies on the opinions offered by Drs. Nathan and Woolpert.

Each of the aforementioned physicians related claimant's bilateral ulnar nerve condition to the period of his convalescence. (Dr. Nathan attributes the condition to claimant's sitting in a recliner, while Dr. Woolpert opined that the condition was the result of claimant's "recumbency or use with crutches."). Nevertheless, it is apparent from their opinions that included within this period of convalescence was claimant's recovery from the initial October 1987 left heel and bone graft surgery. Inasmuch as this convalescence period preceded December 1987, we are unable to conclude that claimant's bilateral ulnar nerve condition resulted from the malpractice. Consequently, SAIF has not established that its expenses concerning the condition were incurred as a result of the December 1987 malpractice. Therefore, SAIF is not entitled to include such claim costs in its lien; i.e., medical expenses and permanent disability benefits.

In light of the aforementioned conclusions, we find that SAIF's lien consists of the following claim costs: (1) $33,733.61 for actual medical expenses; (2) $5,229.31 for temporary disability benefits; (3) $16,683 for permanent disability benefits for the left lower leg; and (4) $16,763 for future medical expenses. The total of this claim costs equals $72,408.92, which rounded to the nearest dollar is $72,409.

Having determined the amount of SAIF's lien, we conclude that the total proceeds shall be allocated to the following individuals and entities in the amounts (rounded to the nearest dollar) described below:

Settlement (Total Proceeds)	$249,375
Litigation Costs	- 502
Attorney Fee (30%)	- 74,812
Subtotal	$174,061
Claimant's Share (1/3)	- 58,020
Subtotal	$116,041
SAIF's Lien	- 72,409
Remainder to Claimant	$ 43,632

In accordance with the Traver/Schemmel/Cole rationale, the proceeds from this structured third party settlement shall be distributed in the following manner. Claimant's attorney shall receive $75,314 ($74,812 attorney fee + $502 litigation costs) of the $95,000 lump sum payment. The remaining $19,686 will be distributed to claimant as partial payment of his statutory 1/3 share ($58,020). Claimant shall continue to receive his $15,018 annuity payments until he receives another $38,334. (This amount would bring the total of claimant's recovery to his $58,020 statutory share). Thereafter, SAIF shall receive all or any portion of claimant's annuities until it eventually recovers its lien ($72,409). Once SAIF's lien is satisfied, claimant shall receive all or any portion of the remaining annuities.

IT IS SO ORDERED.

In the Matter of the Compensation of
SHIRLEY J. DAVIS, Claimant
WCB Case Nos. 91-18467 & 91-13994
ORDER OF DISMISSAL (REMANDING)
Pozzi, et al., Claimant Attorneys
Miller, et al., Defense Attorneys
Cooney, et al., Defense Attorneys

Fred Meyer, Inc., a self-insured employer, has requested, and claimant has cross-requested, Board review of Referee Davis' March 11, 1992 "Order Vacating Joinder and Dismissing Case." 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

On December 30, 1991, Referee Peterson granted Fred Meyer's motion to join Portland Community College and its insurer as a party to claimant's hearing request concerning Fred Meyer's disclaimer of responsibility for her aggravation claim. Thereafter, claimant and Portland Community College moved for reconsideration of the joinder order.

On March 11, 1992, Referee Davis issued an "Order Vacating Joinder and Dismissing Case." Because claimant had not previously appealed Portland Community College's denial of her "new injury" claim, the Referee reasoned that it would be inappropriate to join Portland Community College as a party to the proceeding. Furthermore, finding that Fred Meyer had complied with its statutory obligations under 1990 Oregon Laws (Special Session), ch. 2, Section 49, the

Referee concluded that Fred Meyer could assert that actual responsibility for claimant's current condition rested with Portland Community College. The Referee's order contained a statement explaining the parties' rights of appeal pursuant to ORS 656.289(3).

Within 30 days of the Referee's order, both Fred Meyer and claimant filed requests for Board review.

FINDINGS OF ULTIMATE FACT

The Referee's March 11, 1992 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, further action is required as a result of the Referee's March 11, 1992 order. The order neither finally disposed of, nor allowed, the claim. Moreover, the order did not fix the amount of claimant's compensation. Rather, notwithstanding the inclusion of a statement explaining the parties' rights of appeal, the order was preliminary in nature. In effect, Portland Community College was notified that its appearance at an upcoming hearing concerning Fred Meyer and claimant was not required.

Furthermore, although not expressly articulated in a such a manner by the Referee, Portland Community College's formal dismissal as a party to the proceedings would logically be incorporated into the Referee's eventual final, appealable order. Such a procedure would be in keeping with the Board's longstanding interest in avoiding piecemeal review of multiple issues arising in a single case. Maria Martinez, 40 Van Natta 57 (1988); Harris E. Jackson, 35 Van Natta 1674, 1676 (1983).

In conclusion, as a result of the Referee's order, further proceedings will be required to determine claimant's entitlement to, and/or the amount of, compensation. Under such circumstances, we conclude that, notwithstanding the statement regarding the parties' rights of appeal, the Referee's order is not a final, appealable order. Price v. SAIF, supra; Lindamood v. SAIF, supra; Maria Martinez, supra. Therefore, we currently lack jurisdiction to consider the parties' requests for Board review. Consideration of such matters must await the eventual issuance of the Referee's final, appealable order determining claimant's entitlement to and/or the amount of compensation (assuming that Board review is subsequently requested).

Accordingly, the requests for Board review are dismissed and this matter is returned to Referee Davis for further proceedings consistent with this order and the Referee's March 11, 1992 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROY HANSEN, Claimant
Own Motion No. 66-0200M
OWN MOTION ORDER ON RECONSIDERATION
Emerson G. Fisher, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our March 13, 1992 Own Motion Order in the above-captioned case. Claimant also requests a "formal hearing before a Judge" concerning this matter.

By a January 30, 1991 Own Motion Order, we requested the SAIF Corporation to schedule an inpatient evaluation at the University of Washington Medical School, Oregon Health Sciences University or any other comparable medical facility to diagnose whether claimant suffers from an alleged malabsorption syndrome and whether claimant has need for medication at the apparently excessive levels prescribed. This inpatient evaluation has not been performed. Because this information has not been provided, we issued our March 13, 1992 Own Motion Order denying the reopening of claimant's claim and reimbursement for these medications. To date, claimant has failed to provide any additional information regarding these matters. We accordingly decline to alter our March 13, 1992 Own Motion Order. Upon provision of the required information by either party, we will reconsider this matter.

We interpret claimant's request for a formal hearing as a request for an evidentiary hearing before the Hearings Division. The Board may refer this matter to the Hearings Division for an evidentiary hearing. OAR 438-12-040(3). However, these circumstances, which require a medical evaluation, do not warrant an evidentiary hearing. Accordingly we deny claimant's request for hearing.

Claimant's letter also requests, for the first time, approval of an annual physical in Seattle. We have forwarded this request to SAIF Corporation for action on this request for own motion relief.

IT IS SO ORDERED.

In the Matter of the Compensation of
JULIO G. MEJIA, Claimant
WCB Case No. TP-92003
THIRD PARTY ORDER OF DISMISSAL
Doblie & Associates, Claimant Attorneys
Roberts, et al., Defense Attorneys

Claimant has petitioned the Board for "relief concerning a third party claim." Specifically, claimant contends that "the arbitrary, capricious and unreasonable conduct of The Travelers is interfering with reasonable settlement negotiations and the preparation for trial." Inasmuch as no third party settlement offer has been proposed nor has a third party recovery been achieved, we consider claimant's petition to be premature. Consequently, the petition is dismissed.

FINDINGS OF FACT

In December 1984, while performing his work activities as a mechanic, claimant injured his knees. His claim was accepted and benefits were provided by Travelers.

An October 1989 Determination Order closed claimant's claim, declaring him medically stationary on September 14, 1989. Claimant was awarded temporary disability through April 23, 1989. In addition, claimant was granted scheduled permanent disability awards of 19 percent for the left leg (knee) and 5 percent for the right leg (knee).

On November 8, 1989, claimant was involved in a non-work-related motor vehicle accident. He suffered multiple injuries, including injuries to his knees. In January 1990, Travelers denied claimant's request for claim reopening.

Claimant requested a hearing concerning the Determination Order and Travelers' denial. Among other findings, a March 28, 1990 Referee's order made the following conclusions: (1) the Determination Order was modified to award temporary disability through June 29, 1989 (the date the Referee found that claimant's condition became medically stationary); (2) the aggravation denial was set aside and the claim remanded to Travelers for processing according to law; and (3) in light of the aggravation finding, a determination of the extent of claimant's permanent disability was deferred.

In reaching the conclusion that claimant's aggravation claim was compensable, the Referee found that claimant's bilateral knee condition worsened during the period he was working for his employer between mid-June 1989 and mid-September 1989. The Referee further found that claimant had not become medically stationary since the worsening.

In August 1990, the Orthopaedic Consultants performed an independent medical examination. The Consultants concluded that claimant's knee condition had not been "materially worsened" by the 1989 motor vehicle accident. A "less strenuous job off his feet" was recommended.

Also in August 1990, claimant filed a cause of action against a restaurant seeking damages resulting from the November 1989 motor vehicle accident. Claimant contended that the restaurant had served alcohol to a visibly intoxicated person, who subsequently drove her vehicle through a red light striking claimant's vehicle.

In September 1990, the Travelers notified claimant of its lien against any recovery resulting from the cause of action. Since the motor vehicle accident, Travelers asserted that it had expended an additional $12,364.53, primarily consisting of "total and partial disability."

In October 1990, claimant requested an explanation concerning the basis for Travelers' assertion that it was entitled to a share of any recovery resulting from his cause of action. Claimant did not acknowledge the validity of Travelers' lien.

In response to claimant's challenge to its lien, Travelers asserted that claimant had been forced to delay a January 1990 vocational training program because of the November 1989 motor vehicle accident. Since that accident had aggravated claimant's knee condition and claimant had been unable to attend the program, Travelers was seeking recovery of temporary disability benefits paid beyond the January 1, 1990 scheduled starting date for the program.

A March 6, 1991 Board order modified a portion of the Referee's March 28, 1990 order. The Board disagreed with claimant's contention that the October 12, 1989 Determination Order had prematurely closed his claim. In addition, claimant was found to be medically stationary on September 6, 1989, rather than June 29, 1989 as found by the Referee. In affirming the remainder of the Referee's

order, the Board concluded that "[claimant] experienced increased loss of use or function of his knees following the November 8, 1989 accident, and that his worsened condition was due, in material part, to his compensable injury."

No current settlement offer concerning claimant's cause of action against the restaurant has materialized. Trial is currently scheduled for July 20, 1992.

Claimant disagrees with Travelers' contention that it is entitled to a share of any eventual recovery. Claimant also seeks further specificity regarding the amount and components of Travelers' lien. Contending that Travelers' presence has disrupted resolution of his cause of action, claimant has petitioned the Board to hold Travelers' lien invalid.

CONCLUSIONS OF LAW

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

Generally, we will approve settlements negotiated between a claimant/plaintiff and a third party defendant, unless the settlement appears to be grossly unreasonable. Dorotha M. Clarke, 40 Van Natta 1125 (1988); Kathryn I. Looney, 39 Van Natta 1140 (1987). However, where a claimant has not accepted a settlement offer, no third party compromise exists for us to consider. Delores M. Shute, 41 Van Natta 1028 (1989).

Here, claimant has not accepted a third party settlement offer because no such offer has materialized. Inasmuch as no compromise between the worker and the third party currently exists, we are without authority to proceed under ORS 656.587. Shute, supra.

Moreover, pursuant to ORS 656.593(3), we are authorized to resolve any conflict concerning the "just and proper distribution" of the remaining proceeds from a third party settlement. See Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). However, where no third party settlement has been reached, there are no proceeds from which we can determine a "just and proper" distribution. See ORS 656.593(3); Shute, supra. Thus, any petition for resolution of such a "dispute," where no settlement has been achieved, is considered to be a request for an advisory opinion, which we are not empowered to issue. Shute, supra.

Claimant argues that he is not seeking an advisory opinion because he is contending that Travelers does not have a valid lien. We addressed a similar contention regarding the validity of a paying agency's lien in Mary E. Bigler, 43 Van Natta 619 (1991).

In Bigler, a paying agency sought a Board order granting it a share of any eventual recovery from an alleged third party action. Although neither a settlement offer nor judgment had been achieved, the paying agency argued that Board resolution of the matter was required to avoid future collection problems should claimant subsequently realize a recovery. We recognized that a dispute existed between the parties concerning the paying agency's entitlement to a share of any future recovery. Nevertheless, in light of our statutory limitations, we held that we were without authority to resolve the parties' current dispute regarding the validity of the paying agency's lien.

Here, as in Bigler, there is a challenge to the validity of the paying agency's lien. Yet, as was the case in Bigler, no settlement offer has been

made nor has a judgment been filed. Under such circumstances, we lack authority to resolve the dispute. Nevertheless, as we stated in Bigler, should a settlement or judgment subsequently materialize and the validity of Travelers' lien remains in dispute, the parties may again seek Board resolution. See SAIF v. Dooley, 107 Or App 287 (1991); Oscar L. Compton, 44 Van Natta 288 (1992); Calina Neathery, 43 Van Natta 2374 (1991); Mark S. Randolph, 43 Van Natta 1770 (1991);

In conclusion, we hold that we are without authority to consider claimant's petition. Accordingly, this matter is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
LOIS M. POTTKER, Claimant
Own Motion No. 91-0358M
OWN MOTION ORDER
Malagon, et al., Claimant Attorneys

The insurer submitted claimant's claim for an alleged worsening of her January 8, 1983 lumbosacral strain injury. Claimant's aggravation rights expired on March 22, 1988. The insurer initially denied the compensability of claimant's current condition and recommended denial of claimant's request for payment of temporary disability compensation. By a December 9, 1991 Stipulation and Order of Dismissal, the insurer accepted the compensability of a lumbar microdiskectomy performed by Dr. Hacker at L5-S1 on August 9, 1991. Based on this stipulation, the insurer now recommends that we authorize the payment of temporary disability compensation and reimbursement from the Reopened Claims Reserve.

The insurer may voluntarily reopen any claim to provide benefits or grant additional medical or hospital care to claimant. ORS 656.278(3). However, we may exercise our own motion authority to award benefits for temporary disability only if we find that there is a worsening of a compensable injury that requires either surgery or hospitalization. ORS 656.278(1)(a).

Here, Drs. Brooks and Tilchin, who performed an independent medical examination and file review on May 22, 1991, stated:

> "There is no evidence to suggest that this disc herniation is related to [claimant's] January 8, 1983 lumbosacral strain. We would refer specifically to the Orthopedic Consultants evaluation of April of 1985, some two years after [claimant's] on-the-job injury. She had no complaints at that time suggestive of radiculopathy. X-rays at that time were normal and did not show any evidence of disc space narrowing. It is clear that over the last several years [claimant] has developed degenerative disc disease of the lumbosacral spine, and more recently has suffered a disc herniation. We are unable to determine the relationship between her current disc herniation and the 1983 injury."

Dr. Hacker, claimant's attending physician, concurred with this opinion, remarking only that claimant says the symptoms were always present since the injury and suggesting that there may have been an initial disc injury, though a true disc herniation was not identified.

We are more persuaded by the well reasoned opinion of Drs. Brooks and Tilchin, with which Dr. Hacker concurred, than with Dr. Hacker's suggestion that there "may" have been an initial unidentified disc injury. See Somers v. SAIF, 770 Or App 259, 262 (1986).

Thus, the record does not establish that claimant's herniated disc represents a worsening of her original injury. Although the insurer voluntarily rescinded its denial of claimant's lumbar discectomy at L5-S1, such an action does not automatically result in our authorizing the reopening of a claim under our own motion jurisdiction and reimbursement from the Reopened Claims Reserve, where the record does not establish that claimant's herniated disc is not causally related to her compensable back injury. See Allan E. Orton, 42 Van Natta 924 (1990). Moreover, our authority is discretionary, not mandatory. See ORS 656.278(1)(a); OAR 438-12-052. Considering the circumstances described herein, we do not choose to exercise our discretion to authorize the reopening of claimant's claim and reimbursement from the Reopened Claims Reserve.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRIAN R. SMALL, Claimant
WCB Case No. 91-01343
ORDER ON REVIEW
Sellers & Jacobs, Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Gunn and Tenenbaum.

Claimant requests review of Referee Bethlahmy's order that upheld the insurer's denial of his aggravation claim for a left knee condition. On review, the issues are compensability and aggravation.

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

The Referee is correct that lay testimony may, in certain circumstances, be sufficient to establish the compensability of a claim. While we do not conclude that this case presents such a complex medical question that compensability cannot be resolved by lay evidence, we find the lay evidence in this case to be insufficient to prove the claim.

Claimant testified that he had continuing, if intermittent, problems with his knee from the time of the July 1989 accident until he finally sought medical treatment in May 1990. Yet, the history recorded in May by Dr. Paluska presents a different picture. Dr. Paluska's history reflects that the knee had "suddenly bec[o]me quite swollen three weeks ago." (Ex. 6). While Dr. Paluska was aware of the July 1989 injury, he makes no reference to claimant having reported any knee difficulties between his initial injury and the sudden swelling which prompted him to seek treatment in May 1990. Given the glaring inconsistency between this history and claimant's testimony, we are unable to conclude that the lay evidence in this case is sufficient to establish compensability.

Because claimant's aggravation claim is dependent on the compensability of the meniscus tear, the aggravation claim fails as well.

ORDER

The Referee's order dated June 12, 1991 is affirmed.

In the Matter of the Compensation
DORIS C. CARTER, Claimant
WCB Case No. 91-05482
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of Referee Daughtry's order that set aside an Order on Reconsideration because it was invalidly issued and remanded the matter to the Appellate Unit of the Workers' Compensation Division (WCD) for further processing pursuant to ORS 656.268. On review, the issue is the validity of the WCD's Order on Reconsideration. We reverse the Referee's order and affirm the Order on Reconsideration.

FINDINGS OF FACT

On March 13, 1990, claimant sustained a compensable injury to her low back. She initially sought treatment for this injury from Dr. Duerst, chiropractor. In August 1990, claimant changed her treating physician to Dr. Gabe, M.D.

Claimant's claim was closed by a November 13, 1990 Determination Order. The Determination Order awarded temporary disability benefits and found claimant medically stationary as of October 12, 1990. The Determination Order did not award any permanent disability. Thereafter, claimant requested reconsideration of the Determination Order, contending that she was entitled to a permanent disability award. Her request stated that she did not disagree with the findings of the attending physician, but rather, disagreed with the rating made by the Evaluation Section.

On April 29, 1991, the WCD Appellate Unit issued its Order on Reconsideration. The order affirmed the Determination Order in all aspects. The claim was not referred to a medical arbiter prior to the issuance of the Order on Reconsideration.

Thereafter, claimant requested a hearing concerning the Order on Reconsideration.

Claimant has preexisting scoliosis and a congenital anomalous vertebrae at L5.

CONCLUSIONS OF LAW AND OPINION

Validity of the Order on Reconsideration

The Referee found that the Order on Reconsideration was not valid on the basis that the Director had not appointed a medical arbiter prior to issuing the order. Therefore, the Referee set aside the reconsideration order, remanded the claim to the WCD Appellate unit for processing and dismissed claimant's request for hearing. We disagree.

Claimant became medically stationary after July 1, 1990. Therefore, the 1990 amendments to the Workers' Compensation Act apply to this case. See Or Laws 1990 (Special Session), Ch. 2, 54(3). Furthermore, the Director's rules in effect at the time of the April 1, 1991 Order on Reconsideration are applicable. Former OAR 436-30-003(4) (WCD Admin. Order 7-1990, effective July 1, 1990).

As amended, ORS 656.268(4)(e) provides that: "If a worker objects to the notice of closure, the worker must first request reconsideration by the department under this section." In conjunction with this section, amended ORS 656.268(5) provides that: "If a worker, the insurer or self-insured employer objects to a determination order issued by the department, the objecting party must first request reconsideration of the order." Amended ORS 656.268(6)(b) then provides that:

> "If any party objects to the reconsideration order, the party may request a hearing under ORS 656.283 within 180 days after the copies of the notice of closure or the determination order are mailed, whichever is applicable. The time from the request for reconsideration until the reconsideration is made shall not be counted in any limitation on the time allowed for the request for hearing."

It is clear from ORS 656.268(4)(e), 656.268(5) and 656.268(6)(b), that claimant or the objecting party must not only request reconsideration from a Notice of Closure or Determination Order before requesting a hearing pursuant to ORS 656.283, but the reconsideration process established by ORS 656.268(5) through (7) must be completed before a hearing may be requested. See Lorna D. Hilderbrand, 43 Van Natta 2721 (1991).

ORS 656.268(7) also provides, in part:

> "If the basis for objection to a notice of closure or determination order issued under this section is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter appointed by the director. . . . The findings of the medical arbiter shall be submitted to the department for reconsideration of the determination order or notice of closure. . ." (Emphasis supplied).

We have recently interpreted this provision to mean that where a party requests reconsideration of a Notice of Closure or Determination Order and the basis for that request is a disagreement with the medical findings for impairment, then the Director is required to submit the matter to an medical arbiter or panel of arbiters prior to issuing an Order on Reconsideration. See Olga I. Soto, 44 Van Natta 697 (1992).

In the instant case, claimant did seek reconsideration. However, her basis for seeking reconsideration was not a disagreement with the medical findings of impairment used in rating, but rather, with how the impairment rating was used in evaluating her permanent disability. ORS 656.268(7) provides for referral to an arbiter or panel of arbiters only where there is disagreement with the findings of impairment used in the Notice of Closure or Determination Order. See former OAR 436-30-050(9). (Emphasis supplied). Further, at hearing and on review, claimant has specifically stated that she does not disagree with the impairment rating of her treating physician.

Inasmuch as claimant did not seek reconsideration on the basis of a disagreement with the medical findings of impairment used in rating her disability, the Director was not required to submit claimant's claim to a medical arbiter or panel of arbiters prior to issuing the Order on Reconsideration. ORS 656.268(7); former OAR 436-30-050(9). Therefore, the Order on Reconsideration is valid.

Since we find the record completely developed with regard to the issue of extent of unscheduled permanent disability, we proceed to the merits.

Extent of Unscheduled Permanent Disability

Claimant contends that she is entitled to an award of unscheduled permanent disability. We disagree.

To be entitled to an award of unscheduled permanent disability, claimant must establish that she has sustained a loss of earning capacity as a result of her compensable injury. ORS 656.214(5).

Dr. Gabe, claimant's attending physician, reported that claimant had no objective signs of any permanent impairment as a result of the the compensable injury. Although Dr. Gabe did note tenderness, he could not relate this finding to the compensable injury.

Under these circumstances, we conclude that claimant has not established that she sustained permanent impairment as a result of her compensable injury. Accordingly, claimant is not entitled to an award of unscheduled permanent disability. ORS 656.214(5).

In reaching this conclusion, we note that claimant refers to Dr. Gabe's November 1990 report which was not submitted to the Appellate Unit. OAR 436-30-050(4)(e) and (f) allow for the submission of additional information to clarify or correct a medical record based on physical examinations at or prior to closure. As noted above, Dr. Gabe's November 1990 report was not submitted to the Appellate Unit.

We need not decide in this case whether Dr. Gabe's report can be considered because even if it was considered we would still conclude that claimant has not established entitlement to unscheduled permanent disability. The report references a chronic condition: claimant's preexisting scoliosis and congenital anomaly at L5. Further, although Dr. Gabe does suggest limitations, he does not relate the limitations to the compensable injury and in fact describes claimant's current difficulties as temporary. Therefore, consideration of Dr. Gabe's November 1990 report would not alter our conclusion.

Finally, the insurer requests that we authorize an offset in the amount of $1,069.97 for an overpayment of temporary disability benefits. Claimant has agreed that the insurer is entitled to an offset in this amount. (Ex. 25D). Although we have not granted claimant an award of permanent disability at this time, we may authorize an offset of overpaid temporary disability benefits against future awards of permanent disability. See Robert E. Kubala, 43 Van Natta 1495 (1991). Accordingly, we authorize the insurer an offset in the amount of $1,069.97, against claimant's future permanent disability awards on this claim.

ORDER

The Referee's order dated August 21, 1991, as amended September 27, 1991 is reversed. The Reconsideration Order is reinstated and affirmed. The insurer is authorized to offset $1,069.97 against claimant's future awards of permanent disability on this claim.

Member Kinsley and Tenenbaum dissenting:

We disagree with the majority that this case is in a posture to proceed to a decision on the merits. In order to resolve the issues in this case, we need to know the record made at the Appellate Unit. However, we have not received a certified record from the Appellate Unit and, therefore, the record we have is incomplete. As a result, we would remand the case to the Hearings Division pursuant to ORS 656.295(5) for further evidence taking.

The initial issue presented on Board review is whether the Appellate Unit was required to refer the claim to a medical arbiter pursuant to ORS 656.268(7). By the terms of that statute, the referral is required "[i]f the basis for objection to a notice of closure or determination order issued under this section is disagreement with the impairment used in rating of the worker's disability . . . ." The record before us does not contain a copy (or original) of the request for reconsideration received by the Appellate Unit so that we can determine what the actual issues were before the Appellate Unit. The parties have submitted Exhibit 27 which is a copy of a January 16, 1991 letter to the Appellate Unit from claimant's attorney's office stating the basis for an objection to the November 13, 1990 Determination Order. However, there is no evidence that the Appellate Unit received this letter (such as by a receipt date stamp). Generally, parties may stipulate to facts as a substitute to the offer of documentary or testimonial evidence. However, the hearing record contains no stipulation by the parties that the Appellate Unit's record contains the original of Exhibit 27 and that there is no other pleading contained in the Appellate Unit's record that would augment or alter the bases for objection raised in Exhibit 27.

We also disagree with the finding of the majority that Dr. Gabe's November 29, 1990 report, Exhibit 25, was not submitted to the Appellant Unit. Further, the majority opinion fails to address whether this report was admissable evidence at hearing.

First, since our record does not contain the Appellant Unit's certified record, it is impossible to tell whether they had the report. Again, in the absence of the Appellant Unit's record, there is no stipulation by the parties as to what the record contained. We gather that the majority decided that the report had not been submitted because the Appellant Unit's Order on Reconsideration stated, "Since claimant did not submit additional information, the reconsideration was based on information already in the file, especially the October 12, 1990 report from claimant's attending physician, Michael Gabe, M.D." (Ex. 26). We know of no statute or rule that gives statements made in an Order on Reconsideration a presumption of correctness. With all due respect to the good people at the Appellant Unit, mistakes can be and are made during the reconsideration process. Our job at the Workers' Compensation Board is to review the orders to determine if they are correct. On the record before us, it it impossible to make that determination.

Second, even assuming that Exhibit 25 was not submitted to the Appellate Unit, we find that it was admissable. There is no statute or rule which limits its admission at hearing. ORS 656.268(5) states, in part:

> "At the reconsideration proceeding, the worker or the insurer or self-insured employer may correct information in the record that is erroneous and may submit any medical evidence that should have been but was not submitted by the physician serving as the attending physician at the time of claim closure."

The statute says nothing about denying admission of the report at hearing if it is not submitted during the reconsideration proceeding. Further, the only statute which refers to a limitation of evidence at hearing is the last sentence of ORS 656.268(7) which covers the medical arbiter procedure:

> "The findings of the medical arbiter or panel of medical arbiters shall be submitted to the department for reconsideration of the determination order or notice of closure, and no subsequent medical evidence of the worker's impairment is admissable before the department, the board or the courts for purposes of making findings of impairment on the claim closure."

Here, where there has been no medical arbiter procedure, the prohibition against submission of additional medical evidence is not triggered. Legislative history only supports the conclusion that the prohibition is applicable when the medical arbiter procedure is used. (Hearings on Senate Bill 1197 before the Joint Interim Special Committee on Workers' Compensation, May 4, 1990, tape 11, side A, in responding to the question of whether further medical evaluations would be allowed: "[M]y impression was that after reconsideration had been requested and an extent of disability and impairment had been determined by a panel of medical arbiters, there would be no further evaluation for or against the disability award." (Emphasis added). Statement of Jim Edmunson, State Representative; Id. at tape 17, side B: "After the panel [of medical arbiters] has come to their conclusion, there can't be additional information or evidence." (Emphasis added). Statement of Gene Derfler, State Representative).

OAR 436-30-050(4)(e) and (f), cited by the majority on this issue pertain to the reconsideration proceeding at the Appellate Unit and do not, and could not, limit admission of evidence at a hearing at the Workers' Compensation Board.

For the above reasons, we dissent.

In the Matter of the Compensation of
DONALD J. FENDRICH, Claimant
WCB Case No. 88-09638
ORDER ON REMAND
Malagon, et al., Claimant Attorneys
Acker, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Fendrich v. Curry County, 110 Or App 409 (1991). In our prior order we affirmed a Referee's order which found that claimant had withdrawn from the work force and, therefore, was not entitled to temporary disability benefits. The court has reversed and remanded with instructions to "make findings on whether claimant was willing to work and, if so, whether it would have been futile for him to have sought employment."

FINDINGS OF FACT

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

Claimant saw Dr. Campagna in April 1987 with increased back pain. (Ex. 4). Dr. Campagna performed surgery on claimant's back on April 17, 1987. (Ex. 5).

Claimant had not worked since leaving his job in April 1985. (Tr. II 14). As of the date of Referee Nichols' June 10, 1988 order in a prior proceeding, claimant had not looked for work since leaving his job in April 1985. (Ex. 16-4). On March 1, 1988, claimant stated he had not looked for work in the past year. (Tr. II 15).

On October 6, 1988, Dr. Ryan's impression was that claimant had severe vocational dysfunction: "[Claimant] was injured over 3 1/2 years ago, and although he claims that he wants to return to work, I cannot help but think that he would rather be in his comfortably established equilibrium." (Ex. 19). Dr. Ryan further noted: "On examination he has virtually no range of motion of his

neck when examined, but looks comfortable and relatively normal in range of motion in conversing." Id.

Claimant periodically assisted his father in his father's metal fabrication business. Although claimant was not paid money for this work, he did receive meals and gasoline for his vehicle . (Tr. II 4).

During the summer of 1988, claimant also asked a hardware store manager about future employment. The inquiry was not based on current openings, but rather when and if claimant could "get to feeling better to be able to do it." (Tr. II 5). Additionally, claimant also inquired about a currently available part-time job stocking shelves. (Tr. II 9).

Finally, claimant spoke to the owner of a fabrication company and was told to call if he was able to work. (Tr. II 5). Claimant is receiving social security disability since February 1988 and PERS retirement benefits since early 1986. (Tr. II 5-7).

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had not shown a willingness to accept employment within his limitations. Consequently, the Referee found claimant had withdrawn from the labor market and was not entitled to temporary disability benefits.

Subsequent to the date of the Referee's order, the Supreme Court issued its opinion in Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989). The Dawkins court listed three situations where a claimant is deemed to be in the work force: (1) The claimant is engaged in regular gainful employment; (2) The claimant, although not employed at the time, is willing to work and is making reasonable efforts to obtain employment; or (3) The claimant is willing to work, although not employed at the time and not making reasonable efforts to obtain employment because of a work related injury, where such efforts would be futile.

On review, we adopted the Referee's order with a citation to Dawkins. Reasoning that the Referee's order did not contain a finding concerning whether claimant was willing to work or whether efforts to find employment would have been futile, the court reversed and remanded for reconsideration.

A worker who has voluntarily withdrawn from the work force at the time of an aggravation of a compensable injury is not entitled to temporary total disability. Cutright v. Weyerhaeuser, 299 Or 290, 293 (1985). The critical time for determining whether claimant has withdrawn from the work force is at the time of his disability. Weyerhaeuser Co. v. Kepford, 100 Or App 410, 414 (1990).

We find that claimant has not shown a desire to obtain employment at the time of his disability in April 1987. Claimant's testimony that he has not withdrawn from the work force does not, of itself, convince us that he is willing to work or that it is futile for him to seek work. In fact, the remainder of the record contradicts claimant's contention.

Claimant has not worked since April 1985. He has been receiving PERS retirement benefits since early 1986 and Social Security disability since February 1988. Claimant made no attempts to secure employment between April 1985 and March 1988. (Ex. 16-4). Thus, for several years prior to, as well as at the time of his disability in April 1987, claimant made no effort to find employment and evidenced no willingness to seek work. Claimant's only attempts to seek work were made in the summer of 1988, when claimant made two inquiries about employment. These inquiries were essentially not about present employment, but

rather were vague inquiries about the possibility of employment at some indefinite period of time in the future. Claimant's lack of reasonable efforts to obtain employment is further evidence, albeit not determinative, of a lack of willingness to work. Fendrich, supra, 110 Or App at 413.

Although claimant testified that he unsuccessfully sought an existing part-time job stocking shelves in the summer of 1988, we do not consider such inquiries in 1988 sufficient to establish that claimant had a desire to obtain work at the time of his April 1987 disability. Moreover, Dr. Ryan has expressed concern that claimant would rather be in his comfortably established equilibrium than return to work.

In conclusion, based on this record, we are not persuaded that, at the time of his disability, claimant was willing to work. Considering such a conclusion, it is unnecessary to determine whether it would have been futile for claimant to seek employment. Nevertheless, had we been required to address that issue, we would have found, based on Dr. Ryan's observations, that it would not have been futile for claimant to have sought employment. Consequently, we hold that claimant is not entitled to temporary disability benefits.

Accordingly, on reconsideration, as supplemented herein, we affirm the Referee's order dated April 4, 1989.

IT IS SO ORDERED.

In the Matter of the Compensation of
LEROY A. FRIEND, Claimant
WCB Case No. 91-13315
ORDER OF DISMISSAL
Doblie & Associates, Claimant Attorneys
Williams, et al., Defense Attorneys

Claimant has requested Board review of Referee Barber's December 10, 1991 "Interim Order on Remand." We have reviewed the request to determine whether we have authority to consider the matter. We conclude that the Referee's order constitutes a final order and that claimant's request for Board review is untimely. Consequently, we dismiss the request for review.

FINDINGS OF FACT

On December 10, 1991, the Referee issued an "Interim Order on Remand." Finding that a medical arbiter's report concerning claimant's impairment had not been considered by the Appellate Unit for the Evaluation Section of the Workers' Compensation Division, the Referee concluded that the Order on Reconsideration was invalid.

Consequently, the Referee set aside the Reconsideration Order and remanded the matter to the Appellate Unit for consideration of the medical arbiter's report. Reasoning that the interim order was not a final order, the Referee did not include a statement explaining the parties' rights of appeal under ORS 656.289(3) and 656.295.

On January 21, 1992, the Board received claimant's request for review of the Referee's December 10, 1991 order. The request included a "Certificate of Service" from claimant's attorney stating that the request had been mailed to the Board on January 17, 1992.

CONCLUSIONS OF LAW AND OPINION

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, if the Referee's order is correct, it is not a final appealable order because it does not finally determine the rights of the parties concerning claimant's hearing request from the Order on Reconsideration. Nevertheless, if the Referee's order is incorrect, the Referee's order will have finally determined the rights of the parties by effectively dismissing the only request for hearing which would allow for litigation and modification of the Department's Reconsideration Order.

Inasmuch as claimant's entitlement to temporary and permanent disability is potentially impacted by the Referee's order, we conclude that it is an appealable final order. See Mickey L. Platz, 44 Van Natta 16 (1992). The fact that the Referee's order did not contain a statement explaining the parties' rights of appeal does not alter our conclusion. Glen D. Roles, 42 Van Natta 68, 72 (1990) (A Referee's order does not depend upon notice of appeal rights to be final).

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). Here, the 30th day after the Referee's December 10, 1991 order was January 9, 1992. Claimant's request was mailed to the Board on January 17, 1992, more than 30 days after the Referee's December 10, 1991 order. Consequently, we lack authority to review the order which has become final by operation of law. See ORS 656.289(3); 656.295(2).

Accordingly, the request for Board review is dismissed.[1]

IT IS SO ORDERED.

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[1] The Referee set aside the Order on Reconsideration as invalid for failure of the Appellate Unit to consider a medical arbiter's report. Thus, in effect, claimant has already obtained from the Referee the relief this Board might have given had we not dismissed claimant's request for review for untimeliness. See Olga I. Soto, 44 Van Natta 697 (1992). Any further relief must be sought from the Director, or if necessary, from a court by way of writ of mandamus or other judicial proceeding.

In the Matter of the Compensation of
ARLENE J. KOITZSCH, Claimant
WCB Case No. 90-13984
ORDER ON RECONSIDERATION
Craine & Love, Claimant Attorneys
Pamela Schultz, Defense Attorney

On January 29, 1992, we vacated the Referee's order which had awarded claimant 34 percent (51 degrees) scheduled permanent disability for loss of use or function of the right forearm. In addition, we remanded to the Referee with instructions to determine whether Dr. Johnson was an "attending physician" under

ORS 656.005(12)(a)(A). Thereafter, claimant moved for reconsideration. Noting that a medical doctor practicing and licensed under the laws of another state was included within the definition of "attending physician" under OAR 436-10-005(1)(b), claimant contended that our order suggested that an out-of-state worker was foreclosed from receiving medical benefits and that the aforementioned rule was invalid. In light of such circumstances, claimant sought clarification of our order.

On February 6, 1992, we withdrew our order for reconsideration. The insurer was granted 10 days within which to respond. Inasmuch as that 10-day period has expired and no such response has been forthcoming, we proceed with our reconsideration.

On review, claimant objected to the Referee's apparent reliance on the impairment findings offered by Dr. Nathan, an independent medical examiner. Based on these findings, the Referee granted claimant a 34 percent scheduled permanent disability award for the right forearm. Contending that only the attending physician could rate impairment under ORS 656.245(3)(b)(B), claimant argued that she was entitled to the 66 percent impairment finding advanced by Dr. Johnson combined with a 5 percent "chronic condition" award for a total of 68 percent.

In our prior order, we were unable to determine whether Dr. Johnson, a Washington practitioner, was licensed in the state of Oregon. Reasoning that such a requirement was necessary to constitute an "attending physician," we vacated the Referee's order and remanded for further proceedings concerning Dr. Johnson's status.

After further consideration, we conclude that remand is not necessary because, even if Dr. Johnson is an "attending physician," we do not find his findings to be persuasive evidence concerning claimant's permanent impairment. We base this conclusion on the following reasoning.

To begin, Dr. Johnson initially concurred with Dr. Nathan's April 1990 report which determined that there was no evidence of permanent impairment. Subsequently, other than noting that claimant had been re-examined in October 1990, Dr. Johnson provided no explanation for why he found claimant to have a combined impairment rating of 66 percent (30 percent for reduced grip strength and 44 percent for sensory deficit). Lacking a persuasive explanation for this change of opinion, we do not consider Dr. Johnson's findings to be reliable. See Kelso v. City of Salem, 87 Or App 630 (1987).

Moreover, Dr. Johnson's findings are conclusory and provide little, if any, discussion of the manner in which these findings were obtained. For example, Dr. Johnson's conclusion of a 30 percent grip strength loss provided no explanation concerning the number of tests performed or what was the normal measurement standard. Furthermore, there is no indication that such a finding was in accordance with the AMA Guidelines. See former OAR 436-35-005(1). Considering the conclusory nature of these findings as well as the physician's failure to provide a readily discernible basis for measuring the grip strength loss, Dr. Johnson's grip strength loss findings are not reliable. See Moe v. Ceiling Systems, 44 Or App 429 (1980); Paul F. Weigel, 44 Van Natta 44 (1992).

Dr. Johnson did provide a brief discussion regarding the methods used to determine claimant's sensory deficit; i.e., "hot and cold perception" and "light touch and two-point discrimination." Based on such testing, Dr. Johnson rated claimant's loss of function as related to sensory deficit at 44 percent. This rating would equal the "maximum % loss of function due to sensory deficit" for the median nerve as set forth in former OAR 436-35-110(3)(a). Yet, such a "maximum" rating would be inconsistent with Dr. Johnson's observations that

claimant's "hot and cold perception" was "intact grossly" and that her "light touch and two-point discrimination are severely impaired."

In addition, Dr. Nathan persuasively rebutted this sensory deficit finding by noting that a 44 percent rating would be indicative of a "complete transsection of the median nerve," which has not occurred. (In reviewing this case, Dr. Nathan's opinion has not been considered for its impairment findings, but rather for purposes of supporting or impeaching the opinion and ratings offered by Dr. Johnson). In light of the aforementioned inconsistency, as well as our previous reservations concerning his rating methods, we consider Dr. Johnson's "sensory deficit" findings to be likewise unreliable.

In conclusion, for the reasons detailed above, we decline to rely on Dr. Johnson's findings regarding claimant's permanent impairment. Therefore, assuming without deciding that Dr. Johnson is claimant's "attending physician," such findings are not persuasive evidence that claimant's scheduled permanent disability for loss of use or function of the right forearm exceeds the 34 percent award granted by the Referee. Finally, inasmuch as the insurer did not seek reduction of that award, it shall not be disturbed. Daniel M. Alire, 41 Van Natta 752 (1989).

Accordingly, on reconsideration, we affirm the Referee's order dated March 11, 1991.

IT IS SO ORDERED.

In the Matter of the Compensation of
EUZELLA SMITH, Claimant
WCB Case No. 90-06401
ORDER ON REMAND
Max Rae, Claimant Attorney
Roberts, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Smith v. Hazelwoods Farms Bakery, 110 Or App 369 (1991). Our prior order affirmed and adopted the Referee's order that declined to award an assessed attorney fee under former ORS 656.386(1) for services regarding the insurer's pre-hearing rescission of its denial of claimant's left wrist injury claim. Citing Jones v. OSCI, 108 Or App 230 (1991), the court has reversed and remanded for reconsideration.

FINDINGS OF FACT

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

On January 20, 1989, claimant suffered a left wrist sprain while performing her work activities as an accounts payable clerk. She immediately reported the injury to her employer. Her medical bills were paid by her employer. No written claim was filed.

In December 1989 claimant retained an attorney. In March 1990, claimant's attorney asked the insurer for its records concerning the January 1989 injury. When the insurer responded that no record existed concerning claimant's injury, claimant's attorney filed a hearing request regarding the insurer's "de facto" denial. Claimant also sought penalties and attorney fees.

In March 1990, claimant's attorney obtained from Dr. Blake, claimant's treating orthopedist, copies of claimant's medical bills and a report. Dr. Blake confirmed that claimant had related her left wrist problem to a work accident.

On April 10, 1990, claimant's attorney referred copies of claimant's medical bills to the insurer. On April 13, 1990, claimant's attorney submitted Dr. Blake's report to the insurer.

An Informal Dispute Resolution Conference (IDRC) was scheduled for April 23, 1990. Claimant and her attorney appeared at that conference. Neither the employer nor its representative appeared at the scheduled time.

On May 18, 1990, the insurer's counsel responded to claimant's hearing request. The insurer denied the issues raised by claimant: (1) "de facto" denial; and (2) penalties and attorney fees.

On June 5, 1990, prior to the scheduled June 25, 1990 hearing, the insurer accepted claimant's injury claim as nondisabling.

Claimant's attorney was instrumental in obtaining compensation for claimant without a hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was not entitled to an assessed attorney fee under former ORS 656.386(1). The Referee relied on our order in Duane L. Jones, 42 Van Natta 875 (1990), which held that former ORS 656.386(1) provided no basis for an award of insurer-paid attorney fees to a claimant when a carrier withdraws its denial prior to hearing. We affirmed and adopted the order of Referee.

Our order in Jones initially was affirmed by the Court of Appeals. Jones v. OSCI, 107 Or App 78 (1991). The court subsequently allowed reconsideration, however, and withdrew its opinion. Jones v. OSCI, 108 Or App 230, 232 (1991). The court's action was based on the 1991 amendment to ORS 656.386(1) providing 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." Id. Relying on its decision in Jones, the court has reversed and remanded for reconsideration.

On remand, the insurer contends that claimant is not entitled to an attorney fee award under ORS 656.386(1). Specifically, it asserts that: (1) claimant has not prevailed against a "rejected" case; and (2) claimant's attorney was not "instrumental" in "obtaining compensation." We reject each of these contentions for the following reasons.

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. ORS 656.386(1). 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. Id.

A claim is denied "de facto" after the expiration of the statutory period within which to accept or deny the claim under ORS 656.262(6). See Barr v. EBI Companies, 88 Or App 132, 134 (1987); Doris J. Hornbeck, 43 Van Natta 2397 (1991).

Here, the employer received notice of claimant's injury on January 20, 1989. Such knowledge is sufficient to constitute a "claim." ORS 656.005(6). Although the employer paid for claimant's medical bills, these payments are not considered acceptance of a claim or an admission of liability. ORS 656.262(9). Inasmuch as no acceptance or denial of the claim was issued within the then-required 60-day period of ORS 656.262(6), claimant's attorney filed a hearing request, raising the issues of "de facto" denial, penalties, and attorney fees. Moreover, in response to the March 1990 hearing request, the insurer's counsel denied claimant's assertions, including the "de facto" denial.

Under such circumstances, we conclude that the insurer denied the compensability of claimant's left wrist injury claim. Consequently, this case constitutes a "rejected" case under ORS 656.386(1).

Furthermore, we find that claimant's attorney was instrumental in obtaining compensation for claimant without a hearing. The insurer argues that claimant's attorney was not "instrumental" in prompting the acceptance of the claim. We disagree. Claimant's attorney obtained claimant's medical records and provided them to the insurer. In addition, claimant's attorney filed a March 1990 hearing request concerning the insurer's "de facto" denial and appeared at the April 1990 IDRC. Finally, in its May 1990 response to claimant's hearing request, the insurer disputed the "de facto" denial. In light of these circumstances, as well as the insurer's subsequent June 5, 1990 acceptance of the claim prior to the June 25, 1990 hearing, we conclude that claimant's attorney was instrumental in obtaining compensation for claimant without a hearing.

In reaching this conclusion, we disagree with the insurer's contention that claimant did not obtain compensation as a result of her attorney's efforts. "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). Here, as a result of claimant's attorney's efforts, the insurer accepted claimant's March 1989 left wrist injury claim. Pursuant to the aforementioned statute, such an acceptance established claimant's entitlement to all benefits, including medical services, as set forth in ORS Chapter 656 resulting from that injury. Inasmuch as claimant's right to such benefits under the workers' compensation system had not been secured until the insurer's acceptance of the claim, we conclude that claimant's attorney was instrumental in obtaining compensation for claimant without a hearing. See Fidel D. Chavez, 43 Van Natta 2515 (1991).

Consequently, we hold that claimant is entitled to a carrier-paid attorney fee under amended ORS 656.386(1). We proceed to a determination of a reasonable fee.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable attorney fee concerning the insurer's pre-hearing acceptance of claimant's left wrist injury claim prior to hearing 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 the record and claimant's attorney's statement of service), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney might go uncompensated. In making this determination, we have not considered claimant's attorney's efforts rendered after the insurer's June 5, 1990 claim acceptance.

Accordingly, on reconsideration, we reverse the Referee's order dated August 20, 1990. For services concerning the insurer's acceptance of claimant's

injury claim prior to hearing, claimant's attorney is awarded $500, to be paid by the insurer.

IT IS SO ORDERED.

April 15, 1992 Cite as 44 Van Natta 781 (1992)

In the Matter of the Compensation of
LaDONNA F. BURK, Claimant
WCB Case No. 91-03511
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of those portions of Referee Livesley's order which: (1) set aside the insurer's partial denial of claimant's low back degenerative disc condition; and (2) assessed penalties and related attorney fees for the insurer's allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except his "Findings of Ultimate Fact," with the following supplementation.

Claimant's October 30, 1990 compensable left sacroiliac strain injury caused her preexisting asymptomatic, degenerative disc disease to become symptomatic. The major contributing cause of claimant's current disability and need for medical treatment for this resultant condition is and remains the compensable injury.

CONCLUSIONS OF LAW AND OPINION

Compensability

Because claimant requested a hearing after May 1, 1990 and a hearing was convened after July 1, 1990, the Referee applied the law as amended by Oregon Laws 1990 (Special Session). We concur and accordingly analyze this matter under the Workers' Compensation Act effective July 1, 1990. See 1990 Or Laws, ch. 2, Section 54(2); Ida M. Walker, 43 Van Natta 1402 (1991).

The Referee found that claimant's October 30, 1990 compensable left sacroiliac strain injury materially worsened her preexisting degenerative disc disease, causing her current disability and need for medical treatment. While we agree with the Referee's ultimate conclusion, we offer the following analysis.

Subsequent to the Referee's order, we held that in cases involving preexisting conditions, whether a claim is compensable is a two-part test. Bahman M. Nazari, 43 Van Natta 2368 (1991). First, claimant must establish that she suffered an accidental injury arising out of and in the course of employment, which was a material contributing cause of her disability or need for medical treatment. See ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). Then, if it is determined that there is a preexisting condition and that the condition combined with the injury to cause or prolong disability or need for treatment, claimant is entitled to disability compensation and treatment only to the extent

that her injury remained the major contributing cause of her resulting disability. ORS 656.005(7)(a)(B); Bahman M. Nazari, supra.

Because the insurer accepted claimant's October 30, 1990 left sacroiliac strain as a compensable injury, we need not address whether claimant has established a compensable injury under the first prong of this two-part test. However, as to the second prong of the test, we find that the cause of claimant's current disability is a complex medical question requiring expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Here, the record contains the opinions of Dr. McGirr, claimant's treating physician, Dr. Anderson, claimant's consulting physician, and Dr. Woolpert, an orthopedic surgeon who performed an independent medical examination. Following his examination, Woolpert opined that claimant suffered from a preexisting degenerative disc disease, which had been asymptomatic, and that her injury on October 30, 1990 caused her disc condition to become symptomatic. (Ex. 4-4). Dr. Woolpert also opined that, although claimant had shown a definite improvement with conservative treatment, she was still symptomatic and not medically stationary. (Id). Dr. McGirr concurred with Woolpert's findings via a "fill-in-the-blank" form letter. (Ex. 6). McGirr subsequently agreed with claimant's counsel's statement in a "check-the-box" form letter that claimant's lumbar strain had materially worsened claimant's preexisting degenerative disc disease and further concluded that claimant's lumbar strain had resolved with therapy. (Ex. 9). Dr. Anderson also concurred with claimant's counsel's statement in a "check-the-box" form letter that claimant's lumbar strain had materially worsened her preexisting disease and further noted that claimant's complaints were "more radiculopathy than strain." (Ex. 10).

All three physicians determined that claimant's compensable injury caused her asymptomatic degenerative disc condition to worsen. While McGirr and Anderson agreed that the injury "materially worsened" claimant's underlying condition and opined that the compensable strain had totally or partially resolved, Woolpert stated that the injury symptomatically worsened claimant's underlying condition and that claimant was still symptomatic as a result of the injury.

Although we generally give greater weight to the conclusion of the treating physician, we will not so defer if there are persuasive reasons not to do so or we find another opinion more thorough and well-reasoned. See Somers v. SAIF, 77 Or App 259 (1986); Taylor v. SAIF, 75 Or App 583 (1985).

In this case, we find Dr. Woolpert's opinion more persuasive because it is well-reasoned and thorough, whereas the opinions of Drs. McGirr and Anderson are conclusory in that their "check-the-box" format provides no explanation for their conclusions. Moreover, because their opinions are conclusory, we do not find the notations by McGirr and Anderson indicating claimant's strain had resolved persuasive, particularly when compared to the observations offered by Dr. Woolpert. Based on Dr. Woolpert's persuasive opinion, we conclude that claimant's October 30, 1990 compensable injury was and remains the major contributing cause of her current symptomatic disability and need for medical treatment. See ORS 656.005(7)(a)(B); Bahman M. Nazari, supra.

In reaching this conclusion, we note that Dr. Woolpert did not quantify the magnitude of causation in terms of the "major contributing cause." "Magic words," however, are not required. McClendon v. Nabisco Brands, 77 Or App 259 (1986). Moreover, after our review of the record, we conclude that Woolpert's opinion is sufficiently persuasive to find that claimant has established that her compensable injury was the major, if not the sole, contributing cause of her current symptomatic condition.

In reaching this conclusion, we wish to emphasize that we are finding claimant's current resultant disability and medical treatment compensable. This is not a determination that claimant's underlying degenerative disc condition is itself compensable. Rather, it is a conclusion that claimant's current disability and need for medical treatment is attributable to her symptoms from a preexisting degenerative condition, the major contributing cause of which remains her October 1990 compensable injury. Should the symptoms of claimant's degenerative disc condition reach a stage where claimant's compensable October 1990 injury no longer remains the major contributing cause of her disability and need for medical treatment, the insurer would be entitled to contest its ongoing responsibility. See ORS 656.005(7)(a)(B).

Unreasonable Denial

The Referee found the insurer's denial of claimant's degenerative disc disease condition unreasonable. We disagree.

In determining if a denial is unreasonable, the question is whether the insurer had a legitimate doubt as to its liability. If the insurer based its denial upon a legitimate doubt, the denial is not unreasonable. Brown v. Argonaut Co., 93 Or App 588 (1988). The insurer's "reasonableness" and "legitimate doubt" must be evaluated in light of the information available to it at the time of the denial. Id. When the law is uncertain, a legitimate doubt may exist. See e.g., Gregorio P. Pereyra, 43 Van Natta 1076 (1991); Maria R. Porras, 42 Van Natta 2625 (1990).

Here, at the time of its denial, the insurer was in possession of Dr. Woolpert's opinion and Dr. McGirr's concurrence. These reports indicate that claimant had a preexisting condition that had become symptomatic because of the compensable injury. (Exs. 4 and 6). Furthermore, at that time no Board decision had issued interpreting a carrier's responsibility for a preexisting condition under ORS 656.005(7)(a)(B), a statute which is capable of more than one reasonable interpretation. Under these circumstances, we find that the insurer had a legitimate doubt regarding its liability for claimant's disability attributable to her preexisting condition. Accordingly, we do not consider its denial to have been unreasonable.

Because the insurer initiated the request for 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), we find that a reasonable assessed attorney fee for claimant's counsel's services on review concerning the compensability issue is $750. 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 further note that claimant's counsel is not entitled to an attorney fee concerning the unreasonable denial issue.

ORDER

The Referee's order dated July 23, 1991 is affirmed in part and reversed in part. The Referee's penalty assessment (to be equally shared by claimant's counsel) under ORS 656.262(10) is reversed. The remainder of the order is affirmed. For services rendered on review concerning the compensability issue, claimant's counsel is awarded $750, to be paid by the insurer.

In the Matter of the Compensation of
DONNA S. COLIRON, Claimant
WCB Case No. 91-00825
ORDER ON REVIEW
Roger D. Wallingford, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Bethlahmy's order that: (1) upheld the insurer's partial denial of her claim for a psychological condition; (2) found that claimant was not entitled to temporary disability benefits; and (3) declined to assess a penalty for an allegedly unreasonable denial. On review, the issues are res judicata, compensability, temporary disability benefits, and penalties. We reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the Referee's order with the exception of the last finding on page 3 and with the following supplementation.

The parties previously litigated the issue of whether claimant's psychological condition was compensably related to her 1988 industrial injury. As a result of this litigation, an Opinion and Order by an earlier referee issued in August 1990 which found that claimant's psychological condition was compensably related to her 1988 industrial injury. This Opinion and Order was not appealed and became final by operation of law.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found that claimant's compensable injury was not the major contributing cause of her psychological condition and therefore upheld the denial. Claimant contends that the insurer's denial is barred by res judicata and should be set aside. We agree with claimant.

Under the res judicata doctrine of issue preclusion, if an issue of fact or law is actually litigated and determined by a valid and final judgment and the determination is essential to the judgment, the determination is conclusive in a subsequent action between the parties whether on the same or a different claim. Drews v. EBI Companies, 310 Or 134, 139-40 (1990); North Clackamas School District v. White, 305 Or 48, 50, modified 305 Or 468 (1988).

In March 1990, claimant began treating with Dr. Larsen for a psychological condition. In April 1990, the insurer denied claimant's psychological condition on the basis that it was unrelated to her compensable injury. Claimant requested a hearing on the insurer's denial. The parties went to hearing and on August 10, 1990, an earlier referee issued an Opinion and Order which found that claimant's psychological condition was compensably related to claimant's 1988 industrial injury. The Opinion and Order was not appealed and became final by operation of law.

In March 1991, the insurer denied claimant's psychological condition on the basis that it was not related to her compensable injury.

The record establishes that the psychological condition denied by the insurer in March 1991 was the same condition the insurer denied in April 1990. Thus, under the doctrine of issue preclusion, the August 1990 Opinion and Order establishes as a matter of law that claimant's psychological condition is compensably related to her 1988 industrial injury. Inasmuch as the compensability of claimant's psychological condition was actually litigated by the parties and found compensable, the insurer is precluded from subsequently denying claimant's psychological condition on the basis that it is not related to the 1988 industrial injury. Accordingly, the denial must be set aside under the res judicata doctrine of issue preclusion. See Susie A. Fimbres, 43 Van Natta 2289 (1991).

Temporary Disability Benefits

We adopt the conclusions and reasoning concerning claimant's entitlement to temporary disability benefits as set forth in the Referee's order.

Penalties

The Referee declined to assess a penalty or related attorney fee for the insurer's allegedly unreasonable denial. We modify.

Penalties or attorney fees may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10); 656.382(1). The reasonableness of a carrier's denial of compensation must be gauged based upon the information available to the carrier at the time of its denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

The insurer contends that its denial was not unreasonable based on Dr. Turco's report and the 1990 amendments to Chapter 656. We disagree. The insurer did not receive Dr. Turco's report until after it had issued its denial. Further, inasmuch as the compensability of claimant's consequential psychological condition had been previously litigated, the changes to ORS 656.005(7) do not apply. In this regard, we note that there was no evidence that claimant suffered from a preexisting psychological condition until that theory was proposed by Dr. Turco. Under these circumstances, we find the insurer's denial unreasonable.

Although we have found the insurer's denial unreasonable, we find no amounts "then due" on which we might base a penalty. ORS 656.262(10). Consequently, the Referee was correct in declining to assess a penalty. However, an attorney fee can be awarded in the absence of a penalty if a carrier's action constitutes unreasonable resistance to the payment of compensation. See Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (1989). We find that the issuance of the insurer's denial, particularly in light of the prior litigation, constitutes unreasonable resistance to the payment of compensation. Accordingly, claimant's counsel is entitled to an assessed attorney fee. ORS 656.382(1); Cripe, supra.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services concerning the unreasonable denial is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue, the complexity of the issue, and the value of the interest involved.

Attorney Fees

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's denial. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable

assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $3,000, 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 appellant's brief and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 12, 1991 is reversed in part, modified in part and affirmed in part. That portion which upheld the insurer's denial 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 concerning the compensability issue, claimant's counsel is awarded an assessed attorney fee of $3,000, payable by the insurer. That portion which declined to award a penalty-related attorney fee is reversed. For services rendered in conjunction with the insurer's unreasonable denial, claimant's counsel is awarded an assessed attorney fee of $500, payable by the insurer. The remainder of the order is affirmed.

In the Matter of the Compensation of
TERRY K. DAVIS, Claimant
WCB Case No. 90-09218
ORDER ON REVIEW
Ronald A. Fontana, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Knapp's order which upheld the self-insured employer's denial of his occupational disease claim for a stress-related mental disorder. In his appellant's brief, claimant seeks to have proposed Exhibits "B" (excluded by the Referee as cumulative) and "C" (withdrawn by claimant at the hearing) admitted into the record. On review, the issues are compensability, the Referee's evidentiary rulings, and remand. We reverse.

FINDINGS OF FACT

Claimant, 38 years old at the time of hearing, began working for the employer in 1979. He was laid off from 1982 to 1983 and resumed work for the employer at the end of 1983 as a shell processor. (Tr. 171).

On August 19, 1984, claimant arrived at work around 7 a.m. He spoke with a co-worker, Roger Force. Force told claimant he had not gotten much sleep the night before and was tired. (Tr. 181). Force went to work in a slurry pot near the one where claimant was working, chipping out the slurry pot with an impact gun. At some point, claimant stopped hearing the sound of Force's impact gun. When claimant finished the task he was performing, he went over to the pot where Force was working to find out why he could no longer hear the impact gun. Force was lying in the bottom of the slurry pot and appeared to be comfortably asleep, with the chip gun between his legs. (Tr. 183). Claimant decided to wake Force by "startling him awake by closing the lid on the pot." (Tr. 184). Raising and lowering the lid of the slurry pot took about 30 seconds; it did not rouse Force. Claimant "went back up on the stairs that I was on initially and looked down and saw [Force]." Claimant noticed that Force's color had changed and he realized that something was wrong.

Thereafter, claimant's co-worker, Tomiak, arrived and went to get help. Claimant entered the pot to assist Force. Claimant and co-workers Tomiak and Dalins lifted Force out of the slurry pot and attempted to resuscitate him. Force was taken by ambulance to the hospital. He has remained in a coma since the accident in 1984. Force's injury was caused by exposure to the argon gas being pumped into the slurry pot.

Later the day of the injury, claimant suffered nausea and lightheadedness. Claimant went to the Emergency Room. After an arterial tap, it was discovered that claimant had also been exposed to argon gas. (Tr. 187).

The slurry pot in which Force was working had an argon gas line. (Tr. 32, 37). The workers in the investing department where claimant worked, including claimant, were generally ignorant of the dangerous properties of argon gas. (Tr. 33-34; 51).

In December 1988, claimant was promoted and became a technician in the investing department. (Tr. 192). Claimant worked the graveyard shift. After his first year as a technician, he began to work primarily alone. He began having recurring nightmares about the 1984 injury to Roger Force. Claimant's sleep pattern changed and he had difficulty falling asleep. In December 1989 claimant became more irritable. Claimant began drinking alcohol heavily. Claimant's relationships with his wife and others began to deteriorate. Claimant began missing work. In mid-February, claimant did not come home from work on time. His wife threatened to move with their children. Claimant's wife did not leave him in February 1990. (Tr. 122-123; 238). On February 22, 1990, claimant saw Dr. Manning for a bronchitis infection. (Ex. 1A).

On February 26, 1990, claimant went to work. Claimant saw a worker leaning against a pot holding a chip gun in a position similar to the one Roger Force was found in. (Tr. 200). Claimant felt panicky and went to his office. He turned off the lights and unplugged the phone. Claimant left a note stating that he was not feeling well and left through a back door. (Tr. 200). After this incident, claimant stalled returning to work. It became apparent to claimant that he was going to either lose his job or "get in a lot of trouble."

Claimant sought assistance from an employee assistance program. The program counselor referred claimant to Dr. Pagano, a clinical psychologist. Until he told Dr. Pagano about lowering the lid to the slurry pot on Force, claimant had told no one about the incident. (Tr. 204). Claimant was also treated by Dr. Young, psychiatrist, to whom Dr. Pagano had referred claimant for medication.

CONCLUSIONS OF LAW AND OPINION

Evidence/Remand

On review, claimant seeks admission of proposed Exhibits B and C. At hearing, claimant withdrew proposed Exhibit C. We treat its resubmission on Board review as a motion for remand. 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 hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986). Exhibit C is the Accident Prevention Division report concerning the 1984 injury to Force. We find that the report was obtainable with due diligence at the time of hearing. Moreover, we conclude that the record is

not incompletely developed without it. The record contains other accounts of the 1984 injury to Force. Consequently, we deny the motion to remand.

Claimant also seeks admission of Exhibit B. The Referee declined to admit Exhibit B on the grounds that it was cumulative evidence. Common law or statutory rules of evidence and procedure are not binding on the Referee. The Referee has discretion to conduct the hearing in any manner that will achieve substantial justice. ORS 656.283(7). We find that the Referee acted within his discretion in not admitting Exhibit B. Exhibit B is the employer's confined space entry procedure. It is irrelevant to the issues presented by this case and we decline to admit it.

Timeliness of Claim Filing

The employer argues that claimant did not timely file his occupational disease claim. We disagree.

ORS 656.807(1) provides:

> "(1) All occupational disease claims shall be void unless a claim is filed with the insurer or self-insured employer by whichever is the later of the following dates:
>
> "(a) One year from the date the worker first discovered, or in the exercise of reasonable care should have discovered, the occupational disease; or
>
> "(b) One year from the date the claimant becomes disabled or is informed by a physician that the claimant is suffering from an occupational disease." (Emphasis added).

Here, claimant first discovered he had an occupational disease in March 1990, when Dr. Pagano diagnosed his adjustment disorder. Claimant filed his occupational disease claim in April 1990, within one year of discovering that he was suffering from an occupational disease. We conclude that claimant's claim is timely under ORS 656.807(1)(a). See Bohemia, Inc. v. McKillop, 112 Or App 261 (1992). In addition, we do not accept the employer's argument that claimant was first disabled by the occupational disease in 1984 when the employer gave him a few days off after the injury to his co-worker. During this time claimant was in part recovering from the arterial tap done to ascertain whether he had been exposed to argon gas. There is no evidence that claimant had the mental disorder at that time.

Compensability

The Referee concluded that the evidence was not clear and convincing that claimant's mental condition arose out of or in the course of his employment or that the August 1984 event was the major contributing cause of claimant's mental disorder. Consequently, the Referee found claimant had failed to prove a compensable mental stress claim. We disagree.

Under ORS 656.802(1)(b), "occupational disease" includes any mental disorder which requires medical services or results in physical or mental disability or death. The worker must prove that employment conditions were the major contributing cause of the disease and establish its existence with medical evidence supported by objective findings. ORS 656.802(2). Additionally, the employment conditions producing the mental disorder must exist in a real and objective sense and must be conditions other than those generally inherent in every working situation; there must be a diagnosis of a mental or emotional disorder which

is generally recognized in the medical or psychological community; and there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. ORS 656.802(3)(a)-(d).

Claimant's condition required treatment and resulted in disability. Since March 16, 1990, after being referred to Dr. Pagano by the employee assistance program, claimant has been treated for his disorder by Pagano and by Dr. Young. Moreover, claimant has been unable to return to his job since the February 26, 1990 panic attack at work. Dr. Young took claimant off work on March 23, 1990. (Ex. 6).

Drs. Pagano, Young and Turco all diagnosed claimant as suffering from an adjustment disorder. We find that claimant's condition, diagnosed as an adjustment disorder, is generally recognized in the medical and psychological community.

We also find that the work-related stressors, which produced claimant's mental disorder, existed in a real and objective sense and are conditions other than those generally inherent in every working situation. Drs. Pagano and Young felt that claimant's mental condition was produced by the 1984 incident in which claimant's co-worker was seriously injured and rendered comatose by exposure to argon gas at work. We conclude that the severe injury to claimant's co-worker and claimant's discovery of his injured co-worker were stressors that existed in a real and objective sense.

We further conclude that witnessing a co-worker's severe injury and being exposed to potentially dangerous argon gas oneself are not conditions which are generally inherent in every working situation. The Board has interpreted conditions which are "generally inherent in every working situation" to mean certain conditions which are usually present in all jobs and not merely the specific occupation involved. See Kathleen M. Payne, 42 Van Natta 1900, 1906, on recon 42 Van Natta 2059 (1990), rev'd on other grounds, City of Portland v. Payne, 108 Or App 771 (1991).

The medical evidence is uncontroverted that claimant's need for treatment and disability is due to work-related stress. Dr. Pagano opined that the 1984 work incident was the major contributor to claimant's condition and was the sole factor in his inability to return to the job.

Dr. Pagano referred claimant to Dr. Young, psychiatrist, for medication evaluation. Dr. Young diagnosed an adjustment disorder. (Ex. 5-3). Dr. Young opined that the 1984 incident and the 1990 panic attack at work are the major contributing cause of claimant's diagnosed mental disorder. (Exs. 18, vol. 2, p. 9; 13-4).

On May 21, 1990, claimant was seen by Dr. Turco, psychiatrist, for an independent medical examination (IME). Dr. Turco opined that claimant was experiencing an adjustment disorder with anxiety and mild depression. He further opined that the 1984 work incident appeared to be a contributing factor in claimant's current psychological condition and need for treatment. (Ex. 10-7). At his deposition, Dr. Turco stated that he would defer to the mental health professionals treating claimant as to whether the 1984 incident was the major contributing cause of claimant's mental disorder. (Exs. 17-22, 23). Based on this statement by Dr. Turco, we conclude that the medical evidence is essentially uncontroverted that claimant's mental condition resulted in major part from the 1984 incident.

We are not convinced that claimant's non-work stressors, which consisted of his son's health problems, his father's death and marital problems caused his

mental disorder. Claimant's father died of cancer in the Fall of 1989. He was in his early 90's. (Tr. 175). Claimant stated that his father was quite old and while there was some grief, he and his father had resolved all their differences and it was time for his father to pass on. (Tr. 176). Claimant characterized his father's death as "more of a relief initially." (Tr. 176).

Claimant's son was born with clubfoot which necessitated two surgeries. In April 1988, after the second surgery, it was briefly thought claimant's son might have leukemia. This diagnosis was quickly ruled out. (Tr. 117). Dr. Young opined that claimant put unreasonable emphasis on his father's death and his son's medical problems so that the doctors would feel claimant's story "hung together well," but at the time of claimant's February 1990 panic attack, claimant's father's death and son's condition were "minor stressors." (Ex. 18, vol. 2, p. 8-9). Dr. Young opined that the 1984 incident, and the 1990 panic attack at work were more important stressors and were the major cause of claimant's mental disorder. We conclude that claimant's son's health problems and his 90-year-old father's death were minor stressors.

Claimant subsequently revealed that his wife had never left him as he had initially told Drs. Pagano, Young and Turco. Claimant stated that he told this story in order to get treatment for his problems stemming from the 1984 work incident. All three doctors found this explanation plausible and accepted it. Dr. Pagano felt that claimant's story that he told his doctors that his wife had left him so that he could get help for his problems stemming from the 1984 incident seemed very understandable and plausible. (Ex. 16-29). Dr. Pagano also stated that this information would not have changed his earlier opinion that the 1984 incident was the major cause of claimant's mental disorder. (Ex. 16-28). Dr. Turco agreed that it was understandable for claimant to use the excuse of marital problems to get help. (Ex. 17-21).

Dr. Young stated that after the panic attack at work on February 26, 1990, "[claimant] felt it immediately necessary to leave the work place, and then cover his tracks, by claiming to an EAP representative that he needed to see a psychologist to discuss marital problems. He eventually told me that this was a fabrication, designed to maintain confidentiality, but get him into treatment. His story regarding this seems plausible." (Ex. 13-3).

Based on the opinions of Drs. Pagano, Turco and Young, we conclude that claimant's use of marital problems as an excuse for obtaining treatment for his problems stemming from the 1984 event, which he had never revealed to anyone before telling Dr. Pagano, was reasonable from a psychiatric point of view. We, therefore, accept the testimony of both claimant and his wife that a marital separation did not occur in February 1990. Moreover, we note that there is some evidence in the record that the 1984 event may itself have contributed to claimant's marital problems.

To establish compensability there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. To be clear and convincing, evidence must establish that the truth of the asserted fact is highly probable. Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 402 (1987). Claimant must prove by clear and convincing evidence that work-related stressors, not otherwise excluded by statute, are the major contributing cause of the disorder. Based upon the totality of the evidence, we find it highly probable that the 1984 incident, involving serious injury to claimant's co-worker, was the major contributing cause of claimant's psychological condition. Therefore, we conclude that claimant's mental stress is compensable as an occupational disease.

The Referee concluded that claimant was engaged in horseplay when he lowered the lid on the slurry pot in which his co-worker was "sleeping." We do not

agree. In Brown v. Liberty Northwest Insurance Co., 105 Or App 92 (1990), the court stated: " * * * it is clear that injuries resulting from horseplay are not 'always' compensable. An employer is not liable for any and all injuries to its employees regardless of the cause. A claimant must show a causal link between the occurrence of the injury and a risk connected with his or her employment."

Here, the causal link between both claimant's injury and his co-worker, Force's injury, is the argon gas which was being pumped into the slurry pot in which Force had been working. The evidence indicates that claimant did not know argon gas was being pumped into the slurry pot where Force was lying. The argon gas, not claimant's alleged horseplay, caused Force's injury, and the incident in which Force was injured eventually led to the development of claimant's mental disorder. Thus, we conclude that there is a causal link between the occurrence of the injury and a risk (the argon gas) connected with claimant's employment.

In determining an appropriate fee for claimant's counsel's services at hearing, we consider the factors set out in OAR 438-15-010(4). Those factors include: "(a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill and standing of the attorneys; (e) the nature of the proceeding; (f) the result secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses." Relative to these factors we have considered the statement of services submitted by claimant's attorney.

The hearing in this matter was conducted over two days. In addition, claimant's attorney found it necessary to attend three depositions on separate days. Two of the depositions took more than one day and had to be scheduled for a second day. Claimant's counsel devoted 89 hours attorney time to this case at the hearing level.

This matter involves a complex mental stress claim. Because the claim was found to be compensable, claimant will be entitled to necessary medical care for his psychiatric condition.

Eight witnesses testified during this strongly adversarial hearing; the issues were strenuously and competently litigated by both attorneys.

Claimant's counsel bore a significant risk of his efforts going uncompensated in this complicated case.

Considering the above factors and applying them to this case, we find $11,125 to be a reasonable fee for claimant counsel's services at hearing, to be paid by the employer.

Furthermore, after applying the same factors to this case on review, we find that a reasonable fee for claimant's counsel's service on review concerning the compensability issue is $3,000 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 appellate briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 18, 1991 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review, claimant's counsel is awarded $14,125, to be paid by the employer.

In the Matter of the Compensation of
DOROTHY J. HAYES, Claimant
WCB Case Nos. 88-06310 & 88-08392
ORDER ON REMAND
Rasmussen & Henry, Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney
Meyers & Radler, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Hayes v. Coos County Manpower, 107 Or App 565, on recon 108 Or App 642 (1991). The court has reversed our prior order, Dorothy J. Hayes, 42 Van Natta 1311 (1990), which held that claimant was not entitled to a carrier-paid attorney fee under ORS 656.386(1) because claimant had not finally prevailed against Safeway Stores' compensability denial of claimant's asthma condition. Citing Jones v. OSCI, 108 Or App 230 (1991), the court has "reversed and remanded for reconsideration of attorney fees."

FINDINGS OF FACT

We adopt the "Findings of Fact" contained in the Referee's order with the following supplementation. Claimant finally prevailed against Safeway's compensability denial.

CONCLUSIONS OF LAW AND OPINION

At the commencement of the hearing, the SAIF Corporation continued to concede that claimant's asthma condition was compensable. SAIF merely asserted that it was not responsible for the condition. On the other hand, Safeway continued to contest the compensability of claimant's condition, as well as its responsibility for that condition.

Following the hearing, the Referee continued the case to permit the parties to obtain a deposition from claimant's treating physician. After completion of that deposition, the parties entered into a stipulation. Pursuant to the stipulation, SAIF rescinded its responsibility denial and accepted the claim. The stipulation further provided that Safeway's "denial including all later amendments or clarifications shall be affirmed." Finally, the parties agreed to submit the issue of claimant's entitlement to an attorney fee and the amount, if any, to the Referee.

Although SAIF was responsible for the claim, the Referee reasoned that Safeway's compensability denial had necessitated claimant's attorney's active and meaningful participation. Relying on the rationale set forth in Karen J. Bates, 39 Van Natta 42, 43 (1987), the Referee held that claimant was entitled to a carrier-paid attorney fee under ORS 656.386(1) to be paid by Safeway. After considering the factors set forth in former OAR 438-15-010(6) (now section (4)) and claimant's attorney's statement of services, the Referee determined that a reasonable attorney fee was $4,650.

On review, we distinguished Bates, noting that there we had expressly stated that the carrier's compensability denial had become overcome. In the present case, we noted that the parties' stipulation expressly provided that Safeway's denial was "affirmed." Reasoning that claimant had not "finally prevailed" against Safeway's compensability denial, we concluded that claimant was not entitled to an attorney fee award under ORS 656.386(1).

The court initially affirmed our order, relying on its decision in Jones v. OSCI, 107 Or App 78 (1991). However, citing its reconsideration order in

Jones v. OSCI, 108 Or App 230, 232 (1991), the court subsequently allowed reconsideration and withdrew its opinion. The court's action in Jones was based on the 1991 amendment to ORS 656.386(1) providing 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." Id. Relying on its later decision in Jones, the court has "reversed and remanded for reconsid-eration of attorney fees."

Here, the resolution of this dispute occurred following a hearing, while the record remained open. Inasmuch as a hearing was held, Jones is inapplicable. Notwithstanding this conclusion, on reconsideration, we find that claimant is entitled to an attorney fee award under ORS 656.386(1). We base this conclusion on the following reasoning.

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. ORS 656.386(1). 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. Id. Thus, the statute is premised on claimant finally prevailing against an order or decision denying a claim for compensation. Greenslitt v. City of Lake Oswego, 305 Or 530, 533-34 (1988).

It has been a longstanding Board policy to hold a carrier ultimately determined not responsible for a claimant's condition nonetheless responsible for an attorney fee under ORS 656.386(1) if that carrier denies the claim on a basis which threatens the claimant's entitlement to receive compensation and the responsible carrier denies the claim only on responsibility grounds. Ronald L. Warner, 40 Van Natta 1082, 1194 (1988); Ronald J. Broussard, 38 Van Natta 59, 61 aff'd mem Western Employers Insurance v. Broussard, 82 Or App 550 (1986); Karen J. Bates, supra. In reaching such a result, we have reasoned that had the non-responsible carrier conceded compensability and acceded to the other carrier's request for the designation of a paying agent under ORS 656.307, claimant would have received compensation pending resolution of the responsibility issue. Ronald L. Warner, supra.

Here, from the outset, SAIF has conceded compensability of claimant's condition, but contended that it was not the responsible carrier. After issuing a compensability/responsibility denial, Safeway eventually acceded to the issuance of a "307" order. Consequently, a "307" order was issued. However, the order was rescinded when Safeway subsequently reasserted that it was denying "compensability as well as responsibility." (Ex. 64). Safeway continued to contest compensability at the hearing.

Under such circumstances, it is apparent that, but for Safeway's refusal to concede the compensability of claimant's condition, claimant would have received compensation pursuant to the "307" order pending resolution of the responsibility dispute. Thus, in accordance with the Bates rationale, Safeway is responsible for claimant's attorney fee.

By placing compensability in issue at the hearing, Safeway required claimant to establish the compensability of her claim against SAIF as an aggravation or against Safeway as a "new injury." In other words, the fact that one potentially responsible carrier did not contest compensability did not alter the fact that compensability remained at issue. See Rodney L. Kosta, 43 Van Natta 180 (1991). Thus, because of Safeway's compensability denial, compensability of

claimant's condition was a viable issue at hearing, notwithstanding SAIF's "responsibility only" denial.

In reaching this conclusion, we acknowledge that the parties' stipulation provided that Safeway's denial "including all later amendments or clarifications shall be affirmed." Nevertheless, were we to interpret that provision literally, claimant would not be entitled to any compensation because Safeway's contention that her condition was not compensable would have been "affirmed." Furthermore, as recognized in a prior provision of the stipulation, SAIF was rescinding its responsibility denial and agreeing "to process claimant's claim for her asthmatic condition." Thus, in effect, the parties acknowledged that claimant's condition was compensable and agreed that SAIF was responsible for that compensable condition. Considering such an acknowledgment, it logically follows that claimant overcame the compensability portion of Safeway's denial. See Karen J. Bates, supra.

In conclusion, we find that Safeway's refusal to accede to the compensability of claimant's condition prevented the issuance of a "307" order. Furthermore, because claimant ultimately overcame the compensability portion of Safeway's denial, we conclude that she is entitled to an attorney fee award under ORS 656.386(1) to be paid by Safeway.

For purposes of determining a reasonable assessed attorney fee, we consider the factors set forth in OAR 438-15-010(4). After considering those factors, we find that a reasonable attorney fee concerning the pre-hearing rescission of Safeway's compensability denial is $4,650, to be paid by Safeway. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's attorney's statement of services), the value of the interest involved, and the risk that claimant's attorney's efforts might go uncompensated.

In making this determination, we have not considered any of claimant's counsel's services rendered subsequent to the Referee's order. Since an attorney fee is not "compensation," claimant did not finally prevail after remand "in respect to any claim or award for compensation" as required by ORS 656.388(1). Ernest C. Richter, 44 Van Natta 101 (1992), on recon 44 Van Natta 118 (1992); Juan A. Garcia, 43 Van Natta 2813 (1991); Cleo I. Beswick, 43 Van Natta 1314 (1991). Thus, any of claimant's counsel's efforts devoted to defending the Referee's order and to reversing our prior decision are irrelevant to a determination of a reasonable attorney fee for claimant's counsel's services at the hearing level. See Ernest C. Richter, supra.

Accordingly, on reconsideration, the Referee's order dated November 21, 1988, as reconsidered January 4, 1989, is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
VIRGIL D. KELLER, Claimant
WCB Case No. 89-18916
ORDER ON REVIEW (REMANDING)
Rick W. Roll, Claimant Attorney
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Michael Johnson's order which dismissed claimant's request for hearing in relation to the extent of claimant's permanent disability on the ground that although timely filed as to the March 8, 1989 Determination Order in question, the hearing request did not seek review of that order. In its respondent's brief, the SAIF Corporation contends that claimant's request for hearing was untimely filed. On review, the issue is jurisdiction. We reverse and remand.

FINDINGS OF FACT

Claimant sustained a compensable knee injury on March 8, 1980. The claim was accepted and over the course of the succeeding years, there have been several reopenings and closures.

On March 8, 1989, a Determination Order issued which awarded claimant 90 percent (288 degrees) unscheduled permanent partial disability and temporary total disability compensation.

On March 8, 1989, SAIF conducted a "claim audit" and discovered that certain temporary disability compensation had not been reflected on the March 8, 1989 Determination Order. (Ex. 73). On the same day, the Evaluation Section of the Workers' Compensation Division received instructions to modify the temporary disability award in the March 8, 1989 Determination Order. The task was performed by Evaluator "L.K.N?" on March 30, 1989. (Ex. 75). On April 3, 1989, a Determination Order issued declaring inter alia that:

> "the department, on March 8, 1989, issued a Determination on your claim. That determination was incorrect and is hereby corrected by the following statement: You are entitled to additional compensation for temporary disability, less time worked, as follows: for temporary total disability from August 16, 1985 through April 16, 1986, (per Opinion and Order dated November 10, 1987), and for temporary total disability from April 17, 1986 (per Stipulation dated February 11, 1988), through December 28, 1988. Notice: this Order becomes a part of and should be attached to the prior Determination Order, which remains the same in all other respects." (Ex. 75-1) (Emphasis added).

On September 21, 1989, claimant's attorney mailed a request for hearing to the Board. The request was attached to a transmittal letter and specifically stated that it related to "4-3-89 D.O.," and that the specific issues were "scheduled-perm. part. dis. * * * unscheduled-perm. part. dis. * * * premature closure." (Ex. 80B). The request was mailed by certified mail.

On December 22, 1989, claimant's attorney mailed a "supplemental request for hearing" by certified transmittal letter of the same date. The supplemental request identified the issue as "permanent total disability." The request made no reference to any Determination Order. (Ex. 84D-a).

FINDINGS OF ULTIMATE FACT

Claimant's September 21, 1989 request for hearing was timely filed as to both the March 8, 1989 and April 3, 1989 Determination Orders.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's September 21, 1989 request for hearing was timely filed as to both Determination Orders. We agree, and adopt the Referee's reasoning and conclusion on the question of timeliness.

The Referee also concluded, however, that the issue of extent of claimant's permanent disability was not properly before him, because the September 21, 1989 request cited only the April 3, 1989 Determination Order which did not address the issue. The Referee cited McGinnis v. Tigard School District #23J, 87 Or App 363 (1987), in support of that conclusion. We find that McGinnis does not apply, and reverse.

The issue in McGinnis was whether a request for hearing was timely filed from a July 19, 1984 Determination Order awarding claimant permanent disability. Specifically, in McGinnis, SAIF requested reconsideration of the subject order based on new medical evidence. On August 16, 1984, a second Determination Order issued, which stated that the additional information did not require any modification of the first order. Both orders contained a regular form notice of the right to request a hearing. The claimant filed a request for hearing which was timely as to the second order but which was untimely as to the first order. The Board concluded that as to the first order, the request was untimely and affirmed the referee's dismissal. The court agreed. After the court acknowledged that the hearing was timely as to the second order, the court held that the order did not address the issue of extent of permanent disability except to say that the prior order was not modified. The court concluded that since the claimant did not timely appeal from the first order, that order became final, and the Board lacked jurisdiction over the subject matter of that order.

Here, however, we have found that the hearing request was timely filed as to both Determination Orders. Therefore, unlike in McGinnis, the issue does not concern timeliness of the hearing request. The question is whether claimant's timely hearing request applied to and operated as an appeal from the March 8, 1989 Determination Order's disposition of the question of permanent disability.

We conclude that claimant perfected an appeal from the March 8, 1989 order, and the issue of permanent disability was properly before the Referee. The April 3, 1989 Determination Order modified substantive provisions of the prior order to the extent that the prior order was essentially superseded. The second order expressly incorporated the terms of the March 1989 order, except as that order had been modified. Thus, claimant's request for hearing which cited the April 3, 1989 order did, by that fact, perfect an appeal from those provisions of the prior order which were incorporated by reference. See Connie R. Walker, 40 Van Natta 84 (1988) (where Referee's second order specifically modifies first order, request for Board review of second order includes first order). We further conclude that the request for hearing eliminated any possible cause for doubt about the issues being raised, by specifically stating that the issues are scheduled and unscheduled permanent disability and premature closure. Thus, the contents of claimant's request for hearing gave SAIF ample notice of the issues for hearing and brought those issues properly before the Referee.

Should we determine that a case has been improperly, incompletely or otherwise insufficiently developed, we may remand to the referee for further

evidence taking, correction or other necessary action. See ORS 656.295(5). Considering the circumstances of this case, we conclude that remand is the appropriate action.

The Referee's order indicates that it was decided that the Hearings Division would bifurcate this matter so that all questions relating to jurisdiction would first be resolved and then, if it were decided that the Hearings Division had jurisdiction, another hearing would be convened during which the extent of permanent partial disability would be considered. The Referee concluded that he did not have jurisdiction to hear this matter. Thus, there was no testimony or argument on the issue of the extent of claimant's disability at the hearing.

Under these circumstances, we conclude that the record has been incompletely developed. Accordingly, we remand this matter to Referee Michael V. Johnson for further proceedings consistent with this order, to be conducted in any manner that will achieve substantial justice to all parties.

ORDER

The Referee's order dated April 2, 1991 is reversed. The matter is remanded to Referee Michael Johnson for further proceedings consistent with this order.

In the Matter of the Compensation of
FELIPE A. ROCHA, Claimant
WCB Case No. 90-17478
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of Referee Harri's order which set aside its denial of claimant's hernia condition claim. SAIF also asserts claimant's claim is procedurally barred by lack of timely notice. On review, the issues are jurisdiction and compensability.

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

In the present case, SAIF contends that, during closing argument, it raised the issue of failure to give timely notice and prejudice due to failure to give timely notice. Closing arguments were not recorded. Claimant expressly disputes that lack of timely notice was ever raised at hearing. Claimant asserts that SAIF raised the issue for the first time on Board review. However, even if SAIF raised the issue for the first time in closing argument, we conclude that SAIF did not properly raise the issue of timeliness. See Leslie Thomas, 44 Van Natta 200 (1992) (issue of untimely claim filing not properly raised when first asserted during closing arguments).

In the alternative, even if SAIF had properly raised the issue of claimant's allegedly late claim filing, SAIF has not proven actual prejudice by failure to receive timely notice insofar as passage of time alone is not sufficient to meet SAIF's burden of proof. Argonaut Ins. Co. v. Mock, 95 Or App 1, rev den 308 Or 79 (1989).

Late filing of notice may be excused if the insurer has not been prejudiced by failure to receive timely notice. The insurer has the burden of proving prejudice. Inkley v. Forest Fiber Products Co., 288 Or 337, 348 (1980); Ford v. SAIF, 71 Or App 825, 831, rev den 299 Or 118 (1985); Satterfield v. Compensation Dept., 1 Or App 524, 529 (1970). Specifically, the insurer must prove actual prejudice which occurred after expiration of the 30-day notice period. Grimes v. SAIF, 87 Or App 597, 601 (1987); Ford v. SAIF, supra, 71 Or App at 828; McNett v. Roy-Ladd Const. Co., 46 Or App 601, 605, rev den 289 Or 588 (1980). An insurer must offer facts, not merely conclusory statements or speculation, to make its showing. National Farm Ins. v. Scofield, 57 Or App 23, 26 (1982). Moreover, it is important that the employer/insurer identify precisely in what way it was actually prejudiced. See Aetna v. Kupetz, 106 Or App 670, 675 (1991).

Here, SAIF argues that the delay " . . . destroyed any possibility for the employer to investigate the circumstances of the alleged incident, interview co-workers or supervisors, or have claimant examined by an independent medical panel in a more timely manner." (App. Br. at 5). We disagree.

SAIF asserts that: "Had claimant given the employer a specific incident, the employer could have determined the date of injury." (App. Br. at 5). We do not find SAIF's alleged uncertainty over the precise date of injury to be relevant in establishing prejudice. SAIF has not disputed the fact that claimant was performing heavy work involving lifting and carrying steel fire doors during the time in question. Essentially, SAIF's argument is that claimant is not credible. The Referee, however, found claimant and his wife credible. The finding of credibility is central. The Referee observed their demeanor and manner of testifying, and the credibility finding is based, at least in part, on those observations. Claimant's testimony was plausible, internally consistent and was corroborated in part by his cousin and his treating physician, Dr. McCully.

Specifically, Dr. McCully reported that "the pathologic findings regarding [claimant's] hernia did indeed confirm its chronic longevity and is probably consistent with his history of injury at work." (Ex. 10). At deposition, Dr. McCully thoroughly explained his opinion in which he found that claimant's work constituted the major contributing cause of his hernia condition. (Ex. 11). Further, Dr. McCully opined that claimant's condition would have required treatment even before the subsequent event of his child stepping on his abdomen. Accordingly, we are not persuaded that SAIF was prejudiced by the fact that a precise date of injury has not been established.

SAIF also contends that it was prejudiced by not being able to interview co-workers or supervisors. Again, SAIF has not offered specific facts to establish actual prejudice. SAIF's statements are merely conclusory. SAIF has not identified which co-workers/supervisors it was unable to interview. SAIF has not explained how a delay in reporting of the incident made it unable to interview witnesses or how it would have benefited if interviews were conducted within 30 days. Moreover, the record reveals that even after receipt of notice of the claim, SAIF did not promptly interview potential witnesses. See Paul M. Johnson, 40 Van Natta 532, 534 (1988).

Finally, SAIF maintains that it was prejudiced by not being able to " . . . have claimant examined by an independent medical panel in a more timely manner." (App. Br. at 5). We note, however, that although claimant made his claim in August 1990, SAIF never had him examined by an independent medical panel. Instead, SAIF had Dr. Norton conduct a medical record review. Moreover, even Dr. Norton's review was not conducted until November 1990.

Consequently, based on the aforementioned facts and the record as a whole, we are not persuaded that SAIF has proven actual prejudice as a result of untimely notice of the accident. Thus, the claim was not barred by failure to give notice within 30 days of the injury under ORS 656.265(1) and (2).

Inasmuch as the SAIF Corporation has requested review and claimant's compensation has not been disallowed or reduced, claimant is entitled to a reasonable attorney fee award. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services on Board review is $950, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated May 28, 1991 is affirmed. For services on Board review, claimant's attorney is awarded $950, to be paid by the SAIF Corporation.

April 16, 1992 Cite as 44 Van Natta 799 (1992)

In the Matter of the Compensation of
SARAH J. ROYSE, Claimant
Own Motion No. 91-0532M
OWN MOTION ORDER
Steven E. Benson, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's claim for an alleged worsening of her April 22, 1983 compensable left knee injury. Claimant's aggravation rights expired on March 8, 1989. By an August 30, 1991 Stipulation and Order, SAIF authorized a diagnostic arthroscopy. However, it opposes the reopening of claimant's claim for payment of temporary disability compensation, contending that claimant has removed herself from the work force.

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

However, in order to qualify for the payment of temporary disability compensation, claimant must have been in the work force at the time of the worsening. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Cutright v. Weyerhaeuser Company, 229 Or 290 (1985). SAIF contends that claimant had withdrawn from the work force. Claimant has not responded to SAIF's contention. Claimant has the burden of proof on this issue and must provide evidence, such as copies of paycheck stubs, income tax forms, unemployment compensation records, a list of employers where claimant looked for work, a letter from the employer, or a letter from a doctor stating that a work search would be futile because of claimant's compensable condition. Accordingly, because such evidence is lacking, we deny claimant's request for temporary disability compensation. See id.

Claimant's entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ARTHUR M. MILLER, Claimant
Own Motion No. 92-0113M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's claim for an alleged worsening of his June 25, 1979 compensable left knee bruise and torn meniscus. Claimant's aggravation rights expired on March 12, 1985. SAIF has accepted the compensability of claimant's current need for a left knee arthroscopic surgery which includes a debridement and a limited lateral parapatellar arthrotomy to remove the exostosis off the patella. SAIF recommends that his claim be reopened for further payment of temporary disability compensation.

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

Nevertheless, he is not entitled to additional temporary disability compensation unless the worsening has resulted in lost wages. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Cutright v. Weyerhaeuser Company, 229 Or 290 (1985). On February 22, 1992, claimant wrote a letter to SAIF stating that he had not voluntarily removed himself from the work force. He states he worked part-time until he was laid off in February 1991, and he has not been able to find work since then. However, claimant did not submit any evidence in the way of either the names, addresses and telephone numbers of employers contacted while looking for work or of unemployment benefits received. Nor has he submitted evidence to prove that his compensable injury made it impossible for him to obtain or perform work for which he is qualified. By letter dated January 29, 1992, Dr. Baroff states that claimant's current knee condition is hampering his ability to walk and is interfering with his life style. That letter alone is not sufficient medical evidence to prove that claimant is unable to work. See Dawkins, supra. Accordingly, claimant's request for temporary disability compensation is denied. See id.

Claimant's entitlement to medical benefits pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
CINDY L. SANDERS-AHERN, Claimant
WCB Case Nos. 91-00477 & 90-16283
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Nelson, et al., Defense Attorneys
Carol Taaffe (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Tenenbaum.

Claimant requests review of Referee Otto's order that: (1) upheld the SAIF Corporation's denial of her aggravation claim for a back condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of her "new injury" claim for the same condition. On review, the issues are compensability and, if the claim is compensable, responsibility. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

In compensability/responsibility cases, the threshold issue is compensability. Joseph L. Woodward, 39 Van Natta 1163, 1164 (1987). If the claim is compensable, then the trier of fact must address the issue of responsibility. See Runft v. SAIF, 303 Or 493, 498-99 (1987).

The Referee stated that his "first task [was] to determine whether the compensable 1987 injury combined with [claimant's] preexisting psychological conditions to cause or prolong disability or need for treatment," citing ORS 656.005(7)(a)(B). (O&O p.4). However, because there is no persuasive evidence that a compensable injury combined with a preexisting disease or condition in this case, ORS 656.005(7)(a)(B) is inapplicable.

Concerning the threshold compensability issue, we note claimant's argument that her psychological and physical conditions, both previously deemed compensable, have not changed and, consequently, that they are both still compensable. Claimant also contends that, to the extent that her current problems are psychological in origin, they are compensable nonetheless, because it is the "law of the case" that her psychological condition is compensable. We disagree.

A prior Referee found claimant's then-current psychological condition compensable when it was diagnosed as adjustment disorder with mixed emotional reactive anxiety and mild depression in 1988. (See Ex. 8). However, the same Referee also found that claimant's compensable psychological condition resolved by January 1989. (Id. at p. 3). Under such circumstances, we conclude that claimant's current psychological condition is not a continuation of the condition found compensable in 1988. Moreover, in view of persuasive evidence indicating that claimant has a noncompensable psychological condition, which preexisted both employment exposures, psychological explanations for the recent back problems do not support her claim that her back condition is work related. Consequently, we proceed to consider claimant's claims under the law establishing her burdens as to each insurer.

Aggravation claim

Claimant seeks claim reopening by SAIF, the insurer responsible for her 1988 low back condition (diagnosed as contusion and strain to the dorsal and lumbar spine) as well as the 1988-1989 temporary psychological condition.

Regarding aggravation claims, ORS 656.273(1) provides in relevant part: "[A]n injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury." We have held that a compensable worsening is established by proof that the compensable injury is a material contributing cause of the worsened condition (so long as no off-the-job injury is the major contributing cause of the condition). Robert E. Leatherman, 43 Van Natta 1678 (1991). We have also held that the traditional definition of a "worsened condition," i.e., an increase in symptoms or a pathological change resulting in diminished earning capacity, remains intact. See Leroy Frank, 43 Van Natta 1950 (1991). ORS 656.273(1) also requires that the claimed worsened condition resulting from the original injury be established by medical evidence supported by objective findings.

Claimant's testimony supports a finding that her back symptoms worsened, at least temporarily, subsequent to claim closure in August 1990. However, claimant's complaints do not carry her burden in the present case, for the following reasons.

First, persuasive medical evidence relates claimant's recent back complaints to her preexisting noncompensable psychological condition, rather than to the compensable injury. (See Exs. 23-5, 25-1, 28-6-7, 30-2). Second, the medical evidence offered in support of the aggravation claim is not itself supported by objective findings, as required by ORS 656.273(1). In reaching this conclusion, we note that even Dr. Veroza, attending physician, opined that claimant's symptomatic complaints "outweigh" her objective findings. (Ex. 27-1). Finally, assuming for the moment that claimant's compensable condition did worsen, she has not established that such a worsening was more than waxing and waning contemplated at the time of her last award of compensation of 45 percent unscheduled permanent partial disability for her back condition. For these reasons, we conclude that claimant has not proven that she suffered a compensable aggravation.

New Injury Claim

We adopt the portion of the Referee's order addressing claimant's "new injury" claim against Liberty Northwest and conclude, as he did, that claimant has not established a compensable injury during her later period of employment. See ORS 656.005(7)(a).

Inasmuch as claimant has not established that her recent back problems were compensable as related to her compensable 1987 injury or as a new injury, we do not address the responsibility issue.

ORDER

The Referee's order dated May 2, 1991 is affirmed.

In the Matter of the Compensation of
LINDA D. SANTACRUZ, Claimant
WCB Case No. 91-02332
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

Claimant requests review of that portion of Referee Brown's order which approved the insurer's termination of temporary disability benefits effective January 21, 1991. On review, the issue is entitlement to temporary disability benefits.

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

On review, claimant contends that the employer's failure to notify claimant's attorney of the job offer violated ORS 656.331(1)(b) and, therefore, rendered the offer invalid. ORS 656.331(1)(b) provides:

> "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."

OAR 436-60-015(1)(b) provides for the same notice to claimant's attorney.

The purpose of the statute and rule is to give claimant's attorney an opportunity to advise claimant of her rights regarding the possible denial, reduction or termination of benefits. By their express terms, the statute and rule apply to an insurer or self-insured employer.

Here, the employer is represented by a guaranty contract insurer; it is not self-insured. Nevertheless, to construe the language of the statute and rule literally and allow an insured employer to contact claimant in situations which may have an effect on claimant's workers compensation rights without giving notice to claimant's attorney would circumvent the purpose of the notice requirement. Therefore, to effectuate the intent of the statute, we consider it and the rule applicable to an insured employer. See Anfilofieff v. SAIF, 52 Or App 127, 135 (1981).

However, we agree with the Referee that the requirements for terminating temporary total disability under ORS 656.268(3)(c) were satisfied in this case. Neither the statutes nor rules provide that a job offer is invalidated by the failure to give notice to claimant's attorney. Accordingly, we conclude that the termination of temporary total disability was authorized. We note, however, that the employer or its insurer may be liable for a civil penalty assessed by the Director for an intentional or repeated failure to give the proper notice to claimant's attorney. See OAR 436-60-015(2).

ORDER

The Referee's order dated June 6, 1991 is affirmed.

In the Matter of the Compensation of
SUZANNE A. HOLLAND, Claimant
WCB Case No. 90-04025
ORDER ON REVIEW
Star & Vinson, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee Livesley's order that: (1) set aside the employer's denial of claimant's aggravation claim for a neck and right shoulder condition; and (2) set aside the employer's denial of claimant's neck surgery claim. On review, the issues are jurisdiction, aggravation, and compensability. We affirm in part, modify in part, and vacate in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

Claimant first requested a hearing on the employer's aggravation denial before May 1, 1990, and the hearing was "convened and continued" pursuant to notice on June 25, 1990. Accordingly, we analyze the aggravation claim 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). However, the issues raised by the employer's September 27, 1990 denial of surgery are analyzed under the 1990 amendments. Claimant did not request a hearing on the denial of surgery before May 1, 1990 and a hearing was not convened before July 1, 1990. Accordingly, we analyze the issues raised by the surgery denial under the 1990 amendments to the Workers' Compensation Act. See Ida M. Walker, 43 Van Natta 1402 (1991).

Aggravation

We adopt the "Conclusions of Law and Opinion" as set forth in the Referee's order insofar as they pertain to the Referee's conclusion that claimant's current neck and shoulder condition (irrespective of the neck surgery claim) represents a worsening of claimant's December 1983 compensable injury since the last arrangement of compensation (an August 1989 stipulation). But see Gary L. Waldrupe, 44 Van Natta 702 (1992) (where sole basis of aggravation claim is surgery claim and Referee lacked jurisdiction to resolve surgery claim because of treating physician and reasonable and necessary disputes, aggravation issue should be deferred to await resolution of surgery issue by Director).

Jurisdiction

The Referee concluded that he had jurisdiction over the reasonableness and necessity of claimant's surgery as well as the question of whether claimant's cervical disc condition, which necessitated the surgery, was causally related to the compensable injury.

The employer contends both that the Hearings Division did not have jurisdiction over the reasonableness and necessity of the disputed cervical disc surgery and that this surgery was not causally related to claimant's compensable injury. We first address the jurisdictional issue.

Under amended ORS 656.704(3), "matters concerning a claim" do not include any dispute regarding medical treatment or fees for which a resolution procedure is otherwise provided in ORS Chapter 656. ORS 656.327 provides a procedure for the resolution of disputes between the employer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services."

Subsequent to the Referee's order, we concluded that original jurisdiction over such disputes is no longer shared by the Director and the Hearings Division. Stanley Meyers, 43 Van Natta 2643 (1991). Rather, because such disputes do not constitute matters concerning a claim, original jurisdiction lies exclusively with the Director. See Stanley Meyers, supra. Furthermore, we have recently held that disputes regarding proposed medical services, as well as those regarding current medical services and medical services which are disputed, but which have already been performed, are within the Director's original jurisdiction pursuant to ORS 656.327. See Kevin S. Keller, 44 Van Natta 225 (1992).

Although we do not have jurisdiction over the reasonableness and necessity of claimant's surgery, we have recently held that we do have jurisdiction to consider disputes concerning whether the medical services at issue are causally related to the compensable injury. In Michael A. Jaquay, 44 Van Natta 173 (1992), we held that because there is no other procedure provided by ORS Chapter 656 for resolving disputes concerning the causal relationship between an injury and a need for medical services, the Board retains jurisdiction over these matters.

Accordingly, in light of the aforementioned holdings, we conclude that the Hearings Division lacks jurisdiction to address whether the surgery was reasonable and necessary. Kevin S. Keller, supra. Nevertheless, we further hold that the Hearings Division has jurisdiction to address the causal relationship between the surgery and claimant's compensable injury. Michael A. Jaquay, supra.

We agree with the Referee that claimant's need for cervical discectomy surgery was related to her compensable injury. Claimant must prove that her need for medical services is materially related to her compensable injury. See Van Blokland v. OHSU, 87 Or App 694, 698 (1987). An MRI was essentially negative but showed minor disc bulging at C5-6. A discogram showed that claimant had marked incompetence of the annulus of the disc at C5-6. Dr. Smith concluded that the MRI findings represented a spondylosis or spondylopathy secondary to the traumatic injury of December 1983. Dr. Smith further opined that the findings of disc bulging at C5-6 plus claimant's lack of response to other treatment confirm that claimant has "post-traumatic cervical spondylosis- - spondylopathy, and this has been present and has continued to worsen since her injury of 12-9-83."

Dr. Black, a family practitioner, agreed with Dr. Smith's assessment, concluding that:

> "I feel that the symptoms that [claimant] was suffering from last winter are directely [sic] related to her neck. It is my feeling that the discogram was a very positive test. With the total relief of symptoms that she experienced when the xylocaine was injected, I feel that this has been the cause of her long-term difficulties and has finally manifested itself fully. * * *" (Emphasis added).

We further note that the discogram and MRI findings were confirmed by the discovery, during subsequent discectomy surgery by Dr. Smith, of a "definite wad of diskal material * * * this was felt to possibly constitute a recurrent disk

in this area which would explain the patient's right neck/shoulder/pectoral pain."

Accordingly, on this record, we conclude that claimant has shown that her cervical disc condition is materially related to the 1983 compensable injury.

We vacate that portion of the Referee's order which set aside the employer's surgery denial to the extent that the employer denied the reasonableness and necessity of the surgery, and we dismiss claimant's hearing request on that issue. To the extent that the employer's surgery denial denied a "causal relationship" between the need for disc surgery and the compensable injury, that portion of the employer's denial remains set aside. In light of our conclusions, we modify the Referee's $1,900 attorney fee award for totally prevailing against the employer's surgery denial. As a result of our decision, claimant is only entitled to an attorney fee for prevailing against the employer's denial of a causal relationship between the cervical disc condition and the compensable injury. ORS 656.386(1). In addition, claimant is entitled to an attorney fee for services on Board review concerning her successful defense of that portion of the Referee's order pertaining to the causal relationship issue, as well as her successful defense of the aggravation issue.

After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable attorney fee for claimant's counsel's services at the hearing level concerning the "causal relationship" issue is $1,200, to be paid by the self-insured employer. This fee is in lieu of, rather than in addition to, the Referee's $1,900 attorney fee award. In reaching this conclusion, we note that claimant's attorney has been awarded $2,900 for services at the hearing level concerning the aggravation issue. For services on Board review concerning the successful defense of the Referee's order regarding the "causal relationship" issue and aggravation issue, we find that a reasonable fee is $1,000 to be paid by the employer. In reaching these conclusions, we have particularly considered the time devoted to the issues (as represented by the record and claimant's appellate briefs), the complexity of the issues, the value of the interest involved, and the risk that claimant's attorney might go uncompensated.

ORDER

The Referee's order dated May 21, 1991 is affirmed in part, modified in part and vacated in part. That portion of the Referee's order which set aside the employer's surgery denial is vacated for lack of jurisdiction insofar as it pertained to the reasonableness and necessity of claimant's cervical disc surgery. That portion of the Referee's order which set aside the employer's denial is affirmed insofar as it pertained to the "causal relationship" issue. That portion of the Referee's order which awarded a $1,900 attorney fee for prevailing in setting aside the employer's September 27, 1990 surgery denial is modified. In lieu of the Referee's $1,900 attorney fee award, claimant's counsel is awarded an assessed fee of $1,200, for services at hearing concerning the "causal relationship" issue, to be paid by the employer. For services on review concerning the "causal relationship" and aggravation issues, claimant's counsel is entitled to an assessed attorney fee of $1,000, to be paid by the employer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
LINDA K. BROWN-KELLY, Claimant
WCB Case No. 91-01433
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Moller and Westerband.

The self-insured employer requests review of Referee Galton's order which set aside the employer's denial of: (1) compensability of claimant's current condition; and (2) claimant's aggravation claim for a cervical condition. On review, the issues are compensability and aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The employer denied both that claimant's current condition was compensably related to her 1988 compensable injury and that claimant had proven a compensable worsening of her condition. The Referee concluded that claimant's current condition was compensable and that claimant had established a compensable aggravation of her 1988 injury. In reaching this conclusion, the Referee found that claimant need only prove that the compensable injury was a material contributing cause of her current condition. We do not agree that the standard for compensability in this case is the material contributing cause standard. Instead, we conclude that claimant's compensable injury must be the major contributing cause of her current condition. However, we find that claimant has sustained this higher burden. Further, we agree that claimant has established a compensable aggravation.

Compensability of Current Condition

Dr. Cook opined, and we agree, that claimant's current cervical condition at C6-7 arose as a consequence of her compensable disc herniation at C5-6 for which she required surgery. Therefore, the compensability of claimant's current cervical condition is properly analyzed under ORS 656.005(7)(a)(A) as a secondary consequence of her 1988 compensable cervical spine injury. Julie K. Gasperino, 43 Van Natta 1151, 1153 (1991). We conclude that claimant has the burden to prove her 1988 compensable injury is the major contributing cause of her current condition and need for treatment. ORS 656.005(7)(a)(A). We find that the causation issue is a complex medical question, resolution of which turns largely on the medical evidence. See Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

In this case, two physicians give opinions on the causation of claimant's current condition. Dr. Waller is the neurologist who performed claimant's 1988 cervical spine surgery. Dr. Waller felt claimant's symptoms were related to the C6-7 level and are caused by degenerative changes as opposed to claimant's prior work injury or Dr. Waller's prior surgery.

Dr. Cook, orthopedist, is claimant's treating physician. He opined that claimant's initial injury in 1988 continues to be the major contributing cause relating to her chronic symptomatology. Dr. Cook felt claimant's current problems were directly related to the initial injury. Dr. Cook does not challenge Dr. Waller's finding that claimant's current symptoms may be coming from the C6-

7 level as opposed to the C5-6 level, but believes that claimant's current problems at C6-7 are a continuation of the 1988 injury. (Ex. 39-10,-11). Dr. Cook further opined that an injury to any part of a linkage system predisposes additional components to further wear and tear and increased symptomatology.

Where medical evidence is in conflict, we give greater weight to those opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). We give greater weight to the opinion of claimant's treating doctor unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). In this case, we find no persuasive reasons not to defer to the treating physician's opinions.

Accordingly, we conclude that claimant has sustained her burden to prove that the 1988 compensable injury is the major contributing cause of her current cervical condition and need for treatment thereof. Because claimant has established compensability of her current condition under ORS 656.005(7)(a)(A), we turn to the question whether the current condition has compensably worsened.

Aggravation

Claimant is entitled to additional compensation for a worsened condition resulting from the original injury. ORS 656.273(1). 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 worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 22 (1989) rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Further, the worsened condition must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3). Finally, if the aggravation claim is submitted for an injury or disease for which permanent disability was awarded, claimant must establish that the worsening is more than a waxing and waning of symptoms contemplated by the previous permanent disability award. ORS 656.273(8).

The medical record indicates that after her November 1988 cervical disc surgery, performed by Dr. Waller, claimant was essentially asymptomatic. Claimant's claim was closed by Determination Order on June 12, 1989.

Claimant returned to Dr. Waller in July 1989 with renewed arm and neck complaints. In August 1989 claimant left her job because of physical inability to do her job. Claimant's increased symptoms persisted and she was taken off work by Dr. Cook on December 26, 1989. Claimant returned to Dr. Waller in February 1990 and had an MRI which showed spondylitic changes and a mild foraminal narrowing a C5-6. At C6-7 there was mild to moderate narrowing of the intervertebral foramina bilaterally. Dr. Cook referred claimant to Dr. Hill, neurologist. Dr. Hill had a myelogram and CT scan performed. These studies could not rule out a small disc herniation at C5-6 or C6-7 on the right. The MRI and CT findings constitute objective findings.

We conclude from the above that claimant has proven by medical evidence supported by objective findings that she had increased symptoms starting about six months after her cervical surgery. We further conclude that this worsened condition resulted in diminished earning capacity when claimant was taken off work by Dr. Cook.

The employer argues that claimant's symptoms are no more than a waxing and waning contemplated by the previous permanent disability award. We disagree. We find no evidence that a waxing or waning of symptoms was contemplated by the 10 percent unscheduled permanent disability awarded by the June 12, 1989

Determination Order. Furthermore, no medical reports predict or mention the possibility of such a waxing and waning prior to the issuance of the Determination Order.

We conclude that claimant has established a compensable worsening of her cervical condition.

Inasmuch as the employer requested review, claimant is entitled to an attorney fee pursuant to ORS 656.382(2). However, claimant did not file a brief; therefore, no attorney fee shall be awarded. Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated July 5, 1991 is affirmed.

April 20, 1992 Cite as 44 Van Natta 809 (1992)

In the Matter of the Compensation of
JOSE VERGARA, Claimant
WCB Case No. 90-17262
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of those portions of Referee Michael Johnson's order that: (1) found that claimant was entitled to temporary disability benefits; (2) assessed a penalty for the employer's allegedly unreasonable failure to pay temporary disability benefits. On review, the issues are entitlement to temporary disability benefits and penalties.

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

The employer contends that OAR 436-60-030(4)(b), which deals with the resumption of temporary total disability benefits where modified work is no longer available, is inconsistent with amended ORS 656.268. We disagree.

ORS 656.268, as amended, does not reference temporary partial disability benefits nor the resumption of temporary total disability benefits after modified work is no longer available to an injured worker. Moreover, we find that OAR 436-60-030(4)(b) is consistent with the statute's purpose which is to compensate workers "for wages lost because of inability or reduced capacity to work as a result of the compensable injury." Noffsinger v. Yoncalla Timber Products, 88 Or App 118 (1987) quoting Cutright v. Weyerhaeuser Co., 299 Or 90, 296 (1985) (Emphasis supplied).

Here, claimant could only perform modified work as a result of the industrial injury and therefore had a reduced capacity to work. Accordingly, we agree with the Referee that claimant was entitled to reinstatement of temporary total disability benefits after being laid off from his modified work.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. 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 attorney's services on review

concerning the temporary disability benefits issue is $1,200, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and statement of services), the complexity of the issue, and the value of the interest involved. We note that claimant is not entitled to an attorney fee for defending against the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated July 26, 1991 is affirmed. For services on review concerning the temporary disability benefits issue, claimant's counsel is awarded an assessed attorney fee of $1,200, payable by the self-insured employer.

In the Matter of the Compensation of
BERTHA M. GRAY, Claimant
WCB Case No. 90-14568
ORDER ON REVIEW
Brothers, et al., Claimant Attorneys
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Neidig, Moller and Tenenbaum.

The SAIF Corporation requests review of that portion of Referee Kinsley's order which set aside its partial denial of claimant's current low back condition. On review, the issues are compensability and aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" but not her first "Ultimate Finding of Fact."

CONCLUSIONS OF LAW AND OPINION

The Referee analyzed this claim solely as an aggravation under ORS 656.273. However, SAIF's June 22, 1990 denial was both of compensability of claimant's current condition and of aggravation. (Ex. 19, Tr. 4). With regard to the denial of claimant's current condition, SAIF asserted that claimant's compensable condition was not the major contributing cause of her need for treatment but, rather, that claimant's current need for treatment was caused by a preexisting degenerative disease. (Ex. 19).

The first issue we address is whether claimant's current condition is compensable. If it is compensable, then we determine whether claimant has established a compensable worsening under ORS 656.273. See Lareta C. Creasey, 43 Van Natta 1735 (1991).[1]

Current Condition

In this case, the medical evidence shows that claimant's current condition

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[1] It is axiomatic that if a post-closure consequential condition is not compensable under ORS 656.005(7)(a)(B), then that condition cannot represent a compensable aggravation.

is a result of her compensable lumbosacral strain and a preexisting degenerative disc disease. Because the injury combined with a preexisting disease to cause a need for treatment and disability, the appropriate statute for determining compensability of the resultant condition is ORS 656.005(7)(a)(B). See Creasey, supra. Under ORS 656.005(7)(a)(B), claimant must prove that the compensable injury, rather than the preexisting condition, is the major contributing cause of her disability or need for treatment. Bahman M. Nazari, 43 Van Natta 2368, 2370 (1991). We conclude that claimant has failed to sustain this burden.

The medical evidence is in agreement that claimant's degenerative disc disease preexisted her February 1989 injury. There is also little question that the underlying degenerative condition is the major contributing cause of claimant's current symptoms. Dr. Newby, orthopedic surgeon, who has been treating claimant since April 1989, opined that claimant's injury "aggravated" her preexisting condition, creating stress to that area and triggering her symptoms. He found, however, that the preexisting degenerative disease was the current cause of her symptoms. (Ex. 24-10, 24-21). Dr. Sulkosky, M.D., who saw claimant on referral, diagnosed "foraminal stenosis" and reported that obesity was contributing to the condition and that "degenerative facets" were "increasing the symptomatology." (Ex. 15-2).

The Western Medical Consultants also concluded that claimant's "current symptomatology is stemming from her degenerative disease," (Ex. 16-5), and that the compensable injury "has no significant relationship to her current symptoms." (Ex. 17). Dr. Skotte, M.D., who treated claimant from February 1989 until January 1990, concurred with the reports from the Western Medical Consultants. (Ex. 18).

Because claimant did not prove that the compensable injury was the major contributing cause of her current need for treatment and disability, her claim fails under ORS 656.005(7)(a)(B).

Aggravation

The Referee concluded that claimant's current condition represented a worsening of her compensable injury. However, we have concluded above that claimant's current condition is not compensable under ORS 656.005(7)(a)(B). Because claimant's current condition is not compensable, we need not address her aggravation claim arising out of her current condition.

ORDER

The Referee's order dated May 22, 1991 is reversed in part and affirmed in part. The SAIF Corporation's denial is reinstated and upheld. The Referee's $2,250 attorney fee award is reversed. The remainder of the Referee's order is affirmed.

Board Member Tenenbaum specially concurring.

I agree with the majority's conclusion that claimant has failed to establish a compensable claim. I am troubled, however, by the majority's use of ORS 656.005(7)(a)(B) as a threshold requirement to her aggravation claim. I agree that, in certain cases, the provision is applicable in determining whether a claimant is entitled to additional compensation for a worsened condition under ORS 656.273(1). I believe, however, that the limiting provision is more appropriately applied within, rather than prior to, the aggravation analysis.

A review of the statutes may help in explaining my concerns. ORS 656.273(1) provides, in pertinent 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."

That language has long been construed as requiring a claimant who seeks additional compensation for a worsened condition to establish two things: (1) that the compensable condition has worsened since the last award of compensation; and (2) that the worsening is casually related to the compensable injury. Van Horn v. Jerry Jerzel, Inc., 66 Or App 457 rev den 297 Or 82 (1984); Anderson v. West Union Village Square, 43 Or App 295 (1979), modified 44 Or App 685 (1980). Prior to the 1990 amendments to the Workers' Compensation Law, a claimant satisfied the second burden with proof that the compensable injury was a material contributing cause of the worsened condition. Peterson v. Eugene F. Burrill Lumber, 294 Or 537 (183). Sometimes, the carrier only challenges one element to the test, conceding either causal relationship or the worsening.

The 1990 legislature, however, significantly amended the Workers' Compensation Law. Among the revisions, the legislature added subsection (B) to the definition of a compensable injury contained in ORS 656.005(7)(a):

> "If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment." (Emphasis supplied.)

In Bahman M. Nazari, 43 Van Natta 2368 (1991), we construed that subsection as limiting the compensation to which a claimant may be entitled for a compensable injury. Thus, we recognized that, while sustaining a compensable injury, a claimant may not be entitled to claimed compensation if a preexisting disease or condition is the primary cause of that disability or need for treatment.

Because a claim for aggravation is based on an underlying compensable injury, I believe that, by limiting the compensation to which a claimant is entitled for a compensable injury, the legislature has necessarily modified the standard of causation for determining the compensability of worsened condition. Accordingly, in cases where the medical evidence shows that the alleged worsened condition is a result of a combination of the original injury and a preexisting condition, I would hold that a claimant must, in order to establish a compensable aggravation, show that the original injury remains the major, rather than a material, contributing cause of that worsened condition.

It appears that the majority reaches the same conclusion and applies the same test. However, rather than simply requiring a higher standard of causation to establish a causal relationship between the alleged worsening and original injury, the majority views ORS 656.005(7)(a)(B) as an external threshold requirement and first addresses the "compensability" of claimant's current condition. I believe such an approach unnecessarily confuses the aggravation analysis and, as a consequence, I fear that it will lead to increased and unnecessary litigation. Moreover, it erroneously implies that compensability is always a threshold issue to be decided before reaching the merits of a claim for a worsened condition and ignores the fact that the real issues presented are whether the claimant's condition has worsened and, if so, whether the relationship between the original injury and the worsening is sufficient to allow compensability.

In the Matter of the Compensation of
JAMES O. SEIBERT, Claimant
Own Motion No. 91-0722M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Emmons, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

On April 8, 1992, we received additional evidence from claimant regarding his request for reconsideration of our March 24, 1992 Own Motion Order. However, we had already issued an April 7, 1992 Own Motion Order on Reconsideration in which we denied temporary total disability compensation on the ground that claimant was not in the work force at the time his condition worsened. We will consider the additional evidence to be a new request for reconsideration.

Claimant submitted evidence that he received unemployment compensation from November 14, 1989 until May 22, 1990. On December 27, 1990, claimant's treating neurologist, Dr. Golden, diagnosed a recurrent L4-5 herniated disc which required surgery. The request for surgery was withdrawn pending further diagnostic studies. Claimant underwent a program of physical therapy and conservative management provided by Dr. Becker. On May 13, 1991, Dr. Golden again recommended surgery. Dr. Rosenbaum, who performed an independent evaluation, indicated that surgery was not appropriate. In August, claimant discontinued conservative treatment. In October 1991, Dr. Golden was still of the opinion that surgery was appropriate. On December 5, 1991, the insurer authorized the proposed surgery.

However, claimant has not provided evidence that he was willing to work, but unable to work or look for work, after May 22, 1990 until his surgery in January 1992. Evidence that claimant was receiving conservative medical treatment does not indicate that claimant was thereby precluded from working. In order to prevail on this issue, claimant must prove that he was willing to work and that <u>either</u>: (1) he was making reasonable efforts to obtain work after May 22, 1990; or (2) reasonable efforts to obtain work would have been futile due to the compensable injury. <u>See</u> <u>Dawkins v. Pacific Motor Trucking</u>, 308 Or 254, 258 (1989). Claimant has the burden of proof on this issue and must provide evidence, such as copies of paycheck stubs, income tax forms, further unemployment compensation records, a list of employers where claimant looked for work, a letter from the employer, or letter from a doctor stating that a work search would be futile because of claimant's compensable condition for the period in question. Accordingly, because such evidence is lacking, we continue to deny claimant's request for temporary disability compensation. <u>See</u> <u>id</u>.

Thus, having failed to provide the required evidence, we again conclude that claimant has failed to prove that he was in the work force at the time of his current worsening. Accordingly, we continue to deny claimant's request for temporary disability compensation.

Consequently, we withdraw our April 7, 1992 order. As supplemented herein, we adhere to and republish our April 7, 1992 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
WENDY K. SPRINKEL, Claimant
WCB Case No. 90-21499
INTERIM ORDER (REMANDING)
Willard Bodtker, Claimant Attorney
Schwabe, et al., Defense Attorneys

The self-insured employer requests review of Referee Emerson's order that set aside its denial of claimant's occupational disease claim for right finger and left wrist conditions. The employer also moves to "reopen" the record in this case or, alternatively, remand the matter to the Referee for submission of further evidence. On review, the issues are remand and compensability. We remand.

The employer moves to "reopen" the record or, alternatively, remand the matter for submission of further evidence. Claimant does not object to the motion other than to request that, if we grant the motion, we also consider additional evidence proferred by claimant.

We first note that we have no authority to consider any evidence not already included in the record. Under ORS 656.295(5), our only statutory power is to remand the case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See Bailey v. SAIF, 296 Or 41, 45 n. 3 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding; a compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988) (approving applicability of Compton v. Weyerhaeuser Co., supra, to remand by the Board).

Here, the Referee found that claimant proved the compensability of a ganglion in her right index finger. The employer asserts that we should remand to consider reports demonstrating that surgery performed on claimant's right hand after the hearing revealed that claimant did not have a ganglion in her finger. A report from claimant's treating physician and proferred by claimant also shows that a ganglion was not found in the finger. Rather, the surgery revealed what appeared to be a small herniation, and the report found that this condition was related to claimant's work activities.

We find that there is a compelling reason to remand for admission of this additional evidence. The evidence concerns claimant's disability, was not obtainable at the time of hearing, and, because it goes directly to the existence of claimant's condition that was deemed compensable, it is reasonably likely to affect the outcome of the case. See Parmer v. Plaid Pantry #54, 76 Or App 405, 409 (1985). Therefore, we remand to the Referee for the admission of those reports proffered by the employer. In addition, the Referee shall allow claimant an opportunity to cross-examine or rebut this late-produced evidence.

We retain jurisdiction over this matter. After conducting the aforementioned further proceedings, which may be conducted in any manner that will achieve substantial justice, a transcript of any further hearing, along with any admitted exhibits, shall be forwarded to the Board. In addition, Referee Emerson shall provide an interim order on remand explaining the effect, if any, the admission of any additional evidence has upon his prior order. When the interim order on remand has issued and the case is returned to the Board, a supplemental briefing schedule shall be implemented, after which we will proceed with our review.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERTA J. WILSON, Claimant
WCB Case No. 90-15449
ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Tenenbaum and Kinsley.

Claimant requests and the insurer cross-requests reconsideration of our January 31, 1992 Order on Review. We withdrew our order to allow sufficient time to consider the motions. In that order, we concluded that claimant became medically stationary on June 5, 1990 and reinstated the insurer's Notice of Closure. In addition to the temporary disability awarded by the Notice of Closure, we awarded claimant 5 percent (9.6 degrees) scheduled permanent disability for the loss of use or function of the left arm and 5 percent (16 degrees) unscheduled permanent disability for the left shoulder condition.

On reconsideration, claimant argues that she was medically stationary on June 5, 1990 only for her carpal tunnel condition, not the denied neck, shoulder, right and left arm pain. Thus, she contends, the Notice of Closure should have been set aside as premature. In the alternative, she argues that if she were medically stationary on June 5, 1990, the Board did not have jurisdiction to rate the extent of permanent disability.

The insurer contends that claimant was medically stationary on June 5, 1990 and that the Board appropriately proceeded to rate extent of disability. However, it argues that the awards are not supported by the evidence, in that the cumulative trauma disorder is equivalent to claimant's carpal tunnel condition, which resulted in no impairment.

On reconsideration, we conclude that both claimant's and the insurer's arguments were adequately addressed in our initial Order on Review. Further, because the "claim" has already been through the procedure prescribed in former ORS 656.268(3), and all of claimant's conditions were medically stationary on June 5, 1990, it is not inappropriate for the extent of disability to be determined by the Board. We adhere to and republish our January 31, 1992 Order on Review. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DEBRA C. LAYNG, Claimant
WCB Case No. 90-17162
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

On March 23, 1992, we abated our February 25, 1992 Order on Review to allow the self-insured employer to file a response to claimant's motion for reconsideration. Having received the employer's response to claimant's motion for reconsideration, we proceed to our review.

In her request for reconsideration, claimant first contends that this matter involves a "de facto" denial of a medical services bill. Claimant notes that OAR 436-10-046(2) provides that a request for review by the Director must

In the Matter of the Compensation of
BETTY J. RETHERFORD, Claimant
WCB Case No. 90-02078
ORDER ON RECONSIDERATION
Philip H. Garrow, Claimant Attorney
Kevin L. Mannix, Defense Attorney

Claimant requests reconsideration of our March 24, 1992 order which affirmed a Referee's order that upheld the insurer's partial denial of claimant's L4-5 condition, and declined to award interim compensation, penalties and attorney fees for allegedly unreasonable claim processing. Noting that the Referee also found that claimant's compensable condition had aggravated, claimant "believes a clarification by the Board is necessary in order to have the insurer process this claim."

To begin, claimant did not raise this "issue" until her request for reconsideration. On review, she asserted that the Referee erred in upholding the insurer's L4-5 denial and in declining to award interim compensation, penalties and attorney fees. Under such circumstances, we decline to address issues raised for the first time on reconsideration. See James D. Tate, 42 Van Natta 112 (1990).

In any event, had we addressed the merits of claimant's request, we would not have altered our prior decision. Claimant's hearing request pertained to the insurer's denial of claimant's "back at any levels of the spine other than L5-S1." The insurer had previously authorized surgery at L5-S1. Based on such circumstances, the Referee concluded that "[i]t is obvious that the condition at L5-S1 aggravated -- inasmuch as additional surgery was needed. That surgery was authorized in July 1990." The Referee further held that "The aggravation claim for benefits at the L5-S1 level is moot inasmuch as the requested surgery authorization was granted in July 1990."

Asserting that the Referee inaccurately declared the aggravation issue "moot," claimant requests that we find that he proved a compensable aggravation and remand the claim to the insurer for processing. We decline claimant's request. As noted above, the compensability of claimant's L5-S1 condition was not contested at the hearing. That claim had been accepted and the proposed surgery authorized. Claimant's motion suggests that the insurer is not complying with its claim processing obligations concerning the L5-S1 condition. Should that be the case, her remedy does not rest in this case where the compensability of claimant's L5-S1 condition was not in dispute.

Accordingly, we withdraw our March 24, 1992 order. On reconsideration, as supplemented herein, we adhere to and republish our March 24, 1992 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
WANDA L. YOKUM, Claimant
WCB Case No. 90-12197
ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
Pamela Schultz, Defense Attorney

Reviewed by Board Members Gunn, Tenenbaum and Kinsley.

Claimant requests review of Referee Emerson's order that upheld the insurer's denial of claimant's medical services claim for right carpal tunnel release surgery. On review, the issue is medical services. We vacate.

FINDINGS OF FACT

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

On June 26, 1990, the insurer denied claimant's request for right carpal tunnel surgery on the basis that the surgery was neither reasonable nor necessary for claimant's compensable condition.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the medical treatment was not compensable because claimant had failed to establish that the surgery was reasonable or necessary. After our review of the record, we conclude that the Hearings Division lacks jurisdiction to determine the reasonableness and necessity of the proposed treatment and vacate the Referee's order.

On May 7, 1990, the Governor signed into law Senate Bill 1197, an extensive revision of the worker's compensation statutes. Or Laws 1990 (Special Session), ch. 2. Because a hearing was convened after July 1, 1990, this matter is properly analyzed under those revisions. Or Laws 1990, ch. 2, 54; Ida M. Walker, 43 Van Natta 1402 (1991).

Under amended ORS 656.704(3), "matters concerning a claim," over which the Board, and thus our Hearings Division, has jurisdiction, do not include any dispute regarding medical treatment for which a resolution procedure is otherwise provided in ORS Chapter 656. ORS 656.327 provides a procedure for the resolution of disputes concerning treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of [administrative] rules."

Here, the insurer's denial is based solely on the contention that the proposed medical treatment is neither reasonable nor necessary. Original jurisdiction over such a dispute regarding medical treatment is no longer shared between the Board and the Director, even if such treatment is simply proposed. Kevin S. Keller, 44 Van Natta 225 (1992); Stanley Meyers, 43 Van Natta 2643 (1991). Rather, because such disputes do not constitute a matter concerning a claim, original jurisdiction lies exclusively with the Director.[1] Accordingly, we vacate the Referee's order for lack of jurisdiction.

ORDER

The Referee's order dated April 17, 1991 is vacated.

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[1] For the reasons set forth in the dissenting opinion in Keller, Board Members Tenenbaum and Kinsley would conclude that the Referee had jurisdiction to

decide this issue, and would affirm the Referee on the merits. However, based on the majority opinion in Keller, we are constrained to join Member Gunn in this result.

April 24, 1992 Cite as 44 Van Natta 819 (1992)

In the Matter of the Compensation of
STEVEN V. BISCHOF, Claimant
WCB Case No. C2-00607
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Mitchell, Lang & Smith, Claimant Attorneys
Vick & Gutzler, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

On March 20, 1992, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

A claim disposition agreement shall not be approved if, within 30 days of submitting the disposition to us, the worker requests that we disapprove the disposition. ORS 656.236(1)(c).

Here, the disposition was submitted to us on March 20, 1992. The 30th day following the submission is April 20, 1992. Claimant filed his request for disapproval of the disposition on April 20, 1992. Accordingly, we disapprove the disposition. Id.

Inasmuch as the proposed disposition has been disapproved, the self-insured employer 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).

The parties may move for reconsideration of the final Board order by filing a motion for reconsideration within 10 days of the date of mailing of this order. OAR 438-09-035(1).

Finally, we note that the proposed agreement initially submitted by the parties attempted to resolve a lien for attorney fees claimed by claimant's former counsel. The Board has approved a former counsel's petition for attorney fees in a situation in which the counsel submitted a copy of the retainer agreement to the Board and claimant did not rebut counsel's assertions regarding the work performed by the former counsel upon claimant's CDA. See Steven C. Hatfield, 43 Van Natta 1622 (1991).

In a case in which claimant's counsel and former counsel took different positions regarding the amount of attorney fees each attorney claimed for work on one CDA, the Board found that the manner in which the fee was to be distributed was not a matter to be decided by this forum. See Ronald C. Kendall, 43 Van Natta 2388 (1991).

Finally, the parties may wish to consider placing the disputed attorney fee amount in a trust fund account, pending resolution of the dispute between claimant and his former counsel. In such a case, the CDA should note that the amount will be paid into the account, with the approval of claimant. Under those circumstances, the amount of consideration may be reviewed by the Board

separately from the attorney fee dispute. However, in no event shall the total attorney fees payable out of the settlement proceeds into a trust account exceed the strictures of OAR 438-15-052.

IT IS SO ORDERED.

April 24, 1992 Cite as 44 Van Natta 820 (1992)

In the Matter of the Compensation of
JULIE M. HARPER, Claimant
WCB Case No. 90-21191
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board en banc.[1]

Claimant requests review of that portion of Referee McWilliams' order which found that the Hearings Division lacked jurisdiction to consider a medical treatment dispute. The insurer cross-requests review of those portions of the Referee's order which: (1) ordered it to seek the Director's review of the medical services at issue; and (2) found that the insurer had not raised any cross issues at hearing. On review, the issues are jurisdiction and offset.

We affirm and adopt the Referee's order with the following modification and supplementation on the jurisdiction and offset issues.

Jurisdiction

We recently held that ORS 656.327 provides a procedure for the resolution of disputes between the insurer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of [administrative] rules." Stanley Meyers, 43 Van Natta 2643 (1991). Therefore, original jurisdiction over disputes regarding the necessity or reasonableness of medical services now lies exclusively with the Director. Id.

The present case involves a dispute regarding whether chiropractic treatment has been approved by an "attending physician." "Attending physician" and "non-attending physician" are defined in the Director's rules. See OAR 436-10-005(1); 436-10-005(27). Moreover, in accordance with OAR 436-10-050, only an "attending physician" may provide compensable medical services. In light of the aforementioned rules, we conclude that this is a dispute concerning whether the treatment at issue is "in violation of the rules regarding the performance of medical services." Consequently, we hold that the dispute is not a "matter concerning a claim" over which the Hearings Division has jurisdiction.

The insurer argues that the Referee did not have authority to order it to seek the Director's review of the disputed chiropractic treatments. We agree that the Referee had no jurisdiction over this matter. However, we also note that, as in Meyers, the insurer had but two options: either pay for claimant's medical services or initiate Director review of the dispute. Its failure to initiate review procedures or pay for the medical services within 90 days of receipt will ordinarily constitute the unreasonable resistance to the payment of compensation, for which penalties or attorney fees will be assessed. Id.

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[1] Board member Hooton represented one of the parties to this proceeding. Consequently, he has not participated in this review. OAR 438-11-023.

Accordingly, we conclude that the Referee had no jurisdiction over this dispute and could not order the insurer to initiate Director review of this matter. However, we note that the insurer's limited options do not include inaction. Indeed, the insurer will act at its own peril if it continues to refuse to pay the medical billings and also refuses to seek Director review. In the event of such a continued refusal, claimant may request a hearing seeking the assessment of attorney fees under ORS 656.382(1) for the insurer's unreasonable resistance to the payment of compensation.

Offset

At hearing, it became apparent from claimant's testimony that claimant was receiving income from child care she was performing at her home while she was receiving temporary total disability compensation, and that, consequently, the insurer might be entitled to an offset. The insurer was not aware of a potential offset issue until claimant's testimony. After claimant's testimony, counsel for the insurer moved to have the record left open for claimant's records of her earnings from her child care services for purposes of determining whether an offset was appropriate. The Referee allowed this motion.

In her order, the Referee acknowledged that she had left the record open for claimant's financial records. However, the Referee stated that claimant had withdrawn all time loss issues and had objected to admission of claimant's financial records on relevance grounds. The Referee indicated that, because the insurer did not raise any cross-issues regarding claimant's entitlement to temporary total disability, claimant's objection to the financial records should be sustained and they would be excluded from the record. Thus, the Referee did not address the offset issue in her order.

OAR 436-06-031 provides in pertinent part:

> " * * * Amendments shall be freely allowed up to the date of the hearing. If, during the hearing, the evidence supports an issue or issues not previously raised, the referee may allow the issue(s) to be raised during the hearing. The referee may continue the hearing upon motion of an adverse party if the party is surprised and prejudiced by the additional issue(s) and a continuance is necessary to allow the party an opportunity to cure the surprise and prejudice."

Whether a party is allowed to raise an issue for the first time during the course of a hearing is a matter within the Referee's discretion. Susan D. Troxell, 42 Van Natta 1300 (1990). Here, the Referee appeared to allow the issue to be raised and left the record open for claimant's financial records of her earnings while receiving time loss. We note that claimant could have requested a continuance if she was surprised or prejudiced and did not do so. OAR 438-06-031; 438-06-091(3).

Based on these facts, we conclude that the Referee exercised her discretion and allowed the offset issue to be raised. Thus, the Referee was incorrect in stating that the insurer had raised no cross-issues. Since the offset issue did not arise until claimant's testimony, there was no way for this issue to be formally raised prior to that time.

Although we find that the offset issue was raised during the course of the hearing, we conclude that claim closure would be the appropriate time to address the offset request. ORS 656.268(13) allows an offset to be included in a determination order or notice of closure. We have previously held that a Referee has authority to grant an offset request even when no compensation has been awarded

against which the offset may be taken. Robert E. Kubala, 43 Van Natta 1495 (1991). However, in Kubala, the offset request raised at hearing arose from an appeal of a Determination Order. Here, in contrast, the claim has not been closed. Thus, there has not been an opportunity to "include necessary adjustments in compensation" in a Determination Order or Notice of Closure. ORS 656.268(13).

Under such circumstances, we hold that the appropriate time to address the insurer's offset request is at the time of claim closure. Accordingly, we decline to consider the request at this time.

ORDER

The Referee's order dated June 6, 1991 is affirmed.

Board Members Kinsley and Tenenbaum dissenting in part:

Citing the decision in Stanley Meyers, supra, the majority finds that the Hearings Division of the Workers' Compensation Board does not have original jurisdiction over this medical treatment issue. For the reasons stated in our dissent in Stanley Meyers, we disagree. By its terms, the application of ORS 656.327(1)(a) is discretionary upon the parties:

> "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, self-insured employer shall so notify the parties and the director." (Emphasis added).

If the director's jurisdiction has not been invoked by one of the parties for one of the reasons listed in the statute, the parties retain the right to a full hearing on the matter with legal representation at the Hearings Division under ORS 656.283. Lillie M. Willis, 42 Van Natta 1923 (1990); Theron Stiehl, 43 Van Natta 686 (1991). Here, neither party wished to have Director review under ORS 656.283 and, therefore, the request for hearing should not have been dismissed. Further, by the terms of the statute, claimant could not have invoked the jurisdiction of the Director. Claimant takes the position that the treatment she was receiving was not in violation of any medical rule about receiving treatment from an attending physician. Therefore, she was not "an injured worker [who] . . . believes that [she] . . . is receiving medical treatment that is . . . in violation of rules regarding the performance of medical services . . . ."

The majority postulates that the insurer's options "do not include inaction," and that in the event of a "continued refusal" to either pay the bills or seek Director's review, the insurer might be subject to attorney fees under ORS 656.382(1), if claimant seeks a hearing to pursue that alleged violation.

Notwithstanding the majority's inferential reasoning, however, there is no time period in ORS 656.327 within which the insurer must request Director's review or be subject to some sanction. The insurer may delay indefinitely. That is just one of the reasons we dissented in Meyers.

For the above reasons, we respectfully dissent.

In the Matter of the Compensation of
FLORENCE E. HATHORN, Claimant
WCB Case No. 91-14639
ORDER OF DISMISSAL (REMANDING)
Coons, et al., Claimant Attorneys
Pamela Schultz, Defense Attorney

The insurer has requested Board review of Referee Quillinan's April 6, 1992 "Order Compelling Discovery." 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 requested a hearing, contesting a September 30, 1991 denial. In addition to the compensability issue, claimant raised the issues of penalties and attorney fees.

Prior to hearing, claimant filed a "Motion to Compel Discovery." Specifically, claimant requested that the insurer be directed to disclose a video tape. The insurer opposed the motion.

On April 6, 1992, the Referee issued an "Order Compelling Discovery." Relying on Robert J. Smith, 43 Van Natta 104 (1991), and Jon A. Hissner, 42 Van Natta 2731 (1990), the Referee concluded that the video tape was discoverable and disclosable as a claims document prior to hearing. Accordingly, the insurer was directed to provide a certified complete and accurate copy of the video tape to claimant's counsel within 10 days. Finally, the Referee directed that the case be reset for hearing.

On April 13, 1992, the Board received the insurer's request for review of the Referee's April 6, 1992 order.

FINDINGS OF ULTIMATE FACT

The Referee's April 6, 1992 "Order Compelling Discovery" 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 April 6, 1992 order neither finally disposed of, nor allowed, the claim. Moreover, the order did not fix the amount of claimant's compensation. Rather, the order resolved a discovery issue in preparation for a forthcoming hearing. See Tony R. Seeley, 41 Van Natta 130 (1989).

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; Tony R. Seeley, supra. Therefore, we lack jurisdiction to consider the insurer's request for Board review.

Accordingly, this case is returned to the Docketing Section of the Workers' Compensation Board Hearings Division for further action consistent with this order and the Referee's April 6, 1992 "Order Compelling Discovery." In other words, this case shall be scheduled for hearing.

IT IS SO ORDERED.

In the Matter of the Compensation of
KIM S. JEFFRIES, Claimant
WCB Case Nos. 90-15064, 90-05652 & 90-12569
ORDER ON REVIEW
Max Rae, Claimant Attorney
Snarskis, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys
Tooze, et al., Defense Attorneys

Reviewed by the Board en banc.

Sedgwick James & Company, on behalf of Conagra Inc., requests review of Referee Myzak's order which assessed a penalty for Sedgwick's allegedly unreasonable denial of compensability and responsibility for claimant's herniated disc condition. On review, the issue is penalties. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee found that Sedgwick's denial was unreasonable and assessed a penalty based on all compensation due as of the date of hearing. We agree.

Penalties may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10). The reasonableness of a carrier's denial of compensation must be gauged based upon the information available to the carrier at the time of its denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n. 3 (1985).

The information available to Sedgwick supported both compensability and Sedgwick's responsibility. Specifically, on December 22, 1989, claimant lifted a 40 pound carton and turned. He felt the immediate onset of sharp pain in his low back. He told a co-worker that he had injured his back and sought medical treatment from Dr. Schwerzler later that same day. Dr. Schwerzler's chartnotes indicate that claimant had a low back strain and spasms after a lifting incident at work. Following the Christmas holidays, on December 27, 1989, claimant informed the employer that he had hurt his back at work. Claimant was hospitalized on January 2, 1990 and underwent surgery following an MRI. The MRI revealed a preexisting disc herniation at L5-S1 which differed from its status when initially diagnosed in 1985 in that there was now a free fragment in the lateral recess just below the L5-S1 disc compressing the right S1 nerve root. (Ex. 92 E-3). Furthermore, the discharge summary by treating surgeon, Dr. Malos, described the condition as a very large disc herniation trapping the S-1 nerve root, whereas in 1985, Malos had found a "small herniation which doesn't look like it could entrap the S1 nerve root." (Ex. 33). In addition, the admission, operative and discharge reports specifically referred to the December 22, 1989 work incident as an "on-the-job injury." (Exs. 92A-1, 92B-1, 92E-1,

93A). As the Referee found, there was no medical evidence to the contrary when Sedgwick issued its denial on April 6, 1990.

At hearing, no testimony was offered by Sedgwick on the penalty issue. Furthermore, the denial letter stated Sedgwick's ultimate decision, without explaining Sedgwick's reasoning. Therefore, notwithstanding the arguments in Sedgwick's appellant's brief concerning how one might have interpreted the medical evidence available at the time, the record does not establish what medical evidence Sedgwick considered supportive of its denial or why it denied both compensability and responsibility, thereby precluding the issuance of a .307 Order.

Assuming Sedgwick denied compensability and responsibility based on a conclusion that the December 22, 1989 work incident did not worsen claimant's disc pathology or make what was an essentially asymptomatic condition symptomatic to the point that surgery was required, the medical evidence available at the time did not support that conclusion. The December 22, 1989 work incident was such that it would qualify as an industrial injury for which Sedgwick was responsible were it not for claimant's previous compensable back injuries which raised the question of responsibility. Thus, the work incident might arguably have provoked a responsibility denial, but Sedgwick had no reasonable basis for denying compensability. Assuming Sedgwick felt that additional medical information was needed on what was clearly a complex medical question, it did not request any additional information from Dr. Malos (or from any other physician), despite that it corresponded with Dr. Malos around the time of the denial. (Ex. 94A). In short, Sedgwick denied compensability and responsibility without medical evidence supporting its decision. We conclude that at the time of its denial, Sedgwick did not have a legitimate doubt of compensability or responsibility for claimant's disability and need for surgery.

Accordingly, for the above reasons, we find that Sedgwick's denial was unreasonable. The issue now becomes whether there are any "amounts then due" on which to base a penalty for Sedgwick's unreasonable denial.

In this regard, Sedgwick argues that, assuming arguendo its denial was unreasonable, reversal is nonetheless required because the Referee based the penalty on claimant's medical expenses, which she was without authority to do. Sedgwick cites the Court's decision in Eastmoreland Hospital v. Reeves, 94 Or App 698 (1989), for the proposition that medical benefits cannot constitute "amounts then due" under ORS 656.262(10). We disagree.

In Eastmoreland Hospital v. Reeves, supra, the Court determined that interim compensation did not include medical services and that medical services could not form a basis for a penalty arising prior to a determination of compensability. In that case the penalty arose as a consequence of insurer's unreasonable failure to timely provide claims related documents following a request for hearing and request for medical documentation. The penalty is assessed on amounts due during the time of the unreasonable delay in disclosure. Compensability had not been established at the time of disclosure. Consequently, the only amount "then due" was the interim compensation due claimant prior to a favorable determination on the compensability question. That amount does not include medical services. ORS 656.262(6).

Interim compensation is compensation due without regard for the compensability of the claim. It is designed to maintain the claimant during that period of disability when the insurer may investigate the question of compensability. Once a formal denial has issued claimant is no longer entitled to interim compensation, but must prove the compensability of his claim. ORS 656.262(2). Once he has done so, his prior "procedural" right to "interim compensation" becomes a substantive entitlement under the Act.

When a penalty is assessed at the time of a processing infraction, and that infraction occurs before a denial issues, only interim compensation can be considered as an amount "then due." If the infraction occurs after the issuance of a denial but before a hearing on the question of compensability, the only possible amounts "then due" are interim compensation amounts due but unpaid prior to issuance of the denial, since the issuance of the denial terminates any obligation to make further payments on the claim until compensability is established at hearing. ORS 656.262(2).

Where the question is the reasonableness of the denial, however, the penalty is assessed as of the time of the hearing. See Wacker Siltronic Corp. v. Satcher, 91 Or App 654, 658 (1988). This distinction from other forms of penalty is appropriate because the insurer is under a continuing obligation to process the claim. This means that the insurer must continually reevaluate its denial and rescind a denial which is or becomes unreasonable prior to the issuance of an order setting the denial aside. Brown v. Argonaut Insurance Co., supra.

When the penalty is assessed at the time of the hearing, however, the denial has been set aside and all expenses incurred by claimant for medical services and all time loss become amounts then due. We are no longer concerned with the distinction between interim compensation and substantive entitlement under the Act because claimant, as of the time of the order, has become substantively entitled to every benefit the Act allows without regard for the date upon which medical services were rendered or time loss incurred. In this way, the penalty bears a reasonable relationship to the wrong done. Wacker Siltronic Corp. v. Satcher, supra.

This interpretation is consistent with the decision of the Court of Appeals in both Eastmoreland and in Whitman v. Industrial Indemnity Co., 73 Or App 73 (1985). In Whitman the court assessed a penalty on medical services rendered while the compensability of an aggravation/responsibility question was in litigation. The outcome of the aggravation/responsibility question, however, did not affect the compensability of the medical services, which remained compensable under ORS 656.245.

Accordingly, we agree with the Referee that the penalty in this instance is appropriately based on all compensation due at the time of the hearing, including medical services. To the extent that our prior decision in Gene C. Dalton, 43 Van Natta 1191 (1991) is inconsistent with this opinion, we disavow it.

Claimant is not entitled to an attorney fee for defending against the penalty issue. Saxton v. SAIF, 800 App 631 (1987); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated May 6, 1991 is affirmed.

Board Member Kinsley dissenting:

I find that Sedgwick had a legitimate basis to doubt both the compensability and responsibility of this claim at the time of their denial up to the time of hearing and, therefore, I would not find its denial to be unreasonable. Further, based on ORS 656.262(6), I agree with Chair Neidig that outstanding medical bills cannot be a basis for a penalty.

The condition relating to the December 27, 1989 claim against Sedgwick was for a herniated disk at L5-S1. Claimant claimed that, on the morning of December 22, 1989, he strained his lower back while carrying a carton. Claimant attended an office Christmas party before leaving at the end of that work day. He did not file a claim until five days later when he returned after the holiday vacation. Claimant had a prior claim for a herniated disc at L4-L5 related to a 1981 claim against the same employer, but while Industrial Indemnity was on the risk. He had surgery in 1982 and 1986 at L4-L5 related to that claim. While claimant was undergoing testing in 1985 in preparation for surgery in 1986, the doctors discovered a small disc herniation at L5-S1. (Exs. 31, 32, 33, 104.) There is no evidence in the record that this condition was ever claimed or ever accepted as a work related claim against this employer or any other employer. Therefore, the L5-S1 herniated disc was a noncompensable, preexisting condition. The Referee appeared to find significant that no L5-S1 herniated disc was noted in the February 18, 1986 operative report by Dr. Malos. (Ex. 39.) However, a close reading of that report shows that the surgical incision was not carried down far enough to completely expose that area so that a finding would be possible. Also, Michael Malos, M.D., treating neurosurgeon, has confirmed that the L5-S1 disc pathology preexisted the 1989 claim. (Ex. 104.) So, in fact, claimant had a preexisting herniation at L5-S1, the same condition claimed in the 1989 claim. This fact supports the compensability basis for the denial.

The responsibility defense arose because, although claimant had worked continuously for the same employer, he had had three low back claims with three different insurers - the one previously cited in 1981, one in 1987 for a back strain and the current 1989 claim. A prior claim to the same body area, especially where permanent disability has been awarded (Exs. 26, 27 and 66), gives rise to a legitimate doubt as to responsibility.

Sedgwick denied the claim on April 6, 1990. The first medical opinion that discussed causation of the condition as between the three claims was in a June 18, 1990 report by Dr. Farris who conducted an independent medical examination. This report was obtained by Hartford who was the insurer on the 1987 claim. The report's conclusions were directed to Hartford's liability. In that report, Dr. Farris stated that the 1987 injury was not the major cause of the condition. Dr. Farris never made a definitive statement about the 1989 claim as a cause of the condition, although he did state that claimant "was essentially asymptomatic from 1987 until he re-injured himself on December 22, 1989." (Emphasis added). (Ex. 99). Dr. Farris then moved to Wyoming. Dr. Snodgrass was asked to step in for Dr. Farris when the 1987 insurer wrote back to ask Dr. Farris to clarify his opinion on causation. Dr. Snodgrass, who said he reviewed Dr. Farris' report, stated that he thought "Dr. Farris' opinion is clear that the December 22, 1989, injury was responsible for the time loss and surgery which occurred in January of 1990." (Ex. 100.) Dr. Snodgrass' opinion is nothing but pure unreliable hearsay, since there is no evidence he reviewed any of the relevant medical file regarding the claimant's condition (other than Dr. Farris' report), took any opportunity to examine the claimant or ask questions of him, or even talked to Dr. Farris about his opinion. I would not consider that Dr. Farris' report, even when read with Dr. Snodgrass' hearsay report, would have removed all legitimate doubt as to the compensability and responsibility for claimant's condition. Dr. Farris' report does not even note the 1985 diagnosis of the L5-S1 herniated disc, so it does not appear that he had a complete history of the important facts when forming his opinion. Furthermore, as an independent examining doctor, Dr. Farris had seen this claimant only once and long after the three claims and the original and subsequent diagnoses of the L5-S1 herniated disc were made, so there was no reason to give his report any significant weight.

The first (non-hearsay) medical report that directly addresses the question of the relationship of the 1989 claim and the L5-S1 herniated disc is Dr. Malos' November 2, 1990 report. (Ex. 104.) Dr. Malos was in a good position to give an opinion because he was the treating surgeon that was involved in the 1985 testing when the L5-S1 herniation was discovered and he performed the 1986 L4-5 surgery. He also performed the January 2, 1990 surgery on the L5-S1 disc. Dr. Malos found that the 1989 claim was "the most important causative factor leading to Mr. Jeffries disc herniation at L5-S1 and subsequent surgery on January 2, 1990[.]" (Id). However, Dr. Malos also wrote that "prior to December of 1989, he [claimant] was asymptomatic from a pain standpoint . . . ." (Emphasis added.) (Id.)

This report was mailed to Sedgwick on November 7, 1990, only two weeks before the scheduled hearing in this case. An argument could be made that Sedgwick should have conceded and accepted the claim at that point and, therefore, the denial became unreasonable at that time. However, as stated by Sedgwick at hearing (Tr. 25) and in its brief, Sedgwick still had some valid questions about the accuracy of the history that the claimant gave to the doctors. If Sedgwick showed the history to be incorrect, then the reports' persuasiveness would be diminished or nullified. For this reason, Sedgwick had a legitimate reason to continue to doubt the claim. Both Dr. Farris' and Dr. Malos' reports stated that claimant was "asymptomatic" in the period prior to the 1989 claim. However, Sedgwick had contrary information. Sedgwick elicited testimony from the claimant that he told Pat Johnson, supervisor, and others that his back did hurt prior to the 1989 claim. (Tr. 50, 51). A coworker, Marla Ehrens, also confirmed that she observed and claimant reported some back pain prior to the 1989 claim. (Tr. 87). However, what also became clear on extensive cross-examination of the claimant and Ms. Ehrens is that these complaints were more related to an every day type of ache after a hard day of lifting, rather than to a "nerve" type pain associated with a herniated disc. It appears that this testimony is a reason why Sedgwick later voluntarily withdrew its denial and accepted the claim.

The above facts show that Sedgwick had a legitimate basis to doubt the claim all the way up to the time that it had the opportunity to test the claimant, under oath, on the nature of his "asymptomatic" back history.

Finally, even if Sedgwick's denial was unreasonable, it is incorrect to assess a penalty based on medical services that the claimant obtained prior to the hearing and order setting aside its denial. As the majority opinion states, claimant became substantively entitled to benefits "as of the time of the order." There is no statute that requires that an insurer pay for medical services before that time. To the contrary, ORS 656.262(6) states, in part:

> "Pending acceptance or denial of a claim, compensation payable to a claimant does not include the costs of medical benefits or burial expenses."

Because the medical benefits were not due prior to the time that the claim was ordered accepted, there were no amounts due upon which to base a penalty under ORS 656.262(10). See also OAR 436-10-100(4)(on an accepted claim, payment of medical bills is due within 60 days of receipt; billings older than 60 days become due promptly upon claim acceptance). This is the holding in Bono v. SAIF, 298 Or 405, 410-11 (1984), Eastmoreland Hospital v. Reeves, 94 Or App 698, 702 (1989) and Gene C. Dalton, 43 Van Natta 1191, 1195 (1991). The Court of Appeals' earlier 1985 decision in Whitman v. Industrial Indemnity, 73 Or App 73, adds an additional layer of interpretation to ORS 656.262(6) that was not accepted by the Supreme Court in Bono nor in the more recent Eastmoreland

Hospital case. Likewise, the Board in Dalton correctly did not accept that interpretation, and should not be disavowed.

For the above reasons, I respectfully dissent.

Chair Neidig dissenting:

Although I agree with the majority that Sedgwick's denial was unreasonable, I do not agree that there are any amounts on which to base a penalty. Therefore, I dissent.

The majority attempts to distinguish this case from the court's decision in Eastmoreland Hospital v. Reeves, 94 Or App 698 (1989) on the basis that amounts "then due" for an unreasonable denial include medical services, whereas amounts "then due" for a processing violation do not. The court in Eastmoreland did not make such a distinction. Rather, the court flatly stated:

> "'Pending acceptance or denial of a claim, compensation payable to a claimant does not include the **coststs of medical benefits * * *.' ORS 656.262(6). Therefore, the Board may assess a penalty under ORS 656.262(10) based on interim compensation, but not on medical services. Bono v. SAIF, 298 Or 405, 410-11 (1984)."

Id. at 702. (Emphasis supplied).

As we noted in Gene C. Dalton, 43 Van Natta 1191, the court's decision in Eastmoreland is in direct conflict with its earlier decision in Whitman v. Industrial Indemnity, 73 Or App 73 (1985). In Whitman, court relied on the same language in ORS 656.262(6) and based a penalty on medical services. In Dalton, we followed the court's decision in Eastmoreland inasmuch as it was the court's more recent pronouncement. Dalton at 1195, n. 2.

In sum, I am not persuaded that the present case is distinguishable from Eastmoreland. I would continue to rely on the reasoning that we previously expressed in Gene C. Dalton and find that a penalty in this instance cannot be based on medical services.

For the above reasons, I respectfully dissent.

April 24, 1992 Cite as 44 Van Natta 829 (1992)

In the Matter of the Compensation of
ARLENE J. KOITZSCH, Claimant
WCB Case No. 90-13984
ORDER DENYING RECONSIDERATION
Craine & Love, Claimant Attorneys
Pamela Schultz, Defense Attorney

The insurer requests "clarification" of our April 14, 1992 Order on Reconsideration which affirmed a Referee's order awarding claimant 34 percent (51 degrees) scheduled permanent disability for loss of use or function of the right forearm. Enclosing a copy of a February 12, 1992 letter addressed to the Board at its Portland office address, the insurer seeks clarification of the statement in our order that it did not submit a timely response to our February 6, 1992 Order of Abatement.

A document (other than a request for hearing or a request for Board review of either a referee's order or a Director's order finding no bona fide medical

services dispute) is filed when physically delivered to a permanently staffed Board office or when mailed (provided that an attorney's certificate that the document was deposited in the mail on a stated date accompanies the document). OAR 438-05-046(1)(a), (c). Here, notwithstanding the February 12, 1992 date on the insurer's response, the Board did not physically receive the response until its inclusion with the insurer's April 16, 1992 request for clarification. Inasmuch as the insurer's response was not accompanied by an attorney's certificate of mailing, we continue to adhere to our prior statement that the 10-day period for the insurer's response to our February 6, 1992 abatement order expired without Board receipt of a response.

Accordingly, the request for clarification is denied. The parties' rights of appeal shall continue to run from the date of our April 14, 1992 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANIEL R. BAKKE, Claimant
WCB Case No. 91-02523
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of that portion of Referee Knapp's order which set aside SAIF's partial denial of claimant's current epilepsy and personality disorder conditions. On review, the issue is the propriety of SAIF's partial denial which was issued prior to claim closure. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except for his "Ultimate Findings of Fact," with the following supplementation.

In December 1986, SAIF accepted a temporary exacerbation of claimant's preexisting seizure condition due to stress induced factors.

In February 1991, SAIF denied claimant's current condition "described as idiopathic epilepsy (seizure disorder) and personality disorder." Contending that "the episode we accepted has resolved," SAIF asserted that neither the accepted episode nor claimant's employment was the major contributing cause of claimant's current condition or need for treatment.

CONCLUSIONS OF LAW AND OPINION

Because claimant requested a hearing after May 1, 1990 and the hearing was convened after July 1, 1990, we analyze this matter under the workers' compensation law as amended by Oregon Laws 1990 (Special Session) effective July 1, 1990. See 1990 Oregon Laws, ch. 2, Senate Bill 1197, Sec 54 (2) (now codified at ORS Chapter 656); Ida M. Walker, 43 Van Natta 1402 (1991).

On September 5, 1986, claimant, who had a history of epilepsy (seizure disorder) and organic personality disorder, filed a claim for job stress resulting in increased seizures. (Ex. 2). SAIF subsequently accepted the claim as "a temporary exacerbation of [claimant's] preexisting seizure condition due to stress induced factors." (Ex. 2B).

Thereafter, SAIF provided medical benefits and temporary disability benefits until January 1991 when Dr. Paltrow, claimant's treating psychiatrist, opined that claimant's work-related stress induced condition had resolved. (Ex. 24). On February 22, 1991, SAIF issued a partial denial of claimant's current preexisting idiopathic epilepsy and personality disorder conditions as unrelated to the accepted condition, indicating that the accepted condition had resolved and that claimant's employment was not the major contributing cause of claimant's preexisting conditions. (Ex. 25).

The 1986 claim was closed on March 21, 1991, pursuant to a Notice of Closure, finding a medically stationary date of January 29, 1991 and awarding no permanent disability. (Ex. 29). Claimant timely requested a hearing from both the partial denial and the Notice of Closure.

Relying on Guerrero v. Stayton Canning Co., 92 Or App 209 (1988), the Referee concluded that SAIF's partial denial was impermissible because it was a preclosure denial of a related condition. We disagree.

First, we do not find the Guerrero doctrine applicable. In Guerrero, the Court of Appeals held that a partial denial of a previously accepted inseparable condition may not issue while the claim is still open. Id. at 212-213. However, the Supreme Court has cast considerable doubt on the Guerrero doctrine. In Boise Cascade Corp. v. Katzenbach, 307 Or 391, 394 (1989), the Court expressed agreement with the parties' assessment of the Guerrero doctrine as meritless, stating "[b]oth parties are clear as to the merits of the Guerrero doctrine - they agree that it has none. It may be that, if the merits of the doctrine ever are before us, someone can offer a justification for it that thus far has escaped both counsel." Even assuming that the Guerrero doctrine remains good law, we hold that SAIF's preclosure denial here was procedurally proper.

An insurer may not deny further responsibility for any condition arising from the accepted claim while the claim is in open status and before the extent of the accepted condition has been determined pursuant to the statutory procedures for claim closure. Roller v. Weyerhaeuser Co., 67 Or App 583, amplified 68 Or App 743, rev den 297 Or 601 (1984); Safstrom v. Riedel International, 65 Or App 728 (1983). However, the Supreme Court's holding in Katzenbach, supra, indicates that a preclosure partial denial is procedurally permissible where no one "authorized to do so" has found the worker's two conditions to be inseparable. Id. at 394.

In the present case, we are persuaded by the numerous opinions of Dr. Paltrow which indicate that, although claimant's preexisting condition (idiopathic epilepsy or seizure disorder) and his accepted condition (the temporary exacerbation of the seizure disorder) are related, they are not inseparable. Dr. Paltrow, who has been claimant's treating psychiatrist since 1974, opined that claimant suffered from "Psychological Factors Affecting Physical Condition" caused by work-related stress, which exacerbated his preexisting seizure disorder. (Ex. 2B, 2F, 2H, 8, 19 and 24). Additionally, on January 4, 1991, Paltrow opined that claimant's "Psychological Factors affecting Physical Condition" had resolved. (Ex. 24).

Because Dr. Paltrow consistently discusses the two conditions as separate conditions, we conclude that they are not inseparable and, therefore, SAIF's preclosure partial denial was procedurally proper. See Nola M. Chrestensen, 43 Van Natta 352 (1991). Moreover, we conclude that, even if SAIF's preclosure denial attempted to deny an inseparable condition, the denial was permissible because SAIF's prompt closure of the claim a month after the partial denial indicates that the denial was not intended to shortcut the ordinary process of claim closure. See Chaffee v. Nolt, 94 Or App 83, 85 (1988).

Second, SAIF's preclosure denial was also permissible because the scope of SAIF's 1986 acceptance of the claim was specifically limited to the "temporary exacerbation" of claimant's seizure condition. To conclude otherwise would be inconsistent with the Court's decision in Johnson v. Spectra Physics, 303 Or 49 (1987).

In Johnson, the Supreme Court held that an insurer's acceptance of a claim includes only those conditions specifically accepted in writing and that acceptance of one aspect of a claim is not acceptance of a separate aspect of the same condition. Id. at 55-56. Here, SAIF accepted only the "temporary exacerbation of [claimant's] preexisting seizure condition due to stress induced factors." (Ex. 2B). Based on this language, we conclude that the scope of SAIF's acceptance was specifically limited to the temporary exacerbation of the seizure disorder and did not include the preexisting seizure disorder itself. Consequently, SAIF's partial denial was proper. See Mark S. Hogland, 43 Van Natta 2311 (1991); Kenneth L. Orr, 43 Van Natta 1432 (1991).

Finally, we conclude that SAIF's denial was permitted by amended ORS 656.005(7)(a)(B), which provides that, a resultant condition is compensable so long as the compensable injury is and remains, the major contributing cause of claimant's resultant disability or need for medical treatment.

In Bahman M. Nazari, 43 Van Natta 2368 (1991), we determined that if a "carrier obtains evidence that a claimant's disability is not then caused in major part by the injury, but rather by the preexisting condition, the carrier may partially deny disability compensation for the then-current condition." In light of the statutory requirements for compensability of a resultant condition stemming from the combination of a compensable injury and a preexisting condition, we conclude that amended ORS 656.005(7)(a)(B) has abrogated any former prohibitions against preclosure denials in cases involving preexisting conditions wherein the compensable injury was, but is no longer, the major contributing cause of the claimant's resultant disability or need for medical treatment. Consequently, we hold that SAIF's partial denial was procedurally proper.

Turning to the merits of the denial, we find that claimant's condition presents a complex medical question and rely on expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Dr. Klecan, an examining psychiatrist, opined that claimant did not have a psychiatric disorder that was caused or aggravated by a job injury. (Ex. 21). He said that there was "no job injury" and that claimant's need for psychiatric treatment was caused by claimant's preexisting life long personality disorder. (Id). In response to Dr. Klecan's opinion, Dr. Paltrow, claimant's treating psychiatrist, opined:

> "[Claimant] did suffer with Psychological Factors Affecting Physical Condition caused by vocational/on the job stress. He did have a seizure disorder prior to the on the job injury which laid the foundation for the diagnosis of Psychological Factors. [Claimant] began the process of vocational counselling and gradually became medically stationary as a result of the vocational counselling and continued psychotherapy. He no longer suffers from Psychological Factors Affecting Physical Condition." (Ex. 24). (Emphasis in the original).

Here, the medical evidence is in agreement that claimant's current condition and need for medical treatment is not due to his work stress. Furthermore, as noted by Dr. Paltrow, claimant's long time treating psychiatrist, claimant no longer suffers from the stress attributable to his employment. Under such circumstances, we are not persuaded that claimant's 1986 compensable "temporary exacerbation" is and remains the major contributing cause of his current disability and need for medical treatment. Accordingly, we reinstate SAIF's denial.

ORDER

The Referee's order dated June 10, 1991 is reversed. The SAIF Corporation's partial denial is reinstated and upheld in its entirety. The Referee's $750 attorney fee is reversed.

In the Matter of the Compensation of
JAMES R. BARNETT, Claimant
WCB Case No. 90-20998
ORDER ON REVIEW
Parker & Bush, Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Moller and Westerband.

Claimant requests review of Referee Daron's order which: (1) upheld the insurer's denial of claimant's current contact dermatitis condition; (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial; and (3) declined to consider whether claimant had established "good cause" for his untimely hearing request. On review, the issues are good cause, compensability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

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

FINDINGS OF ULTIMATE FACT

On September 22, 1990, claimant had constructive knowledge of the denial, when unbeknownst to him, a relative received and signed on claimant's behalf at the correct address, a certified letter from the insurer notifying claimant of the denial.

Claimant did not have actual knowledge of the denial until November 27, 1990 when it was delivered to claimant's attorney in discovery materials and was shown to claimant in his attorney's office.

Claimant did not file a request for hearing on the denial within 60 days after he received constructive knowledge of the denial.

Claimant established "good cause" for failing to timely file a request for hearing.

CONCLUSION OF LAW AND OPINION

Timeliness/Good Cause

Because he decided the merits of the case against claimant, the Referee declined to reach the question of whether claimant established good cause for failing to timely file a request for hearing. The question of whether claimant established good cause is jurisdictional. Therefore, we must decide that question before we reach the merits. We conclude that claimant established good cause.

Under ORS 262.268(8) as amended by Oregon Laws 1990, Chapter 2, Secion 15, and ORS 656.319, claimant had 60 days from September 22, 1990 when he received constructive knowledge of the denial, to file a request for hearing. Thomas E. Edison, 44 Van Natta 211 (1992). Claimant did not file a request within 60 days (i.e., by November 20, 1990). Therefore, his request for hearing was untimely.

The test for determining if good cause exists has been equated to the standard of "mistake, inadvertance, surprise or excusable neglect" recognized under ORCP 71B(1) and former ORS 18.160. Anderson v. Publishers Paper Co., 78 Or App 513, 517, rev den 301 Or 666 (1986); see also Brown v. EBI Companies, 289

Or 455 (1980). Claimant has the burden of proving good cause. Cogswell v. SAIF, 71 Or App 234, 237 (1985).

Turning to the present case, claimant was in the process of moving when the insurer issued its denial. The denial was mailed on September 21, 1990. The return receipt bears a signature dated September 22, 1990. Although the return receipt on the denial bears a signature purporting to be claimant's, a cousin of claimant's actually signed the receipt. In accordance with claimant's testimony, we have found that the cousin did not give him the letter, and claimant did not have actual knowledge of the denial letter until November 27, 1990 when he was shown the denial while at his attorney's office. (Tr. 4; App. Br. at 3). However, on November 15, 1990, six days before claimant's statutory 60 days had run, his attorney requested from the insurer the status of claimant's claim and all discovery materials. (Ex. 26). On November 19, 1990, the insurer prepared the discovery materials but did not expressly respond to claimant's counsel's question about the status of claimant's claim. Furthermore, the insurer did not mail the discovery materials until a week after they were prepared, November 26, 1990 (Exs. 27, 28), and 5 days after the 60 days for requesting a hearing had run.

Thus, claimant clearly did not have actual knowledge of the denial until after the 60 days had run. We conclude that claimant has established good cause for filing a late hearing request. International Paper Co. v. Cress, 104 Or App 496, 497 (1990).

Compensability

We turn to the merits of claimant's claim. The Referee concluded that claimant's June 1990 outbreak of contact dermatitis was not compensable. We disagree.

The Referee analyzed this case as a claim for aggravation. However, as noted by the Referee, claimant's July 1990 symptomatic outbreak occurred prior to closure of his claim. Accordingly, we do not analyze his claim as an aggravation, but rather as a partial denial of the July 1990 outbreak. In this regard, ORS 656.005(7)(a)(A) provides, in relevant part, that "[n]o injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition." 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 conditions that arise from conditions previously deemed compensable, as opposed to conditions that allegedly arose 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.

Here, Dr. Datloff, claimant's treating physician, has persuasively reported that:

> "The original injury was the development of this allergic contact dermatitis. It is for this reason that his future allergic bouts from contact with metal would be related to the original development of allergies while working at [his employer]."

We conclude that claimant's July 1990 symptomatic outbreak is intrinsically related to the underlying compensable event which resulted in the development of claimant's allergic contact dermatitis. Accordingly, the July 1990 outbreak is properly characterized as a primary consequence of his initial February 1990 development of allergic contact dermatitis. Therefore, in order to

establish compensability, claimant need show that the February 1990 compensable event was a material contributing cause of his July 1990 outbreak requiring medical services. However, we further conclude that, even if the July 1990 condition were considered a secondary consequential condition, claimant has nonetheless established that the original event is the major cause of the July 1990 condition.

We generally defer to the opinion of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 65 Or App 810 (1983). Here, we find persuasive reasons to defer to the opinions of Dr. Datloff, claimant's treating physician.

As previously noted, Dr. Datloff reported that claimant suffered from allergic contact dermatitis. He characterized this condition as a sensitivity to cobalt chloride and nickel sulphate while working for the employer at a steel mill. Dr. Datloff opined that:

> "All subsequent breakouts of allergic contact dermatitis to nickel and cobalt would be connected to the original injury. It is the original sensitization to nickel and cobalt in February of 1990 that is the major contributor of resulting flare-ups. If [claimant] did not have the original exposure and developed allergic contact dermatitis, then he would not have had a flare-up in July of 1990. It is probable that future contact with nickel and cobalt will cause similar exacerbations. Therefore, the original exposure from February of 1990 is the major contributor to [claimant's] sensitivity to nickel and cobalt." (Ex. 30-1).

It is clear from Dr. Datloff's reports that, having contracted the allergic dermatitis condition at the workplace, claimant will now break out in a rash somewhere on his body (not necessarily or always in the same place) when he comes into contact with the offending metals. (Ex. 20). Thus, the flareups are in the nature of symptoms of the underlying allergic disorder.

We find Dr. Datloff's opinion complete and well-reasoned. Consequently, we find it persuasive. Somers v. SAIF, 77 Or App 259 (1986).

Therefore, under these circumstances, we find that claimant's initial compensable event was the major contributing cause of his July 1990 symptomatic outbreak. Accordingly, we conclude that claimant has established compensability of his claim as either a primary or secondary consequence of his compensable claim.

Penalties

Having decided the merits against claimant, the Referee did not reach the question of penalties for an allegedly unreasonable denial. We address the issue.

A penalty may be assessed under 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 the denial. Brown v. Argonaut Ins. 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 Ins. Co., supra.

Here, claimant no longer worked for the employer when, in July 1990, he had the outbreak in question. The insurer issued its September 21, 1990 denial

based on a report from Dr. Datloff in which he mentioned claimant having a new outbreak while working at a steel mill. Further, the insurer had knowledge that claimant had not been working for its insured since April 1990. Moreover, the insurer's claims examiner spoke with claimant on the telephone on August 10, 1990. The claims examiner testified that claimant informed her that "he was working for his dad in the steel mill for only a couple of days before he broke out again." (Tr. 90). Claimant and his wife denied that he made such a statement. However, the claims examiner made a note to that effect in her computer the day of the conversation. We conclude that her contemporaneous note is more reliable than the after-the-fact recollections of claimant and his wife. The claims examiner also testified that claimant would not tell her who he had been working for because he felt this new employer was not responsible for his condition. (Tr. 72).

The insurer's subsequent denial stated that it was the insurer's belief that claimant's current condition was the responsibility of the undisclosed employer noted both in Dr. Datloff's July 24, 1990 report as well as the claims examiner's August 10, 1990 conversation with claimant. Based on this information, the insurer believed that claimant's injury did not arise from his employment with its insured.

Dr. Datloff's reports clearly implicated claimant's original compensable claim as a significant causative factor in the July 1990 outbreak. Therefore, those reports supported compensability of the condition. However, in light of the information available to the insurer through its investigation of the claim, an issue of legal responsibility for the claim remained unresolved. Under such circumstances, we conclude that the insurer had a legitimate doubt as to its responsibility concerning claimant's current condition. Thus, the insurer's denial was not unreasonable. See Agripac v. Zimmerman, 97 Or App 512 (1989).

For finally prevailing on the issue of compensability, claimant's counsel is entitled to an assessed attorney fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $3,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 19, 1991 is reversed in part and affirmed in part. That portion of the Referee's order that upheld the insurer's denial is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review concerning the compensability issue, claimant's counsel is awarded $3,500, to be paid by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
DONALD K. BREEN, Claimant
WCB Case Nos. 90-02683, 89-26201, 90-02682, 90-02496 & 90-02497
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
VavRosky, et al., Defense Attorneys
Bottini, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Alexsis Risk Management, on behalf of Fred Meyer, Inc., requests review of that portion of Arbitrator Leahy's order on remand that: (1) set aside its denial of claimant's "new injury" claim for a back condition; and (2) upheld SAFECO Insurance Company's denial, issued on behalf of Beaverton Volkswagen, of claimant's aggravation claim for the same condition. In its respondent's brief, SAFECO moves to remand for admission of additional evidence. On review, the issues are remand and responsibility. We affirm.

We review the Arbitrator's order solely on questions of law. ORS 656.307(2); Timothy R. Schroeder, 41 Van Natta 568 (1989). We, therefore, accept the Arbitrator's Findings of Fact.

Remand

Following the Arbitrator's order on remand, SAFECO has renewed its motion for remand for the admission of medical reports generated after the date of hearing. SAFECO contends that, because the report references a diagnosis obtained after the hearing, such records could not have been obtained prior to hearing.

We conclude that SAFECO has failed to establish that the records at issue could not have been developed or produced prior to hearing. SAFECO has not argued that it was somehow precluded from obtaining such medical reports before the hearing or that medical reports obtained at the time of hearing would not have contained similar information. Under the circumstances, we do not find that the record has been inadequately or inappropriately developed. SAFECO's motion for remand is denied.

Responsibility

On remand, the Arbitrator concluded that, because SAFECO accepted responsibility for claimant's prior back injury, the burden was on SAFECO to establish that the second injury with Alexsis' insured had contributed to the worsening of claimant's underlying condition. The Arbitrator further concluded that SAFECO had successfully established that claimant's condition pathologically worsened as a result of his employment with Alexsis' insured. (This case is subject to the law in existence prior to July 1, 1990).

On review, Alexsis argues that claimant's October 17, 1989 injury with its insured resulted in only a recurrence of symptoms, rather than a worsening of claimant's underlying condition.

We conclude that Alexsis' dispute is with the Arbitrator's finding that the second injury resulted in a pathological worsening of claimant's condition. Our review in this case, however, is limited to questions of law. We do not review the Arbitrator's findings. ORS 656.307(2); Liberty Northwest Insurance Corp. v. Oregon Steel Mills, 105 Or App 547 (1991); John L. Riggs III, 42 Van Natta 2816, 2877 (1990). Accordingly, the Arbitrator's order is affirmed.

ORDER

The Arbitrator's order dated August 13, 1991 is affirmed.

April 27, 1992 Cite as 44 Van Natta 839 (1992)

In the Matter of the Compensation of
RANDY G. HETTWER, Claimant
WCB Case Nos. 89-22645, 90-14277, 90-14278, 90-14279, 90-14280 & 90-05934
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Universal Underwriters requests review of that portion of Referee Livesley's order which set aside its denial of claimant's "new injury" claim for an upper back and neck condition and upheld Aetna's denials of claimant's aggravation claim for the same condition. Claimant cross-requests review of that portion of the order which upheld Aetna's denial of claimant's medical services claim for a low back condition. On review, the issues are responsibility and medical services. We reverse in part and affirm in part.

FINDINGS OF FACT

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

Aetna, on behalf of Americo U-Haul, issued denials of claimant's aggravation claim on November 1, 1989, and January 17, 1990. Universal Underwriters, on behalf of Holloman Ford, denied claimant's "new injury" claim on April 20, 1990. Claimant filed requests for hearing concerning all of the denials before May 1, 1990. A hearing was convened and continued on June 25, 1990.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

We first note that this case comes under the law before the enactment of the 1990 Act. Claimant filed his requests for hearing before May 1, 1990. A hearing was convened before July 1, 1990. The new law therefore does not retroactively apply to this claim. See Or Laws 1990 (Special Session), ch 2, 54; John K. French, 43 Van Natta 836 (1991).

Responsibility

The Referee concluded that responsibility for claimant's condition shifted to the subsequent employer, Holloman Ford, finding that the initial employer, Americo U-Haul, had proved that claimant's work at Holloman Ford had independently contributed to a worsening of claimant's degenerative disc disease. Universal Underwriters, on behalf of Holloman Ford, challenges the Referee's conclusion, arguing that Aetna, on behalf of Americo-U-Haul, did not satisfy its burden for shifting responsibility to a subsequent employer. We agree.

Under Linda L. Wise, 42 Van Natta 115, 116-17 (1990), when a case involved an accepted compensable injury or occupational disease followed by an increase in disability during or after employment with a later employer, responsibility was fixed with the employer which accepted the claim. In order to shift

responsibility, the original employer had to prove affirmatively that a later employment independently contributed, even slightly, to a pathological worsening of the accepted condition. Id. at 117.

The record in this case is a very difficult one in determining whether Aetna successfully carried its burden for shifting responsibility to Universal. The medical evidence establishes that claimant's condition, which includes a degenerative disc disease, has pathologically worsened since beginning his current employment. (Exs. 31, 41-15, 42-9). In regards to whether claimant's current employment independently contributed to the worsening, the record contains opinions from three sources: Dr. Tutak, D.C., who has treated claimant since 1988; Dr. Schachner, orthopedist, who saw claimant several times on referral from Dr. Tutak; and Dr. Duncan, D.C., who evaluated claimant once for an independent medical examination.

Dr. Duncan found that claimant's "degenerative joint disease" was "aggravated by contemporary activities." (Ex. 32-4). Duncan further reported that, "[b]ecause of his degenerative condition, [claimant] has a compromised neck and undoubtedly will continue to experience similar complaints with periodic flareups secondary to increased activities or compromised postures, either on or off of the job." (Id. at 4-5).

Tutak initially reported that "it is medically probable that the patients [sic] current employment could possibly contribute to his present condition. This case as with any other injury of this nature and region of the trauma any activity requiring even slight stress can cause re-exaserbation [sic] of presently dormant symptoms." (Ex. 31).

During her deposition, Tutak stated that she "could not say" whether claimant's work activities at Holloman Ford independently contributed to the worsening of claimant's condition. (Exs. 42-13, 42-21). Tutak agreed that, as a general rule, heavy work would worsen claimant's condition. (Id. at 45). However, in this case, Tutak found that claimant experienced symptoms whether sedentary or working. (Id. at 22, 25). Tutak found this "baffling" because, contrary to the general rule, it indicated that claimant was worsening even when not working. (Id. at 44). In response to questions by Aetna's counsel, however, Tutak agreed that claimant's work as a mechanic would have contributed to a worsening of claimant's condition, although she could not state to what extent. (Id. at 31-32).

Dr. Schachner also was deposed. He initially agreed that there was no evidence demonstrating that employment conditions at Holloman Ford independently contributed to the worsening of claimant's condition. (Ex. 41-10). When questioned by counsel for Aetna, however, Schachner stated that claimant's work as an automobile mechanic "might accelerate the [worsening] process." (Id. at 12). He also agreed that any utilization by claimant of his neck and upper back would contribute to the degenerative process. (Id. at 13). Counsel further questioned Schachner:

> "Q: Doctor, is it your testimony that his work activities then for Holloman Ford, assuming that they used the neck and he had to get in awkward positions and assuming that he relates his flare-up of pains as working as an automobile mechanic -- then that's going to add to his degenerative condition? Is that right?
>
> "A: Yes.
>
> "Q: And if he had a flare-up of pain and symptoms such that it becomes disabling pain and that he can't work because of that,

that increase in whatever activity caused that is also adding to the degenerative condition?

"A: The answer to your question is yes. * * * [However], I would make the opinion that what contribution he has referrable to his work has not been a significant contribution.

"* * * * *

"Q: * * * And the most significant factor obviously is time, as you say, and his general activity with his neck. But as well as the outside activities, his work at Holloman Ford did contribute to the condition however slightly?

"A: Okay. Yes."

(Id. at 14-16). Later, Schachner responded to a question as to whether work activities could or did contribute to the worsening by stating that such activities could contribute. (Id. at 28).

Although the opinions of Tutak and Schachner display some inconsistencies, we find them sufficient to demonstrate that claimant's work activities at Holloman Ford did not independently contribute to the worsening of claimant's condition. Dr. Schachner agrees that work at Holloman Ford contributed to claimant's condition only when assuming certain facts about claimant's job conditions and history. However, when Schachner was simply asked the same question without making such assumptions, he could only state that his work activities could contribute to the worsening, thus demonstrating that, when Schachner based his opinion on his own knowledge of claimant's history, he could not definitely relate the work activities to the worsening. We therefore conclude that the latter opinion is the more accurate one.

We further conclude that Tutak also essentially only opined that claimant's employment conditions at Holloman Ford could have contributed to the worsening. She stated that claimant's work worsened his condition in the context that any neck activity would cause deterioration. Moreover, Tutak explained why she could not relate claimant's worsened condition with work, since claimant experienced symptoms whether sedentary or not. Furthermore, we note the remaining opinion by Dr. Duncan stated only that claimant's condition was "aggravated" by current activities.

Consequently, we find that Aetna failed to prove that work activities with Universal's insured, Holloman Ford, independently contributed to the worsening of claimant's condition. Therefore, responsibility for claimant's condition remains with Aetna.

Finally, we note that claimant's counsel is not entitled to an award for services on review. First, because claimant did not initiate review, an attorney fee award is not authorized under ORS 656.386(1). Furthermore, because only responsibility was litigated at hearing and determined by the Referee, claimant's right to compensation was not at risk of disallowance. Claimant also does not allege, nor does the record establish, that his compensation is at risk of reduction. Therefore, claimant is not entitled to a carrier-paid fee for services rendered on review pursuant to ORS 656.382(2). See Riley E. Lott, Jr., 43 Van Natta 209, 212 (1991).

Medical Services

Although claimant concedes that his low back condition is not compensable, he contends that treatment for his low back pain is compensable under

Fitzpatrick v. Freightliner Corp., 67 Or App 450 (1984). In that case, medical treatment was rendered for the claimant's compensable and noncompensable conditions. The court determined that, because claimant's noncompensable condition was benefitted "by using procedures that are inseparable from those that benefitted her compensable conditions does not render the entire treatment non-compensable." Id. at 452. Claimant argues that, like the claimant in Fitzpatrick, Dr. Tutak's treatment for his low back pain was inseparable from her treatment of his compensable neck and upper back condition. We disagree.

Dr. Tutak indicated that her treatments were for claimant's degenerative disease condition and for a myofascial condition, as well as low back pain. Tutak stated that she had billed for treatment of low back pain, "[b]ecause I treated the whole thing, you know. When I treat, I treat everything." (Ex. 42-58). In response to whether treatment for claimant's cervical and upper back benefitted his low back, she answered in the affirmative, adding that "I've never just treated for the cervical, upper back and not treated the low back when he's come in and just said, 'Oh, well.' I've always treated it as a holistic." (Id).

We are not convinced that such testimony demonstrates that treatment for the compensable condition was inseparable from treatment for the noncompensable condition. Rather, we find that her testimony proves that, for efficiency sake, Tutak treats every condition on the occasions when she sees a patient. We therefore conclude that Fitzpatrick is not applicable and that treatment for low back pain is not compensable.

ORDER

The Referee's order dated April 29, 1991 is reversed in part and affirmed in part. That portion of the order shifting responsibility for claimant's condition from Aetna to Universal Underwriters is reversed. We conclude that responsibility remains with Aetna and therefore we set aside its November 1, 1989 and January 17, 1990 denials but reinstate and uphold the April 20, 1990 denial by Universal Underwriters Group. Aetna is responsible for the Referee's $2,500 attorney fee award. The remainder of order is affirmed.

In the Matter of the Compensation of
DARWIN E. HOLBROOK, JR., Claimant
WCB Case No. 91-02042
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Daryl Nelson, Defense Attorney

Reviewed by Board Members Westerband and Moller.

Claimant requests review of Referee Livesley's order that upheld the insurer's denial of claimant's low back injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction. The alleged work injury occurred on October 31, 1990.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's reasoning and conclusions regarding the issue of compensability with the following supplementation.

Claimant argues that the compensability of his low back injury does not present a complex medical question. Therefore, he argues, medical evidence relating to causation is not necessary in his case. Relying on Uris v. Compensation Department, 247 Or 420 (1967), he asserts that his testimony establishes the compensability of his claim. We disagree.

We find Uris distinguishable on the facts. In Uris, the claimant, who had had no trouble with his back since he was 13 or 14 years old, reached out to prevent a cartload of books from tipping over and immediately felt a sharp pain in his back. The facts in Uris present no other possible cause of the back pain.

Here, claimant awoke with a sore back on the morning that the alleged work injury occurred. This soreness was caused by increased training, including weight lifting, in preparation for a karate competition. After some stretching exercises, claimant felt better and went to work. After working at loading a truck for about half an hour, claimant began to notice low back pain which increased until claimant was no longer able to work.

We find that the cause of claimant's back condition presents a complex medical question given: (1) the proximity of the weight lifting activity and the onset of back pain at work the next day with no specific incident occurring at work; and (2) the fact that claimant had back pain prior to going to work that morning.

Furthermore, we decline to infer a causal relationship between claimant's back injury and his work activity based solely on a temporal relationship. Allie v. SAIF, 79 Or App 284 (1986).

ORDER

The Referee's order dated June 25, 1991 is affirmed.

In the Matter of the Compensation of
DOUGLAS K. JOHNSON, Claimant
WCB Case No. 90-19139
ORDER ON REVIEW
William H. Skalak, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of Referee Otto's order that: (1) set aside its partial denial of claimant's medical services claim for certain prescriptions; and (2) set aside its partial denial of claimant's claim for diagnostic medical services. Claimant cross-requests review of that portion of the order that declined to find that the insurer's notification letter regarding palliative care constituted a denial. On review, the issues are jurisdiction and medical services. We vacate in part, modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

April 19, 1991 denial of prescription medications

On April 19, 1991, the insurer issued a partial denial of claimant's medical services claim for reimbursement of prescription medications for treatment of a 1987 compensable back injury. The insurer contended that the treatment was palliative care, which was no longer compensable following the 1990 amendments to the Workers' Compensation Law. (Ex. 20A). Claimant filed a request for hearing challenging the denial. The Referee set aside the partial denial, finding that the prescription medications were required to maintain claimant in a medically stationary condition within the meaning of ORS 656.245(1)(b). We vacate this portion of the Referee's decision for lack of jurisdiction.

On May 7, 1990, the Oregon Legislature passed Senate Bill 1197, an extensive revision of the Workers' Compensation Law. Or Laws 1990 (Special Session), ch. 2. Because a hearing was convened after July 1, 1990, this matter is properly analyzed under those revisions. Or Laws 1990 (Special Session), ch. 2, 54; Ida M. Walker, 43 Van Natta 1402 (1991).

Subsequent to the Referee's decision, we issued Robert D. Cox, 43 Van Natta 2726 (1991), wherein we held that pursuant to amended ORS 656.245 and amended ORS 656.327, the Hearings Division no longer has original jurisdiction to decide issues regarding entitlement to palliative care.

Here, the insurer's denial was based on its characterization of the prescription medications as noncompensable palliative care. Claimant argued that the treatment came within the exception to noncompensable palliative care; that is, it was "necessary to monitor administration of prescription medication required to maintain the worker in a medically stationary condition. . ." ORS 656.245(1)(b). The Referee also analyzed the issue as involving entitlement to palliative care, finding that the prescription medication was required to maintain claimant in a medically stationary condition.

After our review of the record, we find that the April 19, 1991 partial denial involves entitlement to palliative care pursuant to ORS 656.245(1)(b). Accordingly, we hold that the Referee did not have jurisdiction to consider the issue. Robert D. Cox, supra. Original jurisdiction over such a dispute lies exclusively with the Director. To have the matter considered, claimant's attending physician may request approval from the Director for the treatment pursuant to the Director's rules on the subject. ORS 656.245(1)(b).

Consequently, we vacate the Referee's decision to the extent that it purports to set aside the April 19, 1991 denial and award an attorney fee for prevailing against the denial.

February 14, 1991 denial of medical services

On February 14, 1991, the insurer issued a partial denial of emergency medical services rendered on October 22, 1990, including a CT scan. (Ex. 16). The Referee found that the CT scan was compensable. On review, the insurer argues that the medical services were not related to claimant's compensable back strain, but were due to a "new injury" sustained on October 22, 1990. We find that the denial of February 14, 1991 raises the issue of whether the medical services were compensably related to claimant's accepted 1987 back strain.

As a preliminary matter, we find that the Referee had jurisdiction to decide this matter. Subsequent to the Referee's order, we held that there is no other procedure provided by ORS Chapter 656 for resolving disputes concerning

the causal relationship between an injury and a need for medical services. Michael A. Jaquay, 44 Van Natta 173 (1992). Accordingly, where a denial is based on the ground that the need for medical services is not causally related to the compensable injury, the Board has jurisdiction. Jaquay, supra.

After our review of the record, we affirm and adopt the Referee's finding that the disputed medical services, including the diagnostic CT scan, were related to claimant's 1987 compensable back strain.

September 7, 1990 notification regarding palliative care

We affirm and adopt the Referee's finding that the insurer's notification letter (Ex. 9) did not constitute a "de facto" or prospective denial of palliative care.

Attorney fees

For claimant's counsel's services at hearing in prevailing against two denials, the Referee awarded an assessed attorney fee of $2,200. We vacated the Referee's order with respect to the April 19, 1991 denial of prescription medications, but affirmed the order with respect to the February 14, 1991 denial of medical services. Accordingly, claimant is entitled to an assessed attorney fee award for his counsel's services at hearing in prevailing against only one denial. ORS 656.386(1). Therefore, we modify the Referee's order with respect to the attorney fee award.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing concerning the February 14, 1991 denial is $1,400, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record and statement of services), the complexity of the issue, and the value of the interest involved.

Because the insurer requested review and we did not disallow or reduce claimant's compensation with respect to the February 14, 1991 partial denial of medical services, claimant is entitled to an assessed attorney fee for his counsel's services on review regarding this issue. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 20, 1991 is vacated in part, modified in part, and affirmed in part. That portion of the Referee's order that set aside the insurer's April 19, 1991 partial denial of medical services (prescriptions) is vacated. In lieu of the Referee's $2,200 attorney fee award, for services at hearing for prevailing against the February 14, 1991 partial denial of medical services, and for services on Board review concerning that issue, claimant's counsel is awarded a total assessed attorney fee of $1,900, payable by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
DOLORES J. LEE, Claimant
WCB Case Nos. 90-07915 & 90-19176
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Garrett, et al., Defense Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of those portions of Referee McWilliams' order that: (1) set aside its partial denial of claimant's "new injury" claim for a cervical condition insofar as it denied compensability of that condition; and (2) upheld St. Paul Fire and Marine Insurance Company's partial denial of claimant's aggravation claim for the same condition. Claimant cross-requests review of those portions of the order that: (1) upheld SAIF's partial denial of claimant's low back injury claim; (2) set aside as prospective, SAIF's partial denial of claimant's alleged medical services claim for cervical and low back surgeries; and (3) declined to assess attorney fees for SAIF and St. Paul's allegedly unreasonable failure to timely accept or deny claimant's requests for surgery. On review, the issues are compensability, responsibility, timeliness of medical services denials, and attorney fees.

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

Claimant does not dispute that, because her compensable low back injury has combined with her preexisting degenerative disc disease, she must prove that her injury is the major contributing cause of her resulting disabling low back condition or need for medical treatment. See ORS 656.005(7)(a)(B); Bahman M. Nazari, 43 Van Natta 2368 (1991)(an injury is compensable if it was sustained in the course and scope of employment and it was a material contributing cause of claimant's disability and need for medical services; however, one who also suffers from a preexisting condition or disease that combines to cause or prolong disability or need for treatment, will be compensated for disability and treatment only if the compensable injury is the major contributing cause of that disability or need for particular treatment). On review, claimant suggests that the Referee placed an additional burden on her beyond that required by the statute, by requiring proof that she suffered a "'hard' neurological injury" such as a fracture or rupture of a disc.

We do not read the Referee's order as imposing any such attenuated burden of proof. Instead, we find the Referee merely enumerated some of the findings upon which Dr. Baker relied in concluding that claimant's low back injury caused only a temporary symptomatic worsening of her preexisting condition, and that claimant's current disability and need for treatment are the result of her preexisting degenerative disc and joint disease.

The Referee found that claimant's injury while working for SAIF's insured was the major contributing cause of claimant's resulting disability and need for treatment, and that therefore, responsibility for the condition shifted from St. Paul to SAIF. St. Paul, as the insurer for claimant's accepted cervical condition, agrees with the Referee's ultimate conclusion, but contends that in order to shift responsibility for claimant's current condition to SAIF, St. Paul need only prove that claimant sustained a new cervical injury during employment with SAIF's insured. Relying on ORS 656.005(7)(a) and Mark N. Weidle, 43 Van Natta 855 (1991), St. Paul argues that compensability of a new injury is established if the injury was a material contributing cause of the disability or need for treatment. Thus, if material contribution is shown, the first carrier is

relieved of responsibility. See Oregon Laws 1990 (Special Session), chapter 2, section 49(1) (codified ORS 656.308).

We agree with St. Paul's contention. As we recently held in Rosalie Drews, 44 Van Natta 26 (1992), ORS 656.005(7)(a)(B) is not applicable in the responsibility context. We reasoned that ORS 656.005(7)(a)(B) does not determine compensability of the initial injury, but rather limits a carrier's liability for continuing disability or medical services. See also Bahman M. Nazari, supra. Only after initial compensability has been favorably decided do we inquire whether because of a preexisting condition, the liability of the responsible carrier for continued disability or medical services is limited under ORS 656.005(7)(a)(B).

Thus, in the case at bar, to shift responsibility to SAIF, it is not St. Paul's burden to establish that claimant's injury while working for SAIF's insured was the major contributing cause of claimant's condition. St. Paul's burden went no further than proving material contributing causation in order to establish the occurrence of a "new compensable injury" while claimant worked for SAIF's insured.

The Referee concluded, and we agree, that the evidence establishes that claimant's injury while working for SAIF's insured was the major contributing cause of claimant's disability and need for treatment. It necessarily follows, therefore, that St. Paul proved a new compensable injury under the less burdensome material contributing cause test to shift responsibility for claimant's condition to SAIF.

Although claimant did not prevail on her cross-request for review, because SAIF initiated the request for 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 a reasonable fee for claimant's counsel's services on review concerning the compensability of claimant's cervical condition is $800, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 12, 1991 is affirmed. For services on review concerning the compensability of claimant's cervical condition, claimant's counsel is awarded an assessed attorney fee of $800, payable by the SAIF Corporation.

In the Matter of the Compensation of
CHESTER S. OSTROWSKI, Claimant
WCB Case No. 90-18875
ORDER ON REVIEW (REMANDING)
Foss, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Livesley's order that: (1) declined to admit two medical reports (Exhibits 36 and 37) into evidence as untimely; (2) declined to admit claim processing records (Exhibit 38) as irrelevant; (3) upheld the self-insured employer's denial of claimant's aggravation claim for a back condition; and (4) awarded claimant 10 percent (32 degrees) unscheduled permanent disability for a back injury, whereas a Notice of Closure had awarded no permanent disability. The employer cross-requests review, seeking reduction or elimination of the permanent disability award. On review, the issues are the Referee's evidentiary ruling, aggravation and extent of unscheduled permanent disability. We remand.

FINDINGS OF FACT

Five days before his January 29, 1991 hearing, claimant retained new counsel.

At the January 29, 1991 hearing, claimant sought to submit two exhibits, which were marked as Exhibits 36 and 37. The exhibits were reports by Dr. Crocker, claimant's treating physician. Claimant's new counsel obtained Exhibits 36 and 37 from Dr. Crocker on January 28, 1991. Exhibit 36 was disclosed to the employer on January 28, 1991 and Exhibit 37 was disclosed at hearing on January 29, 1991.

At hearing, claimant also sought to introduce the employer's time loss payment record showing the temporary total disability benefits paid to claimant between September 18, 1990, the date the employer alleged it received notice of claimant's inability to work, and December 19, 1990, the date the employer denied claimant's aggravation claim. It was marked as Exhibit 38.

CONCLUSIONS OF LAW AND OPINION

First, claimant objects to the Referee's exclusion, based on relevancy, of Exhibit 38, the employer's time loss payment record. Claimant argues that the time loss payment record should have been admitted because it is germane to proof of claimant's aggravation claim.

We review the Referee's evidentiary ruling for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991). Under ORS 656.283(7), a hearings officer is not bound by common law or statutory rules of evidence, or by technical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice. Thus, the Referee here had a measure of discretion in determining whether the evidence in question should be admitted. Nonetheless, the purpose of the flexibility given referees is to allow consideration of relevant evidence that a reasonable person might rely on in conducting his most important affairs, even though such evidence would not be admissible in court. See Lucke v. Workers' Compensation Department, 254 Or 439 (1969); see also ORS 183.450(1).

In this case, the employer's time loss payment record was offered twice by claimant. Initially, it was offered to establish the amount of compensation

upon which to base a penalty in relation to the employer's allegedly improper December denial. (Tr. 37). The employer objected to consideration of that issue because it was not previously raised. (Tr. 37-38). Claimant agreed that a penalty issue had not been raised, but nonetheless offered Exhibit 38 for the record. (Tr. 39). The Referee ruled that Exhibit 38 was not relevant and excluded it. (Tr. 41).

On review, claimant contends that the exhibit is relevant to a determination of claimant's aggravation claim in that it provides some evidence as to whether he "was indeed taken off work." Inasmuch as the question of whether claimant's condition worsened since the last award of compensation is essentially a medical question, we are skeptical of the relevance of the employer's time loss payment records to the resolution of the aggravation issue. Moreover, a carrier's payment of compensation does not constitute acceptance of a claim. ORS 656.262(9). Under such circumstances, we agree with the Referee's assessment that the records were irrelevant to the aggravation issue. In any event, we conclude that the Referee did not abuse his discretion in excluding the exhibit.

Second, claimant also objects to the Referee's exclusion of Exhibits 36 and 37, two reports by Dr. Crocker. Claimant argues that the Referee erred in excluding Exhibits 36 and 37 because OAR 438-07-015 requires their admission since they were disclosed within seven days of their receipt by claimant's counsel. We agree.

OAR 438-07-018(2) requires claimant to submit his exhibits 10 days before the hearing. However, nothing in the rules preclude admission of other documents provided they have been timely disclosed. Oliver F. Coon, 42 Van Natta 1845 (1990).

Additionally, OAR 438-07-015 requires the parties to disclose claims documents within 15 days of initial request and to disclose subsequently obtained documents within 7 days of receipt. OAR 438-07-018(4) vests the Referee with discretion to exclude documents not disclosed within the time prescribed by OAR 438-07-015 if there is prejudice to the other party. See also OAR 438-07-015(5). The rule does not, however, vest the Referee with discretion to exclude timely-disclosed documents because the documents could have been obtained at an earlier time. Walter L. Eggleston, 43 Van Natta 43 (1991); Oliver F. Coon, supra; Sabeth Sok, 42 Van Natta 2791 (1990); T. S. Nacoste, 42 Van Natta 1855 (1990). Where, as here, medical reports are produced within 7 days of receipt as required by the rule, but the other party is put at a disadvantage by the delay in obtaining the report, the Referee may continue the hearing to allow post-hearing cross-examination and/or rebuttal. The Referee may not simply exclude the reports. Oliver F. Coon, supra.

In the present case, Dr. Crocker's reports were obtained on or about January 28, 1991. They were timely disclosed on January 28 and 29, 1991 and should have been admitted.

Consequently, because we find that Exhibits 36 and 37 should have been admitted into evidence, we remand the case to the Referee for consideration of this evidence. In addition, the Referee shall allow the employer the opportunity to cross-examine or rebut this evidence. The proceeding to carry out this directive shall be conducted by the Referee in any manner that will achieve substantial justice. Upon admission of the aforementioned additional evidence, the Referee shall close the record and issue a final appealable order.

ORDER

The Referee's order dated June 28, 1991 is vacated and the case is remanded to Referee Livesley for further proceedings consistent with this order.

In the Matter of the Compensation of
RONNIE D. RATLIFF, Claimant
WCB Case No. 90-19350
ORDER ON REVIEW
Ainsworth, et al., Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Mongrain's order that upheld the SAIF Corporation's denial of his low back injury claim. In his brief, claimant contends that the Referee abused his discretion by admitting Exhibits 38, 39, and 40 into evidence. 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.

A hearing was convened in Medford on January 17, 1991 and continued. Neither party objected to this continuance. On April 24, 1991, the hearing was reconvened in Medford. At this reconvened hearing, SAIF submitted new evidence including reports from Dr. Versteeg, treating orthopedic surgeon, and Drs. Brooks and Baker, who performed an independent record review. (Exs. 38, 39, 40). Over claimant's objection, the Referee admitted these exhibits and offered to continue the hearing so that claimant could submit rebuttal evidence or cross-examine the authors of these reports. (Tr. 10). Claimant declined this offer and chose to argue on those exhibits. (Tr. 64).

Claimant requested that the Referee reconsider his ruling concerning the admission of SAIF's Exhibits 38, 39, and 40. The Referee denied this request.

CONCLUSIONS OF LAW AND OPINION

Evidence

On review, claimant argues that Exhibits 38, 39, and 40 should be expunged from the record because the January 17, 1991 hearing was continued for the sole purpose of allowing SAIF an opportunity to depose Dr. Dunn, examining neurosurgeon. However, SAIF decided not to depose Dr. Dunn and submitted new evidence instead. Claimant contends that he was prejudiced in that he, too, could have submitted new evidence if not for his understanding that the continuance was limited to allowing SAIF to depose Dr. Dunn.

The Referee found that he had not limited the additional evidence to be admitted at the reconvened hearing to the deposition of Dr. Dunn. (Tr. #2, p. 9). We agree.

On January 17, 1991, the Referee and the parties convened the hearing for the sole purpose of "continuing" it. (Tr. #1, p. 1). During this January 1991

proceeding, no evidence was admitted, no testimony was taken, and no arguments were made. Neither party objected to this delay. On April 24, 1991, the hearing was reconvened and, over claimant's objection, the Referee admitted Exhibits 38, 39, and 40. Also during this reconvened hearing, claimant and his wife testified and the Referee admitted Exhibits 1 through 37.

ORS 656.283(7) sets the standard by which evidence is admitted in workers' compensation hearings. The statute specifically states that "the referee is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice." Referees have great discretion to allow and deny admission of evidence at hearing. Shirlene E. Volcay, 42 Van Natta 2773 (1990).

Furthermore, assuming that claimant was prejudiced by the submission of Exhibits 38, 39, and 40, the Referee cured any prejudice by offering to further continue the hearing so that claimant could submit rebuttal evidence or cross-examine the authors of these reports. (Tr. #2, p. 10). See Thomas B. Ward, 35 Van Natta 1552 (1983). Claimant declined this offer and chose to argue on those Exhibits. (Tr. #2, p. 64).

Under these circumstances, we conclude that the Referee did not abuse his discretion in admitting Exhibits 38, 39, and 40.

Compensability

We adopt the Referee's reasoning and conclusion on the issue of compensability of claimant's low back condition.

ORDER

The Referee's order dated May 30, 1991 is affirmed.

April 27, 1992 Cite as 44 Van Natta 851 (1992)

In the Matter of the Compensation of
HAROLD F. SCHULTZ, Claimant
Own Motion No. 92-0009M
OWN MOTION ORDER OF ABATEMENT
Margaret M. Maginnis, Claimant Attorney

Claimant requests reconsideration of our March 27, 1992 Own Motion Order in the above-captioned case.

In order to allow sufficient time to consider the motion for reconsideration, we abate our March 27, 1992 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ELIZABETH A. HALLYBURTON, Claimant
WCB Case No. 89-10381
ORDER ON REMAND
Leo & Horton, Claimant Attorneys
Paul G. Mackey, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Multnomah County v. Hallyburton, 108 Or App 777 (1991). The court reversed our prior order, Elizabeth A. Hallyburton, 42 Van Natta 2430 (1990), which found claimant's occupational disease claim for a mental disorder compensable because she had established, by clear and convincing evidence, that her work activities were a material contributing cause of her psychological condition. Citing City of Portland v. Payne, 108 Or App 771 (1991), the court has remanded for reconsideration.

FINDINGS OF FACT

We republish the "Findings of Fact" and "Ultimate Finding of Fact" contained in our October 25, 1990 order with one exception. We do not find that there is clear and convincing evidence that claimant's mental disorder arose out of and in the course of her employment as a corrections officer.

CONCLUSIONS OF LAW AND OPINION

In our prior order, we found that claimant had established that: (1) she suffered a psychological condition generally recognized in the psychological community; (2) her work conditions as a corrections officer, which existed in a real and objective sense and were stressful, were not generally inherent in every working situation; and (3) (by clear and convincing evidence) her work activities were a material contributing cause of her disability and need for medical treatment for her psychological condition. Relying on Donna E. Aschbacher, 41 Van Natta 1242 (1989), we concluded that such a finding established the compensability of her occupational disease claim.

Subsequent to our order, the court has held that to establish the compensability of an occupational disease under former ORS 656.802, a claimant must prove that her work activities were the major contributing cause of her condition or the worsening of her underlying condition. Aetna Casualty Co. v. Aschbacher, supra. Such a standard of proof is likewise applicable to occupational disease claims for a mental disorder. See City of Portland v. Payne, supra. Citing Payne, the court has reversed our prior order and remanded for reconsideration.

Major cause means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening of her condition than all other conditions, explanations, or exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); David K. Boyer, 43 Van Natta 561 (1991).

Here, as detailed in our prior order, the medical evidence essentially consists of three medical opinions. Dr. Johnstone, a treating psychologist; Dr. Rega, internist; and Dr. Parvaresh, psychiatrist.

Dr. Rega, who initially provided treatment, was aware of the stress claimant was experiencing at work, as well as her off-work stressors. These latter stressors included: (1) relationship problems with claimant's boyfriend; (2) disagreements with her daughter; (3) her mother's illness; (4) her brother's alcohol and drug problems; and (5) her personal financial problems.

Based on such circumstances, Dr. Rega ultimately opined that claimant's work "was a contributing factor but hardly the only cause of her emotional distress." (Ex. 27-2). Specifically, Dr. Rega concluded that "[w]hile [claimant's] work was not the sole source of her symptoms, I feel that given the number of hours spent on the job, her work played a significant role in precipitating her symptoms."

Dr. Johnstone, treating psychologist, opined that "there is a strong causal connection between her symptoms and the working conditions at the jail." (Ex. 28-2). In doing so, Dr. Johnstone further noted that "[t]he historical information she provided did not suggest the liklihood [sic] of other possible explanations for the symptoms she experienced."

Finally, Dr. Parvaresh, psychiatrist, performed an independent medical examination. Finding that claimant had been exposed to multiple stressors (one being her working condition), Dr. Parvaresh concluded that "it does not appear to me that her problems were uniquely job related. . . ."

Thus, to varying degrees, all of the physicians support a causal relationship between claimant's psychological condition and her work activities as a corrections officer. Dr. Johnstone determined that there was a "strong causal connection between [claimant's] symptoms and the working conditions." Notwithstanding this determination, the record fails to confirm that Dr. Johnstone was aware of the off-work stressors occurring in claimant's personal life. Moreover, in rendering her opinion, Dr. Johnstone noted that claimant's history did not provide another possible explanation for her psychological disability. Such circumstances suggest that Dr. Johnstone's opinion was not based on a complete and accurate history. Consequently, we do not find the opinion to be persuasive. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Dr. Rega ultimately concluded that claimant's "work played a significant role in precipitating her symptoms." Nevertheless, Dr. Rega also acknowledged that claimant's work was "hardly the only cause of her emotional distress" and was "not the sole source of her symptoms." Finally, in light of claimant's multiple stressors (one being work), Dr. Parveresh opined that claimant's psychological problems "were not uniquely job related."

In order to establish a causal relationship between a claimant's work and her condition, medical evidence is not required to consist of a specific incantation or to mimic the statutory language. Liberty Northwest v. Cross, 109 Or App 109 (1991); McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986) ("Magic words" are not required). However, considering Drs. Rega's and Parvaresh's recognition of claimant's off-work stressors, we are unable to find either opinion sufficient for us to conclude that claimant's work activities were the major contributing cause of her psychological condition. Therefore, claimant's occupational disease claim for mental stress is not compensable. See City of Portland v. Payne, supra. Consequently, the self-insured employer's denial is upheld.

Accordingly, on reconsideration, we affirm the Referee's order dated October 30, 1989.

IT IS SO ORDERED.

In the Matter of the Compensation of
FRED A. NUTTER, Claimant
WCB Case Nos. 90-07946 & 90-07945
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Nelson, et al., Defense Attorneys
Ken Russell (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum and Kinsley.

The SAIF Corporation requests review of Referee Podnar's order that: (1) found claimant had established good cause for an untimely filing of a hearing request; (2) set aside its denial of claimant's claim for a left elbow condition; and (3) upheld Liberty Northwest Insurance Corporation's denial of claimant's claim for the same condition. On review, the issues are timeliness of the hearing request and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings," except for the first paragraph on page 3, with the following supplementation.

On November 15, 1989, the SAIF Corporation denied the compensability of claimant's left elbow condition. (Ex. 43A). On April 3, 1990, Liberty Northwest Insurance Corporation denied only responsibility for that condition. (Ex. 55). At hearing, SAIF conceded that claimant's left elbow condition was work related, but argued that the claim was not compensable for the reason that claimant's hearing request concerning its denial was untimely.

Claimant was first disabled by his left elbow condition in December 1989 during his employment with SAIF's insured.

CONCLUSIONS OF LAW AND OPINION

Claimant filed hearing requests against both insurers on April 12, 1990 and the consolidated hearings convened on October 1, 1990. Consequently, we analyze this matter under the Workers' Compensation Law as amended effective July 1, 1990. See Ida M. Walker, 43 Van Natta 1402 (1991).

Timeliness/Good Cause

We adopt the Referee's "Conclusions" on this issue, and conclude that the claim is not barred due to claimant's untimely hearing request against SAIF.

Nature of the claim

We note at the outset that the left elbow condition is not claimed as a part of the 1986 right elbow injury claim which Liberty Northwest accepted. In addition, we find that the left elbow condition is not causally related to the right elbow injury because the 1986 incident did not involve injury to the left elbow. Finally, claimant's left elbow symptoms were gradual, rather than sudden, in onset and the medical evidence relates the left elbow condition to repetitive work activities performed for both employers. Consequently, this claim is properly analyzed as an occupational disease. See ORS 656.802(1)(c); see also Valtinson v. SAIF, 56 Or App 184 (1982); O'Neal v. Sisters of Providence, 22 Or App 16 (1975); Brenda M. Winship, 42 Van Natta 2443 (1990) (We are not required to consider the claim as an injury "where the facts indicate its proper classification is as an occupational disease.")

Responsibility

The Referee assigned responsibility to SAIF, citing Hensel Phelps Const. v. Mirich, 81 Or App 290 (1986). He reasoned that, although the left elbow "problem occurred in 1987" while claimant was working for Liberty Northwest's insured, it "worsened as a result of the most recent work exposure" with SAIF's insured. (Opinion and Order p. 4). However, because claimant suffers from an occupational disease rather than successive work injuries, and the left elbow condition has not been accepted, the "aggravation/new injury" analysis is not appropriate and the Hensel Phelps rule is inapplicable. Instead, we must decide which employer is responsible, by applying that responsibility law which is peculiar to occupational diseases.

We have previously determined that ORS 656.308(1), the only statute addressing responsibility, applies to occupational disease claims as well as injury claims. See Donald C. Moon, 43 Van Natta 2595, 2596 n.1 (1991).

The statute provides:

> "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."

However, by its terms, the statute addresses only shifting of responsibility, not its initial assignment. Application of ORS 656.308(1) assumes that there is a compensable injury and that the initially responsible insurer is seeking to shift further liability to another insurer/employer. We find nothing in the legislative history or in any statute indicating that the 1990 amendments were intended to change existing law concerning the initial assignment of liability in the responsibility context. Consequently, the question remains as to which employer is initially responsible when compensability is conceded, but there is no accepted condition.

The last injurious exposure rule provides that where, as here, a worker proves that an occupational disease is caused by work conditions that existed where more than one carrier is on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Meyer v. SAIF, 71 Or App 371, 373 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). The onset of disability is the date upon which the claimant first becomes disabled as a result of the compensable condition or, if the claimant does not become disabled, the date he first seeks medical treatment for the condition. Progress Quarries v. Vaandering, 80 Or App 160 (1986); SAIF v. Carey, 63 Or App 68 (1983).

Here, the evidence indicates that claimant's work exposure with both employers contributed to the left elbow condition. However, although claimant first sought treatment for his left elbow symptoms in November 1988, (see Tr. 11-13, Ex. 60-5, 60-17), he did not become disabled due to his left elbow problems until December 1989, approximately six months after he began working for SAIF's insured. (See Tr. 17-18 & 25). Consequently, responsibility for the occupational disease claim is initially assigned to SAIF, the carrier on the risk during the last "potentially causal" employment exposure prior to the

December 1989 onset of disability. Boise Cascade Corp. v. Starbuck, supra; Meyer v. SAIF, supra.

SAIF can shift responsibility to Liberty Northwest, the prior insurer, by showing that claimant's work exposure with Liberty Northwest's insured was the sole cause of claimant's left elbow disability or that it was impossible for claimant's exposure while SAIF was on the risk to have caused claimant's disability. FMC Corporation v. Mutual Ins. Co., 70 Or App 370 (1984). On this record, we conclude that SAIF has established neither fact. Accordingly, responsibility for claimant's left elbow occupational disease claim remains with SAIF.

Attorney Fees

Claimant's counsel is entitled to an assessed attorney fee for prevailing against SAIF's request for review. 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 $1,000, to be paid by the SAIF Corporation. 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. For services on Board review, claimant is awarded a reasonable assessed attorney fee of $1,000, payable directly to claimant's attorney by the SAIF Corporation.

In the Matter of the Compensation of
CHRISTOPHER H. PEPPLER, Claimant
WCB Case No. 91-01328
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Kinsley.

The insurer requests review of Referee Brazeau's order that set aside its denial of claimant's occupational disease claim for right carpal tunnel syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

In June 1988, claimant sustained an on-the-job injury when he slipped and fell off a loading dock and struck his forearm and elbow against the loading door of a truck. The injury caused a large hematoma and swelling of the right elbow with no evidence of fracture or joint effusion. The insurer accepted the claim as a nondisabling injury, and claimant returned to regular work.

By July 1988, claimant was experiencing sensory abnormalities in the right forearm and hand. He was referred to Dr. Buza, who diagnosed right carpal tunnel syndrome and recommended surgery. The insurer authorized surgery in February 1989, but claimant refused the treatment at that time and continued regular work. In February 1990, the insurer officially accepted right carpal tunnel syndrome as a nondisabling injury related to the June 28, 1988 accident and

closed the claim. The notice provided that claimant was entitled to seek review by the Workers' Compensation Division if he objected to the insurer's decision. Claimant did not file an objection to the acceptance/notice of closure within 180 days.

Corrective surgery was rescheduled for February 1990, but not performed. Surgery was then rescheduled in August 1990, but was delayed to allow for the healing of an unrelated forearm laceration. Surgery was then reset for September 1990, but claimant cancelled it. After claimant declined surgery, and without further examination, Dr. Buza declared claimant's condition to be medically stationary in October 1990.

On October 25, 1990, claimant filed a new claim for his right carpal tunnel syndrome, and identified the date of the disease as February 13, 1990. The insurer denied the claim, asserting that the condition was previously accepted as a nondisabling injury and that "benefits have been and are continuing to be paid for this accepted condition according to the law[.]" (Ex. 22).

CONCLUSIONS OF LAW AND OPINION

In this proceeding, claimant, in an apparent effort to obtain a higher rate of temporary disability, asserts a new occupational disease claim involving his previously accepted right carpal tunnel syndrome. He contends that the condition was improperly accepted and processed as an injury, and relies on medical reports that his need for surgery is caused by his repetitive work activities, rather than the June 1988 slip and fall. The insurer responds that claimant is barred from filing a new claim. It does not dispute compensability of the condition, but argues that claimant is simply suffering from the ongoing symptoms of the accepted condition and that he should continue to receive medical benefits under the old claim.

The insurer is correct, to the extent that claimant may not now litigate the question of whether his carpal tunnel syndrome claim should have been processed as an occupational disease. Claimant first sought compensation for the condition in August 1988, when he came under the care of Dr. Buza. In February 1990, the insurer accepted the condition as a nondisabling injury and closed the claim pursuant to former ORS 656.268(3). That closure was not contested and became final by operation of law 180 days after the date of its mailing. Former ORS 656.268(3)(e). Accordingly, claimant's contention that the February 1990 acceptance of his carpal tunnel syndrome was improperly processed as an injury is barred by claim preclusion. See Drews v. EBI Companies, 310 Or 134, 149 (1990); Chella M. Morton, 43 Van Natta 321 (1991).

Nonetheless, claimant is entitled to file a new claim to establish that, after the February 1990 closure of the earlier claim, he had developed a new and different condition related to his work activities. See Proctor v. SAIF, 68 Or App 333 (1984); Irene Jensen, 42 Van Natta 2838 (1990). That contention, however, is not supported by the medical record. The unrebutted medical opinion of the attending physician, Dr. Buza, as corroborated by Dr. Rosenbaum, is that claimant's current condition is the same as the condition previously accepted as an industrial injury. There is no dispute that claimant has required right carpal tunnel surgery since 1988; his decision to proceed with that treatment at this time does not establish a new condition. Accordingly, the insurer's denial is reinstated and upheld.

ORDER

The Referee's order dated May 20, 1991 is reversed. The insurer's denial of January 22, 1991 is reinstated and upheld. The Referee's assessed attorney fee for prevailing against the denial is reversed.

In the Matter of the Compensation of
ESTHER M. WASSON, Claimant
WCB Case No. 90-20294
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Kinsley's order which: (1) found that a Disputed Claim Settlement (DCS) between the self-insured employer and claimant precluded claimant from recovering benefits for the worsening of a psychological condition; and (2) upheld the self-insured employer's denial of claimant's aggravation claim for a psychological condition. On review, the issues are whether claimant is precluded by the DCS from recovering benefits for her psychological condition. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact and provide the following supplementation.

The Disputed Claim Settlement (DCS) entered into by claimant and the employer provided that "entitlements under the Oregon Workers' Compensation Act for claimant's low back, left hip and psychological condition shall be, and are, in a finally denied status, and she shall have no further rights of any kind whatsoever in relation to these claims." (Ex. 18-3).

CONCLUSIONS OF LAW AND OPINION

Because claimant's psychological claim was settled by DCS, the agreement precludes claimant from further recovery for her psychological condition. Proctor v. SAIF, 68 Or App 333, 336 (1984). Claimant may avoid the effect of the DCS only if she establishes that, after the stipulation, she developed a new psychological condition related to the compensable injury. Id. at 335.

Claimant contends that, although her current condition carries the same psychiatric label, she does suffer from a new psychological condition. Specifically, claimant maintains that her first bout of depression was settled by stipulation, but that condition resolved and then was followed by a separate bout of depression as a result of "factors different from those [existing] prior to the settlement[.]" Claimant therefore asserts that the DCS does not preclude her from recovery for her current psychological condition.

We disagree. The medical evidence establishes that, although intensified, claimant's current psychological condition is a continuation of the same psychological condition that was settled by the DCS. For instance, Dr. Kenyon, M.D., who treated claimant when she was hospitalized in October 1990, diagnosed "chronic depression, acute major exacerbation." (Ex. 39-2). Dr. Kuttner, claimant's treating psychiatrist, although stating that claimant's current depression was not "the same situational depression," analogized claimant's condition to that of a person "suffering an (sic) knee injury and then gradually developing more and more symptoms of back pain and disability related to the alteration in body mechanics." (Ex. 51-1). Dr. Kuttner later stated that claimant's "condition as it was at the end of summer into fall 1990, was an intensification of the symptoms of depression and anxiety she had stemming back to 1987." (Ex. 63-1).

Dr. Jansen, occupational medical specialist, who has been treating claimant since she was injured, also reported that claimant "suffered from depression from 1985 and in subsequent years, which was directly related to her occupation-related knee injury; however, factors affecting the seriousness of the depression shifted gradually." (Ex. 62).

Finally, Dr. Glass, psychiatrist, after conducting an independent psychiatric examination, diagnosed "adjustment disorder with symptoms of anxiety and depression," concluding that her condition "is related to her injury of 1985. She has had ongoing problems with her mood and with anxiety since that time. There appears to be an intensification of those symptoms." (Ex. 61-8).

In short, the evidence demonstrates that claimant's depression has been ongoing since she suffered her compensable knee injury and that her current psychological condition is an intensification of those symptoms. We therefore agree with the Referee that claimant is precluded by the DCS from recovering on her aggravation claim. Therefore, we do not determine whether claimant proved a worsening under ORS 656.273.

ORDER

The Referee's order dated April 18, 1991 is affirmed.

In the Matter of the Compensation of
JAMES E. BRIGHT, Claimant
WCB Case No. TP-91023
THIRD PARTY DISTRIBUTION ORDER
Pozzi, et al., Claimant Attorneys
William E. Brickey (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation, as paying agency, has petitioned the Board for resolution of a conflict concerning the "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, the dispute pertains to SAIF's entitlement to a "third party" lien from the settlement proceeds. We conclude that SAIF is entitled to a share of the proceeds and that a distribution in accordance with ORS 656.593(1) is "just and proper."

FINDINGS OF FACT

In August 1988, claimant sustained a compensable injury when injured in a motor vehicle accident. The accident occurred when the vehicle claimant was driving was rear-ended by another vehicle.

SAIF accepted the claim and has provided compensation. To date, it has incurred actual claim costs totalling $5,379.82. These costs are comprised of $4,518.46 in medical expenses and $861.36 in temporary disability benefits.

Claimant secured legal counsel to consider a lawsuit against the driver of the other vehicle involved in the accident. In January 1991, claimant and the third party insurer reached a $12,879.82 settlement. SAIF approved the compromise, provided that it received its statutory share of third party recovery. In granting its approval, SAIF proposed a distribution of settlement proceeds in a manner in which claimant's attorney would recover $470.20 for litigation costs

and $1,875 for attorney fees, SAIF would receive $5,379.82 in satisfaction of its lien, and claimant would recover the remaining balance of settlement proceeds.

Thereafter, the settlement was achieved. In addition to his own share of the proceeds, claimant retained SAIF's share. When efforts to recover its share of the settlement failed, SAIF petitioned the Board for relief.

CONCLUSIONS OF THE LAW

If a worker receives a compensable injury due to the negligence or wrong of a third party not in the same employ, the worker shall elect whether to recover damages from the third person. ORS 656.578. The proceeds of any damages recovered from the third person by the the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593(1). "Paying agency" means the self-insured employer or insurer paying benefits to the worker or beneficiaries. ORS 656.576.

Here, claimant sustained a compensable injury as a result of the negligence or wrong of a third person. The claim was accepted by SAIF, who has provided compensation. Inasmuch as SAIF has paid benefits to claimant as a result of compensable injury, it is a paying agency. ORS 656.576. As such, it is entitled to its statutory share of the third party recovery. ORS 656.593(1).

When claimant chose to seek recovery from the third party, the provisions of ORS 656.580(2) and 656.593(1) became applicable. Thus, the third party settlement became subject to SAIF's lien for its "just and proper" share. See ORS 656.593(3). We now proceed to a determination of a "just and proper" distribution.

The statutory formula for distribution of a third party recovery obtained by judgment, ORS 656.593(1), is generally applicable to the distribution of a third party recovery obtained by settlement. Robert L. Cavil, 39 Van Natta 721 (1987). We take such an approach to avoid making "equitable distributions on an ad hoc basis and to permit the parties to generally know where they stand as they seek to settle a third party action." See Marvin Thornton, 34 Van Natta 999, 1002 (1982).

We find no persuasive reason to depart from the aforementioned approach. Therefore, after the deduction of attorney fees, litigation costs, and claimant's statutory 1/3 share, SAIF is entitled to retain the balance of the third party recovery to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claims under ORS 656.001 to 656.794. See ORS 656.593(1)(a), (b), & (c).

Claimant has neither contested SAIF's assertion that it has incurred $5,379.82 in actual claim costs nor the ledger sheets/claim examiner's affidavit on which the costs are based. Under such circumstances, we conclude that SAIF has proven that it incurred the aforementioned costs. We further conclude that a distribution of proceeds from the third party settlement in accordance with ORS 656.593(1) would be "just and proper." See ORS 656.593(3).

Pursuant to such a distribution scheme, the settlement proceeds should have been disbursed in the following manner:

Settlement	$12,879.82
Litigation Costs	470.20
Attorney Fee	1,875.00
Subtotal	$10,534.62
Claimant's 1/3 Share	3,511.54
Remaining Balance	$ 7,023.08
SAIF's Lien	5,379.82
Remainder to Claimant	$ 1,643.26

Thus, claimant's share of the $12,879.82 settlement should have been $5,154.80 (claimant's 1/3 statutory share of $3,511.54 + the $1,643.26 remaining balance). Rather than distributing the proceeds in the manner as described above, claimant's attorney disbursed the remaining balance of the settlement (including SAIF's statutory share) to claimant. Such an disbursement was in direct contravention of SAIF's express written approval of the settlement, as well as the statutory distribution scheme. As a result of claimant's counsel's impermissable distribution, SAIF has been unilaterally and unlawfully prevented from recovering its rightful share of the settlement. Under such circumstances, we have previously held that a paying agency may recover its unpaid share of the settlement from claimant's attorney. Manuel A. Ybarra, 43 Van Natta 376 (1991); Steven B. Lubitz, 40 Van Natta 450 (1988).

In accordance with the reasoning discussed above and the Ybarra/Lubitz rationale, we conclude that claimant's attorney is jointly and severally responsible for remedying this situation. Accordingly, claimant and/or claimant's attorney are directed to pay SAIF its "just and proper" share of the settlement, i.e., $5,379.82.

IT IS SO ORDERED.

April 29, 1992 Cite as 44 Van Natta 861 (1992)

In the Matter of the Compensation of
DARRELL D. BROWN, Claimant
WCB Case Nos. 91-17782 & 91-02678
ORDER DENYING MOTION TO DISMISS
Peter O. Hansen, Claimant Attorney
Snarskis, et al., Defense Attorneys
Daryl Nelson, Defense Attorney

Liberty Northwest Insurance Corporation has requested Board review of Referee Galton's March 9, 1992 "Interim Order" and April 8, 1992 "Second Interim Order." Contending that the Referee's orders are interim and not reviewable, claimant moves for dismissal of Liberty Northwest's request for review. We deny the motion to dismiss.

FINDINGS OF FACT

A hearing was convened on March 9, 1992. The parties to the hearing were claimant, Liberty Northwest, and Industrial Indemnity. Among the issues raised at the hearing was claimant's contention that his temporary total disability benefits had been inappropriately and illegally terminated by Liberty Northwest as of May 20, 1991. See OAR 438-06-075; 438-06-078.

On March 9, 1992, the Referee issued an "Interim Order." The Referee concluded that Liberty Northwest was not entitled to terminate claimant's temporary total disability. Consequently, the Referee awarded temporary total disability

from July 10, 1990 through the date of the Referee's order, less amounts previously paid, and continuing until such benefits could be lawfully terminated.

In reaching his decision, the Referee noted that the parties had agreed that the Referee would issue an "Interim Order" concerning the aforementioned matter. Since the order was designed to be interim, the Referee's order did not contain a statement explaining the parties' rights of appeal pursuant to ORS 656.289(3) and 656.295.

On March 20, 1992, Liberty Northwest moved for reconsideration and abatement of the Referee's March 9, 1992 order. In addition to contesting the Referee's determination concerning claimant's entitlement to temporary total disability, Liberty Northwest objected to the award of compensation pending the issuance of a final, appealable order.

On April 8, 1992, the Referee issued a "Second Interim Order." Relying on the understanding prior to the hearing, the Referee noted that the parties had agreed that the hearing would be reconvened "to hear the balance of testimony and argument in these cases." (which apparently pertains to the issues of compensability and responsibility regarding claimant's current low back condition between Liberty Northwest (under an August 1989 cervical and low back claim) and Industrial Indemnity (under a March 1977 low back claim). Following consideration of Liberty Northwest's objections, the Referee adhered to his prior decision. Once again, because the order was purportedly interim, the Referee's order did not include a statement explaining the parties' rights of appeal under ORS 656.289(3) and 656.295.

Also on April 8, 1992, Liberty Northwest mailed by certified mail its request for Board review of the Referee's March 9, 1992 order. On April 17, 1992, Liberty Northwest mailed by certified mail its request for Board review of the Referee's April 8, 1992 order.

FINDINGS OF ULTIMATE FACT

The Referee's March 9, 1992 and April 8, 1992 orders finally allowed and fixed 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). An order which addresses two separate aspects of the same claim, extent of disability on the accepted claim and compensability for an additional allegedly related disease, infection or injury, may finally determine one issue but not the other. Price v. SAIF, supra, at page 316; Dean v. SAIF, 72 Or App 16, 19 (1985). 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 orders were designated as "interim orders." Moreover, further action concerning the compensability of and responsibility for claimant's current low back condition were necessary as a result of the Referee's orders. Finally, neither order included a statement explaining the parties' rights of appeal under ORS 656.289(3) and 656.295. Nevertheless, a Referee's order does not depend upon a notice of appeal rights to be considered final. Glen D. Roles, 42 Van Natta 68, 72 (1990). Furthermore, although further proceedings in the consolidated cases were contemplated, there is no question but that claimant's entitlement to temporary total disability concerning this unilateral termination issue had been finally allowed and fixed. Under such

circumstances, notwithstanding their "interim" designation, the Referee's orders were final and, as such, appealable.

In reaching this conclusion, we acknowledge that the Referee's orders were apparently issued in accordance with the parties' "understanding" that an interim order would be issued followed by a final, appealable order. However, parties are not at liberty to alter fundamental principles of jurisdiction. Inasmuch as the Referee's orders finally allowed and fixed the amount of claimant's compensation concerning the unilateral termination issue, those orders would become final by operation of law unless a party requested Board review within the statutory 30-day period. ORS 656.289(3); OAR 436-60-150(4)(f); Walden J. Beebe, 43 Van Natta 2430 (1991). Because Liberty Northwest requested review within the aforementioned statutory period, we have jurisdiction to consider the order.

As a result of our decision, the parties' consolidated cases have been essentially bifurcated between the Hearings Division and the Board. To rectify this situation as efficiently and expediently as possible, the Hearings Division file shall be returned to the Referee. Thereafter, the Referee shall reconvene the hearing as had been previously intended and proceed to complete the record concerning the remaining issues. Following the closure of the record, the Referee shall issue a final, appealable order regarding the rest of the issues.

Pending the issuance of the Referee's subsequent order, further Board review proceedings regarding the "interim" orders will be held in abeyance. Should a party timely and properly request Board review of the Referee's subsequent order, that order and the file will be consolidated with Liberty Northwest's present request for purposes of review. In the event that no party timely and properly requests Board review of the Referee's subsequent order, Board review proceedings concerning Liberty Northwest's request will be reimplemented, at which time copies of the hearing transcript will be distributed and a briefing schedule established.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES A. HILARY, Claimant
WCB Case No. 90-20640
ORDER ON RECONSIDERATION
Jolles, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Claimant has requested reconsideration of our April 1, 1992 Order on Review. Specifically, he contends that we erred in not granting an award for a chronic condition limiting repetitive use of his cervical spine. In his motion, claimant cites several medical reports which he argues support a conclusion that he has a chronic condition limiting repetitive use of his cervical spine.

Permanent disability is rated at the time of the hearing. Gettman v. SAIF, 289 Or 609 (1980). The majority of the medical reports cited in claimant's motion are dated before claimant became medically stationary. Thus, they are not relevant in rating claimant's permanent disability on the date of hearing. As we indicated in our order, the most recent medical reports do not support a finding that claimant has a chronic condition limiting repetitive use of his cervical spine.

With this clarification, we conclude that our Order on Review adequately addresses the contentions contained in claimant's motion. Our April 1, 1992 order is abated and withdrawn. As supplemented and clarified herein, we republish our April 1, 1992 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

April 29, 1992 Cite as 44 Van Natta 864 (1992)

In the Matter of the Compensation of
DAVID A. PITZER, Claimant
WCB Case Nos. 91-06246 & 91-04855
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Robert Jackson (Saif), Defense Attorney
John M. Pitcher, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Weyerhaeuser Company requests review of Referee Daughtry's order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for a low back condition. On review, the issues are responsibility, res judicata, compensability, and aggravation. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Responsibility

We first address Weyerhaeuser's argument that responsibility for claimant's condition shifts to SAIF because claimant sustained a "new compensable injury" while working at SAIF's insured.

"When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability unless the worker sustains a new compensable injury involving the same condition." ORS 656.308(1). Under this provision, in cases in which an accepted injury is followed by an increase in disability during employment with a later carrier, responsibility presumptively rests with the original carrier unless the material contributing cause of claimant's disability or need for treatment is the work activities with the subsequent employer. Ricardo Vasquez, 43 Van Natta 1678, 1680-81 (1991).

In arguing that responsibility for claimant's condition shifts to SAIF's insured, Weyerhaeuser relies on evidence that claimant suffered an acute exacerbation during his subsequent employment. An early report from Dr. Whitney, orthopedist, claimant's treating physician, stated that claimant experienced an "acute exacerbation" of back symptoms and that "the major cause for the need of treatment is this most recent injury[.]" (Ex. 20B-1).

We attribute little weight to this report, however, for several reasons. First, the report makes it apparent that claimant's condition had been of a "long standing" nature and was "slowly getting worse." (Id). Second, Dr.

Whitney's most recent report states that the major contributing cause of claimant's worsened condition is his degenerative disc disease and fails to refer in any way to the exacerbation. (Ex. 29B-2). Finally, medical reports performed by Dr. Rosenbaum, neurosurgeon, and Dr. McKillop, orthopedic surgeon, both of whom performed independent medical examinations, attributed claimant's condition to the passage of time rather than work activity. (Exs. 21B-4, 22B-6, 22B-7). Whitney concurred with the opinion of Rosenbaum that claimant's condition "was not likely hastened by his work activity." (Exs. 21B-4, 24B).

We conclude that the medical record, as a whole, demonstrates that claimant did not sustain a new compensable injury while working at SAIF's insured. Therefore, responsibility for claimant's compensable injury remains with the initial carrier, Weyerhaeuser.

Res Judicata and Compensability

Weyerhaeuser also argues that claimant's current condition is not within the scope of the condition that it was ordered to accept in March 1987 and, therefore, it may challenge compensability. Specifically, Weyerhaeuser asserts that claimant did not prove that his employment conditions were the major contributing cause of his current symptoms. See ORS 656.005(7)(a)(A), (B).

Claimant's condition currently includes diagnoses of degenerative disc disease and spinal stenosis. (Exs. 21B-4, 22B-5, 29B-1). We agree that there is evidence that both conditions preexisted claimant's job with Weyerhaeuser and that the work activity contributed very little in terms of causation or worsening. (See Exs. 21B-4, 22B-7, 23B-1). Notwithstanding such evidence, we agree with the Referee that Weyerhaeuser is precluded by res judicata from challenging the compensability of claimant's degenerative disc disease.

By Opinion and Order in March 1987, claimant's "low back condition" was found compensable. (Ex. 7B-3). That order indicates that the Referee included the diagnosis of degenerative disc disease within the compensable condition; the Referee relied on the opinion of Dr. Whitney, who diagnosed degenerative disc disease and also found that claimant's work activity was the "major contributing cause of his continued disc degeneration, and the disc degeneration together with the claimant's work activity at the time produced his acute symptoms in February, 1985." (Id). Therefore, we find that Weyerhaeuser is barred by the doctrine of issue preclusion from challenging the compensability of claimant's degenerative disc disease. See North Clackamas School Dist. v. White, 305 Or 48, 53, modified 305 Or 468 (1988); Rose D. Tuttle, 44 Van Natta 339 (1992).

As noted above, however, claimant's current condition also includes spinal stenosis. There is no evidence that this condition was included in the "compensable condition" Weyerhaeuser was ordered to accept in March 1987, nor has Weyerhaeuser accepted this condition. According to Dr. Whitney, at the time that claimant's degenerative disc disease was diagnosed, claimant's "spinal stenosis was unknown and asymptomatic[.]" (Ex. 29B-1). Spinal stenosis was only recently diagnosed after claimant underwent a CAT scan and myelogram. (Ex. 20B-1). Consequently, we conclude that the employer is not precluded from challenging the compensability of the spinal stenosis condition.

The record contains two opinions regarding the causation of the spinal stenosis. Dr. McKillop stated that the "spinal stenosis is directly related to the degenerative disease of the facets and discs," but also found that the condition was "present for many years and certainly pre-dates the time of the work injury by many years." (Ex. 22B-5). Dr. Whitney indicated that the spinal stenosis has "been worsened by the progressive disease of the facet and disc spaces." (Ex. 29B-1).

We conclude that, whether the degenerative disc disease caused or worsened the spinal stenosis, the latter condition is compensable. Under McKillop's opinion, the degenerative disc disease was the major contributing cause of the spinal stenosis, providing for compensability under ORS 656.005(7)(a)(A). Under Whitney's opinion, the degenerative disc disease was the major contributing cause of the worsening of the spinal stenosis, providing for compensability under ORS 656.005(7)(a)(B).

Aggravation

Finally, we address whether claimant has proved a compensable aggravation of his degenerative disc condition. The Referee found that claimant proved a claim for aggravation because Dr. Whitney indicated that claimant was in need of surgery, which was not contemplated by the last award or arrangement of compensation.

We agree that Dr. Whitney concluded that claimant's condition has deteriorated to the extent that surgery is now required. (See Ex. 29B-1). Claimant's aggravation claim is based on the need for surgery. (See Ex. 27B). However, Whitney indicated that the surgery is to address the spinal stenosis condition rather than the degenerative disc disease. (Ex. 29B-1). Because we have determined that claimant's spinal stenosis is compensable, claimant's surgery is also compensable. Therefore, we find that it is unnecessary to determine whether claimant's degenerative disc disease has worsened under ORS 656.273.

Attorney fees on review

Weyerhaeuser requested review, and the Board did not disallow or reduce the compensation awarded to claimant. Therefore, 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 a reasonable fee for claimant's counsel's services on review is $700, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated August 9, 1991 is affirmed in part and modified in part. That portion of the order finding that Weyerhaeuser is barred by res judicata from denying the compensability of claimant's current condition is modified in part. We agree that Weyerhaeuser is precluded from denying claimant's degenerative disc condition. We further conclude that claimant's spinal stenosis is compensable. Having found that the spinal stenosis is a compensable aggravation, we do not address whether claimant's aggravation claim was for his degenerative disc condition. The remainder of the order is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of $700, payable by Weyerhaeuser.

In the Matter of the Compensation of
TERESA L. WHEELER, Claimant
WCB Case No. 90-21503
ORDER ON REVIEW
Nancy F. A. Chapman, Claimant Attorney
Terrall & Associates, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of those portions of Referee Neal's order which: (1) held that claimant's hearing was convened prior to July 1, 1990; (2) found that the employer improperly unilaterally terminated claimant's temporary total disability; (3) assessed penalties and related attorney fees for the employer's unilateral termination; (4) found that claimant was entitled to temporary disability through April 16, 1990; and (5) assessed penalties and a related attorney fee for the employer's allegedly unreasonable failure to provide claims information concerning claimant's temporary disability compensation.

On review, the employer contends that: (1) the post-July 1, 1990 law is applicable; (2) its termination of claimant's temporary disability was justified; (3) claimant was not entitled to the entire temporary disability awarded by the Referee; and (4) it timely and reasonably complied with claimant's request for claims documents. We modify in part, affirm in part and reverse in part.

FINDINGS OF FACT

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

This matter was initially scheduled to be heard on May 31, 1990. (Ex. 36-3). Because of claimant's attorney's scheduling conflict, the hearing was formally postponed by letter dated May 30, 1990. In postponing the hearing, the Referee indicated that a hearing would be rescheduled before July 1, 1990. Id. The parties were advised by the Referee that the hearing was to be convened on June 27, 1990 at 2:30, before Referee Mongrain. (Ex. 36-1). This notice was not given in written form. However, the Referee was not available until after 3:00 on June 27, 1990. Referee Mongrain attempted to contact the parties after 3:00, but claimant's attorney was unavailable.

The following day, June 28, 1990, an unscheduled telephonic hearing was convened before Referee Mongrain. (Ex. 36). There was no written notice of this hearing provided to the parties. Claimant and her attorney of record were not available, but counsel for the employer was available and took part in the phone conference. Another attorney from claimant's counsel's office substituted for claimant's counsel during the phone conference. The employer's counsel objected to the conference on the basis that it did not constitute a convening of a "hearing." That objection was preserved to be ruled upon when the hearing was reconvened. The employer's counsel made a motion for dismissal of the request for hearing because claimant was not available. This motion was denied. The employer's counsel then made a motion for postponement on the basis that there had not been proper notice of the hearing. This motion was also denied.

Claimant's discovery requests did not contain specific requests for payroll records. (Exs. 9B; 19A). Claimant's attending physician gave claimant a written release to regular work on March 5, 1990. (Ex. 29A).

CONCLUSIONS OF LAW AND OPINION

Applicable Law

The Referee concluded that a hearing was convened prior to July 1, 1990 and that, therefore, the law in effect prior to the 1990 amendments applied to this case. We disagree.

The employer contends that the telephone conference did not constitute a hearing under the applicable statutes and administrative rules. In John K. French, 43 Van Natta 836 (1991), we addressed the question of the Board's statutory authority to accelerate the date of hearing and convene cases before the effective date of the post-July 1, 1990 law. In French, we found no statutory provision that prohibits the Board from rescheduling or accelerating the date of a hearing provided that it give 10 days prior notice of the time and place of hearing to all parties in interest by mail. ORS 656.283(5). In French, such prior written notice was given.

Here, by contrast, there was no such prior written notice of the time and place of hearing mailed to the parties. The Referee's general statement that a hearing would be convened "sometime before July 1" does not constitute sufficient notice of the time and place of hearing. Accordingly, inasmuch as a hearing was not properly convened prior to July 1, 1990, the "new" law applies.

Temporary Total Disability

The Referee found that the employer did not strictly comply with the administrative and statutory requirements regarding the unilateral termination of claimant's temporary total disability. In doing so, the Referee relied on pre-July 1, 1990 law. We have previously held that the post-July 1, 1990 law is applicable. Nevertheless, under either version of the relevant law, we conclude that the employer's termination of claimant's temporary disability was unjustified.

ORS 656.268(3) provides that an insurer may unilaterally terminate payment of temporary total disability compensation only if:

> "(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."

See Rocky L. Coble, 43 Van Natta 1907 (1991). Here, the employer offered claimant a modified job in writing. However, claimant was not given a written release to return to the modified work by her doctor as required by ORS 656.268(3). Rather, she was given a written offer of modified work as a security guard, which did not state that it had been approved by her attending physician. Under the statute, before terminating claimant's temporary total disability, claimant had to be given a written release to modified work from her doctor. ORS 656.268(3)(c). This did not occur. Thus, the employer was not entitled to cease paying temporary total disability compensation.

Moreover, at the time it terminated claimant's temporary total disability, the employer was required to conform its conduct to former OAR 436-60-030. Former OAR 436-60-030(c) states that an insurer can cease paying temporary total

disability payments if "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 added).

Here, the written job offer states that claimant would be "asked to perform only those tasks that are clearly suited to your abilities, as outlined by your treating physician * * *." The offer does not state that claimant's physician had approved the modified job. It is well-settled that strict compliance with the procedural requirements of former OAR 436-60-030(5) is required to authorize the termination of temporary total disability benefits. Safeway Stores, Inc. v. Little, 107 Or App 316 (1991); Eastman v. Georgia Pacific Corp., 79 Or App 610 (1986).

Thus, under either the law in effect prior to the 1990 amendments or after the new amendments became effective, the employer's termination of claimant's temporary total disability was improper as a procedural matter.

The employer resumed paying temporary total disability in January 1990 following claimant's carpal tunnel surgery. However, it ceased paying these benefits on February 14, 1990, asserting that claimant's surgeon had not authorized time loss. The Referee found that this termination was also improper since claimant was not released to regular work until March 1990. The Referee further reasoned that the employer had also failed to pay claimant temporary disability through April 16, 1990, the date the Determination Order found him to be medically stationary. Consequently, the Referee awarded temporary disability, less time worked, through April 16, 1990.

On review, the employer contends that claimant is not entitled to the temporary disability compensation awarded by the Referee's order. We disagree.

To begin, as a procedural matter, we have previously concluded that the employer was not authorized to terminate claimant's temporary disability. Thus, at the time of claimant's January 1990 surgery, she should have already been receiving her temporary disability benefits. These benefits should have continued until her March 5, 1990 written release to regular work. See ORS 656.268(3); Soledad Flores, 43 Van Natta 2504 (1991). Moreover, upon claim closure, a Determination Order awarded claimant temporary disability through April 16, 1990. Consequently, claimant was substantively entitled to such benefits through April 16, 1990, less any time worked. ORS 656.268; Betty J. McKiernan, 43 Van Natta 213 (1991); Julie A. Trujillo, 40 Van Natta 1892 (1988).

Penalty for Unilateral Termination

The Referee found, and we agree, that the employer's unilateral termination of claimant's temporary total disability compensation was unreasonable. We further conclude that the employer's conduct was similarly unjustified under the post-July 1, 1990 laws. Accordingly, as supplemented herein, we adopt the Referee's conclusion and reasoning concerning penalties for improper unilateral termination of temporary total disability.

However, in light of our decision that the law in effect on and after July 1, 1990 applies to this case, we modify the Referee's attorney fee award. Subsequent to the Referee's order, we held that amended ORS 656.262(10) provides that if the worker is represented by an attorney, the worker's attorney shall receive one-half the additional amount, in lieu of an attorney fee. See Nicolasa Martinez, 43 Van Natta 1638 (1991). Accordingly, in lieu of the

Referee's assessed attorney fee award of $600, claimant's attorney is awarded one-half of the penalty awarded by the Referee's order.

Penalty for Failure to Timely Provide Claims Documents

The Referee found that the employer did not provide claimant with requested claims documents in a timely manner. Claimant made two discovery requests, the first on August 9, 1989 and the second on October 3, 1989. (Exs. 9B; 19A). Neither of these discovery requests specifically requested the employer's payroll records. The insurer responded to both discovery requests within 14 days. In response to the first request, the insurer sent a copy of its claim file. In response to the second request for discovery, the insurer sent copies of all documents it had received since the last request.

The employer asserts that the records which it did not produce in a timely manner were payroll records. Relying on OAR 438-07-015(2), the employer contends that claimant must make a specific demand for payroll records. OAR 438-07-015(2) provides in pertinent part: "* * * 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." Asserting that no such specific demand was made by claimant for the documents, the employer argues that its failure to provide these documents in a timely manner was not unreasonable. We agree that in the absence of a specific demand, and in light of the employer's timely responses to claimant's general discovery requests, the employer's conduct was not unreasonable. Consequently, we reverse the Referee's $500 attorney fee award concerning this issue.

Attorney Fee for Board Review

Inasmuch as the employer has requested Board review, and we have found that claimant's temporary disability should not be reduced or eliminated, claimant is entitled to an 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 attorney's services on review concerning the temporary total disability issue is $1,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and statement of services), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee concerning 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 March 18, 1991 is affirmed in part, reversed in part and modified in part. The Referee's $500 assessed attorney fee award for the alleged discovery violation is reversed. In lieu of the Referee's $600 assessed attorney fee concerning the unreasonable unilateral termination issue, claimant's attorney is awarded one-half of the penalty awarded by the Referee's order. The remainder of the Referee's order is affirmed. For services on Board review concerning the temporary total disability issue, claimant's attorney is awarded an assessed attorney fee of $1,000 to be paid by the employer.

In the Matter of the Compensation of
KRISTINA BENES-SMITH, Claimant
WCB Case No. 91-02178
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Tenenbaum and Kinsley.

The insurer requests review of Referee Schultz's order that set aside its denial of claimant's medical services claim for arthroscopic knee surgery. On review, the issue is medical services.

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

The record shows that claimant underwent knee surgery two days before the hearing. There is evidence to indicate that the surgery may have included a meniscectomy (to repair a probable tear of the medial meniscus), in addition to the arthroscopic exam to diagnose claimant's condition. The insurer had denied the "arthroscopic surgery." We interpret the denial as denying only the arthroscopic exam that was performed to diagnose claimant's condition, not any meniscectomy that may have been performed during the same surgery. Therefore, claimant is not precluded from later asserting that a meniscectomy, if performed, was causally related to her accepted injury, and the insurer is not precluded from denying that procedure.

We agree with the Referee that the arthroscopic exam is compensable, because claimant has established that the procedure resulted from the compensable "needle stick" knee injury and was required for diagnostic purposes. See Finch v. Stayton Canning Co., 93 Or App 168, 173 (1988); see also Brooks v. D and R Timber, 55 Or App 688, 692 (1982); Kelly Barfuss, 44 Van Natta 239 (1992). Unlike the Referee, however, we reach this conclusion without considering claimant's "psychological well being." Because claimant suffered a physical injury to her knee and knee symptoms had persisted, she was entitled to know the condition of her knee and whether any subsequent treatment is appropriate for her compensable condition.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. 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 attorney's services on review concerning the medical services issue is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to 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 June 6, 1991 is affirmed. For his services on review, claimant's attorney is awarded an assessed attorney fee of $500, payable by the insurer.

In the Matter of the Compensation of
SHARON L. DOMINY, Claimant
WCB Case No. 90-18458
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Charles Cheek (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum and Kinsley.

Claimant requests review of Referee McWilliams' order that: (1) dismissed her request for hearing for lack of jurisdiction; (2) declined to enforce the June 8, 1990 Stipulation and Order concerning claimant's entitlement to "physical therapy benefits under ORS 656.245;" and (3) declined to assess penalties and attorney fees for the SAIF Corporation's allegedly unreasonable failure to provide those benefits. In her brief, claimant argues that, if the 1990 amendments to ORS 656.245(1) relieve SAIF of its obligations under the June 8, 1990 order, the order should be set aside in its entirety and the case should be remanded for a new hearing under the law in effect on June 8, 1990. On review, the issues are jurisdiction, remand, enforcement of a stipulated order, and penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for her "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The Referee stated that she had jurisdiction over the dispute concerning enforcement of the parties' stipulation. We agree. See Howard v. Liberty Northwest Ins. Corp., 94 Or App 283 (1988). However, the Referee also decided that she did not have jurisdiction to compel the SAIF Corporation to provide physical therapy under the terms of the agreement. She reasoned that, because the June 8, 1990 order referred to ORS 656.245, claimant's stipulated right to physical therapy derived from that statute. Accordingly, because claimant did not exhaust administrative remedies concerning the disputed medical services, the Referee concluded that she lacked jurisdiction over the medical services issue, citing amended ORS 656.245(1) and OAR 436-10-041(3). We disagree.

SAIF contends that, inasmuch as the order refers to ORS 656.245, claimant's rights under the order are limited by the 1990 amendments to that statute. We disagree.

We have previously held that the Hearings Division has jurisdiction to enforce a stipulated order regarding medical services. Patrick E. Riley, 44 Van Natta 281 (1992). In Riley, the stipulated order provided that "claimant shall treat with a psychiatrist" and made no reference to any statute or administrative rule. The self-insured employer argued that psychotherapy provided by a psychologist is not compensable under the terms of the stipulated order. Finding that the dispute concerned solely the meaning and application of the stipulated order's terms, we concluded the Hearings Division had jurisdiction.

Here, by contrast, the June 8, 1990 order expressly refers to ORS 656.245 which is the medical services statute. The parties entered into the order, in part, to resolve claimant's hearing request on the issue of her entitlement to a work hardening program. By the terms of the order, claimant agreed not to seek the work hardening program in exchange for SAIF's agreement that "claimant is entitled to physical therapy benefits under ORS 656.245." We are persuaded that

claimant's entitlement to physical therapy benefits arises from the agreement itself and that the reference to ORS 656.245 was not intended to restrict or eliminate that entitlement.[1] Because there is no other procedure for resolving this dispute, we conclude that we have original jurisdiction to enforce the agreement. See Howard v. Liberty Northwest Ins. Corp., supra; Patrick E. Riley, supra.

Enforcement of the Stipulation

The terms of the parties' agreement are binding. See Evans v. Rookard, 85 Or App 213, 214 (1987) See also Timothy W. Fletcher, 43 Van Natta 1359 (1991), aff'd mem. (January 15, 1992); Charles T. Brence, 41 Van Natta 1429 (1989).

As we have stated, this is not a case where the parties clearly intended their agreement to be subject to a statute or, more specifically, subject to a statute which changed materially subsequent to the agreement. To the contrary, there is no evidence concerning the meaning of the phrase "under ORS 656.245" as it is used in the written agreement. Compare Kevin A. Haines, 43 Van Natta 1041 (1991). Because the agreement before us does not explain the term, the purpose of that term is not clear and unambiguous. Consequently, we consider evidence outside the agreement in order to discern the parties' intent.

The parties agree that claimant gave up her contention that she was entitled to a work hardening program when she entered into the June 8, 1990 stipulation. In so doing, claimant provided consideration in exchange for the right to physical therapy which she received under the order. Prior to hearing, the parties also agreed to the following facts concerning the intent of their agreement: Claimant expected that she would be provided physical therapy and SAIF's representative expected that SAIF would pay for such therapy, as agreed. This exchange represents the essence of the parties' agreement.

We read the wording of the order together with the stipulated facts and conclude that the parties had an agreement whereby claimant was entitled to physical therapy, paid for by SAIF. See Evans v. Rookard, Inc., supra; see also Chris A. Miner, 43 Van Natta 914, 915 (1991) ("Whether or not claimant would have been entitled to an award [of attorney fees] under pertinent law[,] the insurer agreed that claimant was entitled to such an award") (Emphasis added).

In view of the plain meaning of the order and the stipulated facts which are consistent with that meaning, we see no reason to interpret the phrase

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[1] Because the reference to the statute was not intended to limit claimant's entitlement to physical therapy, this case is distinguishable from Kevin A. Haines, 43 Van Natta 1041 (1991), in which we held that the Director had exclusive jurisdiction to enforce an order of the Workers' Compensation Board. According to the stipulation in Haines, the insurer was required to provide vocational services to the claimant until those services could be terminated in accordance with the Director's rules governing vocational assistance. When a dispute regarding the termination of vocational services arose, we held that, because the dispute could only be resolved by interpretion and exercise of discretion in applying the Director's rules, the dispute does not implicate purely contractual rights under the stipulation and must be resolved by the Director. Here, on the other hand, the order does not require the interpretation or application of the Director's administrative rules. Rather, the enforcement dispute in this case is independent of the statute or rules and arises solely from the contractual rights under the order. For that reason, we have jurisdiction of this dispute.

"under ORS 656.245" as SAIF urges. At the time the parties entered this agreement, this was no issue as to the appropriateness, frequency, or conformance with the medical rules as to the treatment in question. There is no evidence of any change in circumstances between the June 9 agreement and SAIF's August 6 letter advising the doctor that he needed to request permission for allegedly palliative care. To adopt SAIF's position would render the parties' agreement meaningless and devoid of consideration. Such an interpretation would amount to setting the agreement aside. We decline to resort to such an extreme "remedy." See Mary Lou Claypool, 34 Van Natta 943, 947 (1982) ("Vacating a prior settlement is an extreme remedy to be granted sparingly in the most extreme situations").

We do note that claimant is entitled to such physical therapy as was anticipated at the time the agreement was signed. SAIF is free to petition the director for relief if it believes that further physical therapy beyond that is inappropriate, ineffective or provided in contravention of the medical services rules.

In light of our conclusion that the order should be enforced, claimant's request for remand is moot.

Claimant seeks penalties and attorney fees based on SAIF's allegedly unreasonable failure to provide physical therapy under the order. Considering the plain language of the order and the undisputed intent of the parties, we agree that SAIF's failure to comply with the terms of the agreement was unreasonable. However, because the services have not yet been rendered, there are no amounts due upon which to base a penalty, and we award none. Nevertheless, inasmuch as claimant would have received physical therapy benefits by the time of hearing had SAIF not unreasonably denied them, an attorney fee of $300 is assessed for SAIF's unreasonable resistance to the payment of compensation. ORS 656.382(1); Nicolasa Martinez, 43 Van Natta 1638, 1640 (1991).

Claimant is also entitled to an assessed attorney fee for prevailing on the issue of enforcement of the order. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the enforcement issue is $1,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, and the value to claimant of the interest involved.

ORDER

The Referee's order dated April 2, 1991 is reversed. The SAIF Corporation is directed to provide such physical therapy benefits as were contemplated by the June 8, 1990 order, without review by the Director. Claimant's counsel is awarded an assessed attorney fee of $300 for SAIF's unreasonable resistance to the payment of compensation. In addition, claimant's counsel is awarded an assessed attorney fee of $1,500, payable by SAIF, for prevailing on the enforcement issue at the hearing and appellate level.

In the Matter of the Compensation of
ARTHUR D. ESGATE, Claimant
WCB Case Nos. 90-12337, 91-00310 & 90-20329
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Beers, et al., Defense Attorneys
Marcia Barton (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

EBI Companies requests review of Referee Black's order that: (1) found that claimant's occupational disease claim with EBI for a right hand condition was not time-barred; (2) set aside EBI's denial; (3) upheld the SAIF Corporations's "amended" denial of claimant's occupational disease claim for the same condition; and (4) awarded a $3,000 carrier-paid attorney fee to be paid by EBI. On review, the issues are compensability, responsibility, res judicata and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Timeliness of Claim Against EBI

The Referee held that claimant's occupational disease claim against EBI was timely filed. Nevertheless, in doing so, the Referee suggested that had prejudice to EBI been established, the claim might be barred.

On review, EBI pursues this "prejudice" argument. While conceding that claimant's occupational disease claim is timely under ORS 656.807(1), EBI argues that since occupational diseases are generally considered injuries for the purposes of Chapter 656, claimant's claim should be found untimely under ORS 656.265(1). EBI's argument is without merit. ORS 656.804 does indeed provide that occupational diseases are to be considered an injury for employees of employers who have come under ORS 656.001 to 656.794, except as otherwise provided in ORS 656.802 to 656.807. ORS 656.807(1) sets out the requirements for timely filing an occupational disease claim. See Bohemia Inc. v. McKillop, 112 Or App 261 (1992). As it is undisputed that claimant's claim was timely filed under ORS 656.807, we adopt the Referee's conclusion.

Claim Preclusion Concerning SAIF Claim

SAIF denied claimant's occupational disease claim for a right hand condition on July 23, 1990. This denial was never appealed and became final by operation of law. Claimant refiled the claim against SAIF on October 11, 1990. SAIF issued an "amended" denial on October 24, 1990. The amended denial contained appeal rights. We adopt the Referee's finding that claimant did not show good cause for failing to timely appeal SAIF's first denial.

However, the Referee found that claimant filed a timely request for hearing with respect to SAIF's October 24, 1990 amended denial. Therefore, the Referee reasoned that he had jurisdiction to consider the compensability of claimant's occupational disease claim with SAIF. On review, SAIF asserts that claim preclusion bars claimant's October 1990 claim for the same condition which was denied in July 1990. We agree with SAIF's contention.

"Claim preclusion" precludes a plaintiff who has prosecuted one action against a defendant to a final judgment from prosecuting another action against the same defendant where the claim in the second action is based on the same

factual transaction that was at issue in the first, and where the plaintiff seeks a remedy additional or alternative to the one sought in the first, and is of such a nature as could have been in the first action. Drews v. EBI Companies, 310 Or 134, 140 (1990), (citing Rennie v. Freeway Transport, 294 Or 319, 323 (1982)). Claim preclusion does not require actual litigation.

Here, SAIF's July 23, 1990 denial became final because claimant chose not to request a hearing within 60 days. Moreover, claimant failed to establish good cause for failing to timely request a hearing. ORS 656.319(1)(b). Consequently, claimant may not litigate the same claim or claims which arise from the same transaction or series of transactions. See Carol D. Goss, 43 Van Natta 821 (1991); aff'd 110 Or App 151 (1991). We conclude that the effect of the July 1990 denial was to finally determine that claimant's right hand condition was not compensable.

Thus, claimant must show that his current right hand condition denied by the October 1990 "amended" denial has changed since the July 23, 1990 denial. See Proctor v. SAIF, 68 Or App 333 (1984); Irene Jensen, 42 Van Natta 2838 (1990). Our review confirms that claimant's present claim is for the identical condition which was denied by the July 23, 1990 denial. Furthermore, there is no evidence that claimant's condition has changed since July 23, 1990. The only medical report in the record after SAIF's October 1990 denial is a report by Dr. Woolpert. This report indicates that claimant has essentially the same symptoms, diagnosis and treatment that he had when he was evaluated by Dr. Herring in February and March of 1990.

Finally, there were no conditions present at the time of the October 1990 denial which did not already exist in July 1990. Accordingly, we find that under the doctrine of claim preclusion, claimant is barred from litigating the compensability of his present right hand condition against SAIF.

Compensability Against EBI

We adopt the conclusions and reasoning of the Referee concerning the compensability of claimant's occupational disease claim against EBI's insured.

Responsibility

Because we have found that claimant's occupational disease claim against SAIF is barred by claim preclusion, claimant's only viable occupational disease claim is against EBI's insured, which we have found to be compensable. Alternatively, in the event claimant's claim against SAIF was not barred, we would still conclude that EBI is the responsible insurer for the reasons given by the Referee. In making this alternative conclusion, we note that the Referee correctly applied 49 of Senate Bill 1197, now codified as ORS 656.308(1), to this case. See Donald C. Moon, 43 Van Natta 2595 (1991), (the term "new injury" as used in 49 applies equally to a new occupational disease).

Attorney Fee

EBI contends that the Referee assessed an excessive attorney fee. We disagree. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree with the Referee that $3,000 is a reasonable fee for claimant's counsel's services at the hearing level regarding this matter. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record, and statement of services), the complexity of the issues, the value of the interest involved, and the risk that claimant's attorney might go uncompensated.

Claimant is entitled to an assessed attorney fee for services on Board review. 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 attorney's services on review is $1,000, to be paid by EBI. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and statement of services), the complexity of the issues, and the value of the interest involved. We further note that claimant unsuccessfully contended on review that his failure to timely appeal SAIF's first denial had no preclusive effect on the litigation of SAIF's "amended" denial. Finally, claimant is not entitled to an attorney fee for services pertaining to the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated March 25, 1991 is affirmed. For services on Board review, claimant's attorney is awarded $1,000 payable by EBI.

April 30, 1992 Cite as 44 Van Natta 877 (1992)

In the Matter of the Compensation
THOMAS L. FITZPATRICK, Claimant
WCB Case No. 90-18827
ORDER ON REVIEW
John Mayfield, Claimant Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum, Hooton and Gunn.

The insurer requests review of Referee Peterson's order that: (1) set aside its denial of claimant's aggravation claim for a right knee condition; and (2) assessed a penalty and related attorney fee for the insurer's allegedly unreasonable denial. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant seeks additional compensation for a worsened right knee condition. The insurer denies compensability of the claimant's current right knee condition, asserting that his left knee and low back conditions, which are unrelated to the compensable right knee injury, are the major contributing cause of his right knee condition. Every aggravation claim has two components: causation and worsening. Both must be established, unless one is conceded. Here, both elements are challenged. Accordingly, we first address whether claimant's current condition is compensable. If it is compensable, then we determine whether claimant's condition is worse. See Bertha M. Gray, 44 Van Natta 810 (1992); Lareta C. Creasey, 43 Van Natta 1735 (1991).

The medical evidence shows that claimant's current right knee condition is a result of a combination of his compensable injury and his preexisting left knee and low back condition. Because the injury combined with a preexisting condition to cause a need for treatment and disability, the appropriate statute for determining compensability of the resultant condition is ORS 656.005(7)(a)(B). See Creasey, supra. Accordingly, claimant must prove that the compensable injury, rather than the preexisting conditions, is the major

contributing cause of his disability or need for treatment. Bahman M. Nazari, 43 Van Natta 2368 (1991). We conclude that claimant has failed to sustain this burden.

The only medical evidence that directly addresses the relative causal factors contributing to of claimant's current right knee condition comes from Dr. Thomas, the treating physician. On June 21, 1990, Dr. Thomas reported that the 1984 compensable injury was a contributing factor in claimant's current condition, but added that the fact that he puts increased stress on his right knee in order to protect his left knee, the fact that he limps due to his left knee and the fact that he has had back problems were also contributing factors. In that report, Dr. Thomas could not identify which of those was the major contributing factor. In a July 26, 1990 concurrence letter, however, he later agreed that those preexisting conditions, when viewed as a whole, were the major contributing cause of claimant's worsened condition.

Based on that report, and in the absence of any contrary evidence, we conclude that claimant has failed to prove by a preponderance of the evidence that the compensable right knee injury was the major contributing cause of the current right knee condition. Because claimant did not prove that the compensable injury was the major contributing cause of his current need for treatment and disability, his claim fails under ORS 656.005(7)(a)(B), and we need not address his aggravation claim arising out of his current condition.

In light of our conclusion, we further hold that the insurer had a legitimate doubt concerning its liability for the claim when it issued its denial. Consequently, we also reverse the Referee's penalty and attorney fee awards.

ORDER

The Referee's order dated February 1, 1990 is reversed. The insurer's denial is reinstated and upheld. The Referee's assessed penalty and related attorney fee award for an allegedly unreasonable denial are reversed.

Board Member Gunn dissenting.

The majority concludes that ORS 656.005(7)(a)(B) is applicable to cases arising under ORS 656.273. Because I believe that conclusion is contrary to the plain language of ORS 656.273, as well as its legislative history, I respectfully dissent.

The requirements necessary to obtain additional compensation for a worsened condition resulting from a compensable injury are contained in ORS 656.273(1), which 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. However, if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable."

That language has long been interpreted as requiring a claimant to prove that his compensable injury is a material contributing cause of the worsened condition, regardless of whether the claimant's initial claim was for an accidental injury or an occupational disease. See Smith v. SAIF, 302 Or 296 (1986); Grable v. Weyerhaeuser, 291 Or 387 (1981). Moreover, the statutory provision does not

refer to ORS 656.005(7)(a)(B) or vice versa; rather, each provision contains its own separate analyses, indicating that ORS 656.005(7)(a)(B) was not intended to be an initial requirement to proving an aggravation.

Despite the plain meaning of the statute, the majority holds that ORS 656.005(7)(a)(B) is applicable to claims arising under ORS 656.273 and, therefore, concludes that claimant must first establish that the compensable injury remains the major contributing cause of his current condition. The majority offers no analysis or support for that conclusion and evidently "assumes" a legislative intent to modify the aggravation analysis by first addressing "compensability" of the current condition. My review of the legislature's actions, however, suggests a contrary conclusion.

During its 1990 Special Session, the legislature amended both ORS 656.005(7)(a) and ORS 656.273. As noted above, however, neither amended statute refers to each other and continue to contain their own separate analyses. Had the legislature intended for the limitations contained in ORS 656.005(7)(a) to apply to aggravation claims, it could have so indicated. The fact that it did not implies a legislative intent to exclude related matters not mentioned. Gantenbein v. PERB, 33 Or App 309, 319, rev den 282 Or 537 (1978).

The majority's conclusion likewise finds no support from the actual revisions made by the legislature. In amending both provisions, the legislature added identical language to each analysis requiring "medical evidence supported by objective findings." If the legislature had indeed intended the limitations contained in ORS 656.005(7)(a) to apply to aggravations claims, a question arises why the legislature felt it was necessary to reiterate the requirement of medical evidence supported by objective findings in ORS 656.273(1).

I also believe that the majority's conclusion in this case is contrary to prior Board cases interpreting both provisions. In Robert E. Leatherman, 43 Van Natta 1677 (1991), we held that the legislature had not changed the standard of causation for an aggravation claim by rejecting the argument that a claimant must prove that the compensable injury was the major contributing cause of the worsened condition. Rather, we held that under ORS 656.273(1), "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 worsened condition." (Emphasis supplied).

More recently, in Rosalie S. Drews, 44 Van Natta 36 (1992), we held that the limitations of ORS 656.005(7)(a)(B) are not applicable in the responsibility context, limiting the application of that provision to determining the compensability of an injury claim. We reached that conclusion notwithstanding the fact that responsibility law explicitly incorporates the compensability definition in ORS 656.005(7)(a). Because ORS 656.273(1) contains no such reference, I find even less support to apply those provisions here, where the question presented is whether claimant has established a worsening of his compensable condition.

In short, I believe that the majority's holding requires statutory "leap of faith" best described in the legislative record by representative Campbell:

> "I want to spend just a minute, one of our fellow legislators made a comment about guts and courage and he also mentioned in passing the word faith. It reminded me of the two nuns that were [in] southeast Texas driving along in their Volkswagon and they ran out of gas miles from nowhere. They did remember [a] one pump station about three and a half miles back. They got out and went back to the one pump station. And the fellow was very understanding. He

said he would like to give them some gas to solve their problem, but there was nothing to carry it in. With that they found a rubbish pile, they found an old urinal bedpan and asked him if they could us it and he said yes. He gave them two gallons of gas. They went back to their Volkswagon, it was a long hot walk. They were very carefully pouring it into the Volkswagon when an old Texas cowboy rode up. He looked down and said, 'Ma'am that has to be the greatest sign of personal faith I've ever seen.'"

The majority makes this leap by ignoring the plain language of the statute and the basic rules of statutory construction. Because I believe the majority position to be in error, I respectfully dissent.

In the Matter of the Compensation of
MICHAEL P. FUNKHOUSER, Claimant
WCB Case No. 90-19982
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum and Gunn.

Claimant requests review of Referee Livesley's order that upheld the SAIF Corporation's denial of his occupational disease claim for bilateral overuse syndrome/degenerative arthritis of the wrists. On review, the issue is compensability.

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

Citing our decision in Rita R. Spurgeon, WCB No. 86-02697, claimant contends that his preexisting condition constitutes a susceptibility or predisposition to overuse problems, and that as such, it should not be considered. Our decision in Spurgeon was reversed on appellate court review. Liberty Northwest Ins. Corp. v. Rita A. Spurgeon, 109 Or App 566 (1991). In pertinent part, the court said:

"The Board concluded that causes of a disease that are personal to a claimant and independent of anything that happens off the job or on the job should not be considered in deciding whether work is the major contributing cause of the claimant's disease, relying in part on the principle that an employer takes the employee as it finds her that analysis fails to take into consideration the difference between a susceptibility or predisposition to a disease and a disease that is actually caused by ideopathic factors, independently of a claimant's activities or exposures anywhere. An employer is responsible for a disease that a claimant who has a particular susceptibility or predisposition develops due in major part to conditions at work. The predisposition to disease is not a ban to compensability, if work causes the disease. In that sense, the employer takes the employee as it finds her if, in contrast, a claimant develops a disease in major part because of factors personal to her that an independent of any activities or exposures either off or on the job, the claim is not compensable, even if work contributed to some degree to causing the disease. All causes of a disease, as opposed merely to a susceptibility or predisposition, must be considered in determining which, if any, was the major contributing cause." (109 Or App 568, 569 (1991)).

Here, we agree with the Referee that the opinions of Dr. Rockey and Dr. Schachaer are the most persuasive evidence on the question of causation. Dr. Schachaer opined that claimant suffers from osteoarthritis, a degenerative breakdown or wearing away of the joints in both wrists. According to Schachner, claimant developed the disease in major part because of genetic factors personal to claimant that are independent of any activities or exposures either off or on the job. Under Liberty Northwest Ins. Corp. v. Rita A. Spurgeon, supra, the genetic cause of claimant's osteoarthritis must be considered, for it is a cause of the osteoarthritis condition, as opposed to a condition which made claimant susceptible to developing osteoarthritis.

ORDER

The Referee's order dated June 7, 1991 is affirmed.

In the Matter of the Compensation of
KATI A. HANKS, Claimant
WCB Case No. 90-16204
ORDER ON RECONSIDERATION
Bischoff & Strooband, Claimant Attorneys
Meyers & Radler, Defense Attorneys

On February 24, 1992, we affirmed a Referee's order that declined to award benefits for temporary disability during the period that claimant was not performing her modified work duties due to a labor dispute lock out. On our own motion, we abated our order on March 25, 1992 for reconsideration and invited the parties to provide further written comment. Inasmuch as the employer's response has been received and the time for providing additional comment has expired, we proceed with our reconsideration.

We begin with a brief summary of the stipulated facts. In September of 1989, claimant injured her right wrist while working as a food clerk for the employer. The employer accepted the claim and offered claimant modified work at her regular wage, which claimant accepted. Claimant performed the modified work until July 21, 1990, at which time she was prevented from working due to a labor dispute lock out. Claimant's medical condition did not change during the three-week lock out, and she returned to her modified job upon the cessation of the labor dispute.

As noted above, the issue is whether claimant was entitled to temporary disability benefits during the lock out. In our Order on Review we concluded that she was not, and cited Roseburg Forest Products v. Wilson, 110 Or App 72 (1991), and Safeway Stores v. Owsley, 91 Or App 475 (1988), for the proposition that, in the absence of legislative direction to the contrary, benefits are not available if the loss of wages results from reasons other than the compensable injury.

On reconsideration, we find that Owsley and Wilson are distinguishable, and that claimant is entitled to the payment of temporary total disability during the period that her modified job was withdrawn by her employer.

In Owsley the court determined that an injured worker was not entitled to the payment of temporary total disability benefits when modified employment was terminated for causes unrelated to the compensable injury. In the present instance, however, claimant's employment was not terminated. The job remained, and claimant returned to her modified job when the employer-initiated lock out ended.

In Wilson, the court determined that an injured worker was not entitled to the resumption of temporary total disability benefits when that worker chose not to cross a picket line. While the offer of employment remained, the worker could have chosen, distasteful as that may be, to return to the modified job. While this case presents a closer issue than does Owsley, the absence of that choice in these circumstances represents a material, and determinative, difference from the facts presented in Wilson.

We note that the current version of OAR 436-60-030(1)(b) provides that temporary partial disability compensation shall continue until:

> "The job no longer exists or the job offer is withdrawn. This includes but is not limited to termination of temporary employment, layoff or plant closure. The worker is entitled to temporary total disability compensation as of the date the job no longer is available. Discharging the worker for violation of normal employment standards is not a withdrawal of a job offer."

That rule would support a conclusion that a claimant is entitled to temporary total disability benefits when a claimant's employer has effectively withdrawn its offer of modified employment by invoking a lock out. While we acknowledge that the current version of the rule did not become effective until December 26, 1990, and therefore does not control our disposition of the present claim, we find that the rule is an appropriate restatement of the law as it existed at the time of the events giving rise to the dispute here.

In Shirley J. Sanderson, 44 Van Natta 484 (1992) we stated that:

> "Former OAR 436-60-030(4)(a) and (b) provide for payment of temporary total disability under circumstances when the physician verifies that a worker cannot continue working or the job offer is withdrawn. These qualifying events are stated in the alternative." 44 Van Natta @ 484 (Emphasis added).

In that case, we found that the employer's inability to place the worker in other modified work, when the modified job offered by the employer was determined to be beyond the worker's physical limitations, represented a withdrawal of the offer of modified employment.

In the present claim, the employer's withdrawal of an offer of modified employment is equally clear. By locking claimant out of the workplace, the employer effectively, even if only temporarily, withdrew modified employment from the claimant. Claimant could not voluntarily choose to participate in the employment, neither is she able to return to her regular employment for another employer because of the disabling effects of her compensable injury. So long as she is unable to perform her regular work, and her modified job remained unavailable as a result of the conduct of the employer, she is unable to work on account of her injury for purposes of determining her entitlement to temporary total disability.

ORS 656.268 does not mandate a different result. The unilateral termination provisions in ORS 656.268(3)(c) are based on the premise that the client is or could be working. Here, claimant is physically unable to perform her regular work, and the offer of modified employment has been temporarily withdrawn. Through no fault, or choice of her own, claimant is unable to work, as a result of her injury.

Accordingly, our February 24, 1992 Order on Review is withdrawn. On reconsideration, the Referee's order dated April 5, 1991, as reconsidered May 15,

1991, is reversed. Claimant is entitled to temporary disability benefits for the period from July 22, 1990 through August 14, 1990, less any "strike benefits" actually received for walking the picket line. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

Board Member Kinsley dissenting.

As the court stated in Roseburg Forest Products v. Wilson, 110 Or App 72, 75 (1991):

> "The legislature intended temporary disability benefits to provide replacement for wages lost because of a compensable injury. Cutright v. Weyerhaeuser Co., 299 Or 290, 296, 702 P2nd 403 (1985). In the absence of a legislative direction to the contrary, TTD benefits are not available if the loss results from other than the compensable injury."

In this case, claimant lost wages due to the employer's action of implementing a lock out due to a labor dispute. Therefore, "the loss results from other than the compensable injury." Id. The majority opinion and the department's rule at OAR 436-60-030 place the claimant in a better position than that of her co-workers who were also locked out, but who did not have open workers' compensation claims. The claimant's remedy for lost wages should be the same as her co-workers: to seek employment elsewhere and apply for unemployment insurance benefits and/or pursue other legal remedies against the employer for implementing the lock out, if appropriate.

A cynic might see the majority opinion and the rule as an instruction manual to all workers to file workers' compensation claims when their employers are about to or have laid off workers for whatever reason, e.g., seasonal work, plant closures or layoffs, and pending labor disputes. By doing so, the worker obtains a revenue source not available to co-workers without claims.

Further, the effect of this policy is to promote an unqualified right to benefits for temporary total disability unless the employer at injury can come up with a job offer within a claimant's work release restrictions. Where, as here, a worker has been released to modified work, this policy puts absolutely no duty on the worker to mitigate the amount of benefits the employer must pay by requiring the worker to seek and obtain work within his or her restrictions to show they are still in the work force and entitled to benefits. Neither ORS 656.268(3) nor any other statute says that a worker does not have such a duty.

In this case, there is no evidence that the claimant sought any employment during the time she was released for modified employment and for which time period she is seeking an award of benefits for total disability. What if the employer at injury is unable to offer a job because business is down; or, worse, it has gone out of business; or, as here, because of a labor dispute? A cynic would say that this policy encourages workers to go on vacation while released for modified employment, yet be entitled to collect the full workers' compensation benefit for temporary total disability.

In conclusion, I believe that no valid workers' compensation system purpose is served by awarding benefits for temporary total disability when the reason a worker is not working is unrelated to the compensable injury. Further, no valid workers' compensation system purpose is served when we award benefits

for temporary total disability when a worker is released for modified work and yet require no action on the worker's part to seek and obtain employment within his or her restrictions. For these reasons, I respectfully dissent.

In the Matter of the Compensation of
STEVEN C. HARSH, Claimant
WCB Case No. 90-21949
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Tenenbaum's order that affirmed the Director's Order which held that he was not entitled to vocational services. On review, the issue is whether the Referee correctly affirmed the Director's order. We affirm.

BACKGROUND

We adopt the Referee's "Findings."

CONCLUSIONS OF LAW AND OPINION

The Referee affirmed the Director's order which found that claimant was not eligible for vocational services. In arriving at her conclusion, the Referee relied upon the reasoning within a Director's Bulletin (Bulletin Number 234, April 16, 1991) and upon the fact that no statute authorized vocational services for a claimant whose aggravation rights have expired.

On review, claimant disagrees with the Referee's interpretation of the Own Motion statute. Claimant contends that the Board has the authority to award vocational services for claimants in Own Motion status.

We note that, because this matter involves a Director's order, our review is limited pursuant to ORS 656.283(2). That statute provides that the Director's decision as to vocational assistance matters may be modified only if the decision: (a) violates a statute or rule; (b) exceeds the statutory authority of the agency; (c) was made upon unlawful procedure; or (d) was characterized by an abuse of discretion or clearly unwarranted exercise of discretion.

A finding of one of the circumstances listed at ORS 656.283(2)(a) though (d) is mandatory before a Director's order may be changed by a Referee. See Lonnie H. Stout, 42 Van Natta 2548 (1990).

In the present case, the Director did not base his conclusion regarding claimant's eligibility for vocational assistance upon a finding that such eligibility would be precluded for a claimant whose claim is in Own Motion status. Accordingly, we do not find that the issue is properly before us in our review of the Director's order.

The Director did, however, find that claimant was unable to provide any documentation of earnings. The Director concluded that only minimal earnings could be assumed and claimant was capable of performing entry level minimum wage jobs within the sedentary and modified light ranges, and such jobs were amply available within claimant's area. In reaching his conclusion, the Director relied upon OAR 436-120-005 and OAR 436-120-040.

On review, claimant apparently contends either that the Director's decision violates a statute or rule or that the Director abused his discretion by applying the aforementioned rules. Claimant argues that the Director should have compared his wages to the wage at the time of the initial injury (as adjusted for inflation), rather than at the time of worsening. Claimant argues that his job at the time of injury was currently paid at approximately $15 per hour, while at the time of hearing he was earning $7.50 per hour, which is not within 80 percent of the current wage for his regular employment. See OAR 436-12-005(6)(a)(B).

The insurer argues that OAR 436-120-005(6)(b) defines regular employment as the kind the worker held at the time of the injury or the claim for aggravation, whichever gave rise to the eligibility for vocational assistance. The insurer contends that the Director found that claimant had been self-employed as a flea market stand operator, and, although he contended he received a net wage of $250 per week, he was unable to document such earnings. Accordingly, the insurer argues that the Director properly presumed a minimum wage and found that claimant was capable of performing entry-level minimum wage jobs within the sedentary to light range.

Upon review of the Director's order, we are unable to conclude that the Director's order falls within one of the circumstances listed in ORS 656.283(a) through (d). We do not find that the Director violated a rule or statute or abused his discretion in determining that claimant earned a minimum wage because he was unable to document his earnings as operator of a flea market stand. We also do not find that the Director abused his discretion by finding that claimant does not have a substantial handicap to employment. Therefore, we conclude that we do not have the authority to modify the Director's order. ORS 656.283(2). The Referee's order is affirmed.

ORDER

The Referee's order dated August 7, 1991 is affirmed.

April 30, 1992 Cite as 44 Van Natta 885 (1992)

In the Matter of the Compensation of
KRISTEN A. HART, Claimant
WCB Case No. 90-16779
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

Claimant requests review of Referee Podnar's order that increased her unscheduled permanent partial disability award from 7 percent (22.4 degrees), as awarded by Determination Order, to 19 percent (60.80 degrees). The self-insured employer argues that the Referee incorrectly rated claimant's impairment; however, the employer contends that the Referee's award should be affirmed. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "FINDINGS," with the following modifications.

Instead of the finding that claimant regularly lifted up to 50 pounds in her job at injury, we find that claimant lifted up to 50 pounds on an occasional to frequent basis, requiring medium to heavy physical capacity.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "CONCLUSIONS," with the following modifications.

Claimant challenges the Referee's rating of the values for the adaptability and impairment factors. Regarding adaptability, claimant contends that the Referee erred in rating the physical capacity of her job at injury as medium. She contends the job required heavy physical capacity. We disagree.

According to former OAR 436-35-310(4), "heavy" physical capacity is the ability to lift over 50 pounds occasionally or up to 50 pounds frequently, while "medium" capacity is the ability to lift up to 50 pounds occasionally or up to 25 pounds frequently.

Claimant testified that, in her job-at-injury as a courtesy clerk, she lifted crates of milk weighing 50 pounds. (Tr. 8). However, she did not indicate whether that activity was frequent or occasional. Absent such evidence, we conclude that this record is insufficient to support a finding that the physical capacity required to perform the job-at-injury was anything more than medium/heavy. Furthermore, claimant does not challenge the Referee's finding that she can perform light/medium work. Accordingly, using the matrix at former OAR 436-35-310(3), we conclude the value of the adaptability factor is 1.5, the same value attributed by the Referee.

Claimant also contends that the Referee erred in rating the impairment factor based on range-of-motion findings in the independent medical examination (IME) report of Drs. Fuller and Fabricius (Ex. 95), rather than the report of Dr. Leistikow (Ex. 92). Claimant argues that Dr. Leistikow's findings should be given greater weight because Dr. Winans, attending physician, concurred with those findings. (Ex. 94). We disagree.

ORS 656.245(3)(b)(B) provides that "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." Thus, the Referee should not have relied on the IME findings in rating impairment. Nevertheless, we are not persuaded that Dr. Winans made any findings regarding claimant's impairment. Rather, the findings were made by Dr. Leistikow, a chiropractor who could not be claimant's attending physician. See ORS 656.005(12)(b). Although Dr. Winans concurred with Dr. Leistikow's findings, he did so by check-the-box response with no explanation or discussion. Furthermore, Dr. Winans referred claimant to Dr. Leistikow for treatment in July 1990 and did not examine claimant again until December 31, 1990. Claimant was not referred by Dr. Leistikow for purposes of rating her impairment. Accordingly, we do not consider Dr. Winans' concurrence to be persuasive evidence concerning claimant's range of motion. Finally, Drs. Fuller and Fabricius, who conducted the IME, found claimant had a greater range of motion than was found by Dr. Leistikow. Under these circumstances, we decline to rely on Dr. Leistikow's findings. See Arlene J. Koitzsch, 44 Van Natta 776 (1992). Accordingly, claimant has not sustained her burden of proving that she is entitled to an additional award of permanent disability.

Finally, although the employer appears to challenge some of the Referee's findings regarding claimant's L4-5 disc and her chronic condition, we decline to consider those challenges because it contends that the Referee's award should be affirmed.

ORDER

The Referee's order dated April 18, 1991 is affirmed.

In the Matter of the Compensation
PRISCILLA V. HERNANDEZ, Claimant
WCB Case No. 91-10952
ORDER OF DISMISSAL (REMANDING)
Whitehead & Klosterman, Claimant Attorneys
James Booth (Saif), Defense Attorney

Claimant requested review of Referee Garaventa's order which: (1) held that an Order on Reconsideration issued by the Director (Appellate Unit of the Evaluation Section) was invalid; (2) jurisdiction remained with the Appellate Unit; and (3) dismissed claimant's hearing request from the Order on Reconsideration. The parties have submitted a proposed "Stipulation and Order of Remand," which is designed to resolve the issue presently pending Board review.

Specifically, the parties expressly agree to "waive any procedural defects mandated by ORS 656.268(7)." Inasmuch as the Referee dismissed claimant's hearing request without a hearing, the parties further seek remand for the convening of a hearing.

We have recently held that an Order on Reconsideration is invalid where the basis for a request for reconsideration is a disagreement with the medical findings for impairment and the Director has not submitted the matter to a medical arbiter or panel of arbiters prior to issuance of the Order on Reconsideration. Olga I. Soto, 44 Van Natta 278 (1992). We have also concluded that, where the basis for a request for reconsideration is not a disagreement with the impairment findings but rather how the Director's standards were applied to those findings, the Director was not required to submit the matter to a medical arbiter or panel of arbiters prior to issuance of an Order on Reconsideration. Doris C. Carter, 44 Van Natta 769 (1992).

Here, claimant's request for reconsideration did not register a disagreement with the attending physician's impairment findings. Rather, she noted her disagreement with the rating of disability by the insurer in its March 19, 1991 Notice of Closure. (Ex. 24A). Under such circumstances, the submission of the matter to a medical arbiter before issuance of an Order on Reconsideration would not be required. Doris C. Carter, supra.

In accordance with the Carter holding, we conclude that the Order on Reconsideration was validly issued. Consequently, the Referee had jurisdiction to consider claimant's hearing request. Thus, we vacate the Referee's order. Inasmuch as the Referee dismissed this matter without a hearing, we remand to Referee Garaventa for the convening of a hearing. In light of our reasoning, it is unnecessary to approve the parties' proposed stipulation.

IT IS SO ORDERED.

In the Matter of the Compensation of
BARBARA J. JAMES, Claimant
WCB Case No. 90-16313
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
David Schieber (Saif), Defense Attorney

Reviewed by Board Members Tenenbaum and Kinsley.

The SAIF Corporation requests review of Referee Mongrain's order that set aside its partial denial of claimant's claim for a C6-7 herniated disc condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except for his "Ultimate Findings of Fact," with the following supplementation.

Radiographic testing did not reveal a protruding or herniated disc at C6-7 until July 1990. (See Exs. 5, 7, 8-4, 12-2, 21, 32).

CONCLUSIONS OF LAW AND OPINION

The sole issue on review is whether claimant's C6-7 herniated disc condition is compensable. The Referee analyzed this claim as an initial injury claim under ORS 656.005(7)(a), and the parties do not dispute that the condition is claimed to be a direct result of the compensable October 15, 1989 left shoulder injury. Accordingly, in order to prove that her C6-7 herniated disc is compensable, claimant must prove that her 1989 work injury is a material cause of that condition. See Mark N. Wiedle, 43 Van Natta 855 (1991).

Referee concluded that the claim is compensable, based on Dr. Campagna's opinion. We disagree.

Considering the number of potential causal factors and the passage of time since the compensable injury, we find that the causation of claimant's current problems is a complex medical question requiring expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986).

The only medical evidence supporting the claim is the opinion of Dr. Campagna, current treating physician. Although we generally defer to the opinion of the treating physician, we do not do so where there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). In this case, we find such reasons. Because Dr. Campagna first treated claimant nine months after her compensable left shoulder injury, he was not in a position to assess first-hand either the initial impact of the injury or the progression of claimant's symptoms and clinical findings. Consequently, we do not defer to Campagna's opinion. Moreover, we find that the opinion lacks persuasive force because it is not adequately explained. See Somers v. SAIF, 77 Or App 259 (1986).

On July 24, 1990, Dr. Campagna examined claimant and diagnosed, without explanation, "[s]evere nerve root compression C8 left, secondary to herniated nucleus pulposus as a result of industrial accident of 10/89." (Ex. 30-3). He found subsequent test results "compatible with C7 nerve root compression on the left." (Ex. 31). On September 6, 1990, Campagna opined, again without explanation, that claimant's October 15, 1989 work injury was the "most probable cause" of her protruding C6-7 disc." (Ex. 41; see Ex. 43A). On October 20, 1990, Dr.

Campagna signed a letter written by claimant's attorney, indicating his concurrence with its contents. (See Ex. 42-2). The letter states that it was "reasonable" that the diagnosis of a herniated cervical disc "arose sometime after" claimant's work injury and that the initial MRI of the cervical spine "did not give a complete diagnostic picture of her condition in late 1989." (Ex. 42-1). The letter also describes Campagna's opinion that the discs, "whether initially present immediately after the injury or not, were neurologically consistent with the mechanics of the described injury, the history of her symptoms . . . and her current symptoms." (Id.) It concludes that the major cause of the herniation was the work injury. (Id.)

Campagna found that claimant's disc problems were "consistent" with her symptoms and the mechanism of the October 1989 injury. However, we find that an opinion based on consistency between the mechanism of injury, symptoms and the current diagnosis, without more, establishes only the possibility of a causal relationship. See Gormley v. SAIF, 52 Or App 1055 (1981). In addition, Campagna found the delay between the injury and the diagnosis to be "reasonable," concluding, essentially that, whenever the herniation happened, the injury was the cause. However, because Campagna failed to explain how the injury caused the herniation, whether at the time of the incident or sometime later, and because he apparently did not consider whether claimant's preexisting degenerative condition was a potential cause, we find that his opinion is not well-reasoned, and accord it little weight. There is no other medical evidence supporting claimant's claim. Consequently, we conclude that she has not carried her burden of establishing by a preponderance of the evidence that her work injury to her left shoulder is the material cause of her C6-7 herniated disc.

ORDER

The Referee's order dated April 17, 1991 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's awards of assessed attorney fees are also reversed.

In the Matter of the Compensation
JIMMIE JORDAN, Claimant
Own Motion No. 90-0193M
OWN MOTION ORDER OF DISMISSAL
Malagon, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

Claimant has requested the assessment of penalties and attorney fees for the insurer's allegedly unreasonable processing of his claim. We dismiss claimant's request for lack of jurisdiction.

ORS 656.262(10)(a) provides that "[n]notwithstanding any other provision of [ORS Chapter 656], the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of [the penalty] described in this subsection." (Emphasis added). Here, claimant is seeking the assessment of penalties and attorney fees. We have previously held that we cannot assess penalty-related attorney fees based on the same conduct for which penalties are assessed under ORS 656.262(10)(a). Nicolasa Martinez, 43 Van Natta 1638 (1991). Consequently, claimant's request is only for the assessment of penalties. Inasmuch as such requests are within the Director's exclusive jurisdiction, notwithstanding any other statutory provision, including ORS 656.278, we conclude that we lack jurisdiction of claimant's request. Accordingly, claimant's request for penalties is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
THURMAN M. MITCHELL, Claimant
WCB Case No. 91-01888
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

The SAIF Corporation requests review of Referee Livesley's order that: (1) directed it to pay claimant temporary total disability benefits from August 1, 1990 to October 1, 1990; and (2) assessed a penalty for SAIF's allegedly unreasonable claims processing. On review, the issues are temporary total disability and penalties. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was procedurally entitled to temporary disability benefits during the time he was incarcerated. We disagree.

Section 50 of Senate Bill 1197 (codified ORS 656.160) provides:

> "Notwithstanding any other provision of this chapter, an injured worker is not eligible to receive compensation under ORS 656.210 or 656.212 [which provide for temporary total and partial disability benefits] for periods of time during which the worker is incarcerated for the commission of a crime. As used in this section, an individual is not 'incarcerated' if the individual is on parole or work release status."

See also OAR 436-60-045(1)(b).

In the present case, claimant contends that he was not "incarcerated" as defined by the statute. Claimant argues that, although he was not medically stationary, he was released for light work. Claimant contends that because he was released for work, he was therefore eligible for work release, and consequently, was on "work release status." We disagree.

At hearing, claimant testified that he participated in a work-release program. Claimant testified that the doctor released him to light duty work detail and he mopped floors and cleaned bathrooms inside the jail. Claimant was not paid for the work but he testified that, for performing such work, his time in jail would be reduced.

We are not persuaded that claimant's light duty work within the jail constitutes a "work release program" for purposes of Section 50 of Senate Bill 1197. ORS 144.420 provides that the Department of Corrections shall establish and administer a work release program in which a !!misdemeanant or felon may participate, and if confined, be authorized to leave assigned quarters for the purposes of, among other things, obtaining additional education, participating in treatment programs and developing independent living skills.

Furthermore, ORS 144.450 provides that when a person is sentenced to the custody of Corrections, the court may recommend the option of serving the sentence by enrollment in a work release program. ORS 144.450 requires the

director to approve or reject each recommendation for enrollment in the work release program and provides that no person may be enrolled without the consent of the person in writing.

In the present case, claimant has not provided evidence that he has been recommended by the court or approved by the director for enrollment in a work release program pursuant to ORS 144.420. Claimant has not testified that he gave his consent, in writing, to enrollment in such a program. Finally, at hearing, claimant testified that he did not perform any work outside of jail and he would not be permitted to do so as he was still under a doctor's care. Moreover, claimant testified that he believed that he was on work-release, but he did not ever receive any documentation to that effect.

Under the circumstances, we do not find that the light duty release by claimant's doctor, or claimant's statements that he believed he was eligible for work release establish that he was, in fact, on work release status.

Claimant next contends that SAIF had a duty to investigate his status before it terminated his temporary disability benefits. Claimant argues that SAIF should have notified him that if he provided proof of parole or work release status that his benefits would not be suspended.

We would agree with claimant's contention if SAIF had evidence that claimant was on parole or work release and it nonetheless terminated his temporary disability benefits. However, in this case, the only information that SAIF received was that claimant had been convicted and incarcerated for a 90 day period. Under the circumstances, SAIF was entitled to terminate claimant's temporary disability benefits. We, therefore, reverse the Referee on the issue of entitlement to temporary disability benefits.

Penalty

The Referee concluded that a penalty was appropriate as there was no evidence that SAIF inquired into whether claimant was on parole or work release status before it terminated his temporary disability benefits. We continue to conclude that, if SAIF had notice that claimant was on such status, it would be required to further investigate before temporary disability benefits could be terminated. However, in the present case, the evidence provided to SAIF was that claimant had been convicted and incarcerated, rather than released on parole or work release. Moreover, we have above concluded that claimant was not on work release for purposes of the statute.

Accordingly, we do not find that SAIF acted unreasonably when it terminated claimant's temporary disability benefits. We therefore reverse the Referee on the penalty and related attorney fee issue. The Referee's approved attorney fee award is also reversed.

ORDER

The Referee's order dated June 21, 1991 is reversed.

In the Matter of the Compensation of
RICHARD L. PAQUETTE, Claimant
WCB Case Nos. 90-19368, 90-19367 & 90-11122
ORDER ON REVIEW
Garlock, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys
Thomas Castle (Saif), Defense Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Gunn.

Claimant requests review of Referee Thye's order that: (1) upheld EBI Companies' denial, on behalf of International Yogurt, of his "new injury" claim for a back condition; (2) upheld the SAIF Corporation's denial, on behalf of Carlton Services, of his aggravation claim for the same condition; and (3) upheld SAIF's denial, on behalf of Little Fleet Trucking, of his aggravation claim for the same condition. On review, the issues are compensability, responsibility, and, if responsibility does not shift from SAIF to EBI, aggravation. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability-cervical condition

Concerning claimant's claim for a cervical condition, we adopt the portion of the Referee's order entitled "New Injury" on page 4 of the order, with the following supplementation.

Claimant did not have a compensable neck or upper back condition prior to the alleged April 17, 1990 work incident. Therefore, compensability of the claimed cervical condition is a threshold issue in this responsibility case. See Joseph L. Woodard, 39 Van Natta 1163, 1164 (1987). Considering the number of potential causal factors, particularly claimant's prior back injuries and multiple work exposures, the causation issue is a complex medical question. Thus, resolution of this issue requires expert medical evidence. Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

We note at the outset that claimant apparently did not seek treatment for his neck until six weeks after the alleged April 17, 1990 work incident. Second, we note that only one medical report in the record, a May 31, 1990 letter by Dr. Baum, (Ex. 124), mentions claimant's cervical complaints. Finally, no medical opinion, including that of Dr. Baum, relates claimant's cervical complaints to his work or to the alleged incident of April 17, 1990. For these reasons, we conclude that claimant has not established that any cervical condition which he may have is work-related. Therefore, the claim is not compensable.

Responsibility for middle and low back conditions

The SAIF Corporation, on behalf of Little Fleet Trucking, the employer/insurer with which claimant has the most recent accepted middle and low back claim, is presumptively responsible for claimant's current middle and low back conditions. See ORS 656.308(1); Ricardo Vasquez, 43 Van Natta 1678 (1991); see also Industrial Indemnity Company v. Kearns, 74 Or App 583 (1984) (Where successive injuries are to the same body part, a rebuttable presumption exists that

the last compensable injury contributed to the worsened condition and that the insurer on the risk at that time is responsible). Thus, SAIF remains responsible for these conditions, unless "the worker sustains a new compensable injury involving the same condition." ORS 656.308(1). In order to shift responsibility to the later carrier, SAIF must show that claimant sustained a new compensable back injury during EBI's coverage.

To establish a new compensable injury, SAIF must establish, by medical evidence supported by objective findings, that claimant sustained a subsequent injury, causing disability or need for medical services involving his middle and low back condition, the material contributing cause of which was his work exposure with EBI's insured. Mark N. Weidle, 43 Van Natta 855 (1991); see ORS 656.005(7)(a); 656.005(19); Suzanne Robertson, 43 Van Natta 1505 (1991).

In the present case, the medical evidence indicates that claimant's current middle and low back problems result from conditions in existence prior to his employment with EBI's insured. In reaching this conclusion, we note and defer to the Referee's demeanor-based negative credibility finding concerning claimant. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). For these reasons, we conclude, as did the Referee, that claimant has not established that he suffered a new injury in April 1990. Therefore, SAIF, on behalf of Little Fleet Trucking, remains responsible for disability and treatment related to claimant's accepted mid/low back condition.

Aggravation

We adopt those portions of the Referee's order, on pages five and six, which address claimant's aggravation claim. We conclude, as did the Referee, that claimant has not proven that any symptomatic worsening which he may have experienced since the last arrangement of compensation has been greater than the waxing and waning of symptoms anticipated (see Ex. 106) by the last arrangement of compensation, a July 28, 1989 Opinion and Order (Ex. 109A). See ORS 656.273. Therefore, claimant has not proven a compensable worsening.

ORDER

The Referee's order dated April 23, 1991 is affirmed.

April 30, 1992 Cite as 44 Van Natta 893 (1992)

In the Matter of the Compensation of
GERALD R. PARKER, Claimant
WCB Case No. 90-20444
ORDER ON REVIEW
Aller & Morrison, Claimant Attorneys
Phillip Nyburg, Defense Attorney

Reviewed by Board Members Moller and Neidig.

The insurer requests review of Referee McWilliams' order that awarded claimant a $3,000 attorney fee under ORS 656.386(1) for obtaining compensation for claimant without a hearing. On review, the insurer contends that the Referee lacked authority to award an attorney fee under the claim number stated in the order and, alternatively, the award was excessive.

We affirm the Referee's conclusion that claimant was entitled to an attorney fee under ORS 656.386(1). However, we modify the Referee's attorney fee award. We provide the following supplementation and modification.

In August 1990, Dr. Cervi-Skinner, claimant's physician, submitted a medical report to the insurer. (Ex. A). Skinner reported that claimant was suffering a "recurrent left inguinal hernia." In addition, Dr. Skinner noted that claimant had previously suffered a left inguinal hernia in 1988. The prior injury had been accepted by the insurer under claim number C604-177307.

In August 1990, claimant also filed a "new injury" claim for his hernia with his employer (the same employer who was insured by the same insurer who had accepted his 1988 hernia claim). (Ex. AA). In October 1990, the insurer denied claimant's August 1990 injury claim. (Ex. B). The insurer noted that the claim number was C604-288629. The insurer did not accept or deny claimant's aggravation claim concerning the 1988 injury.

In November 1990, claimant requested a hearing. As issues, claimant raised compensability and aggravation. Claimant's hearing request carried claim number C604-288629, which was the claim number that corresponded with the insurer's denial. In response, the insurer denied that claimant had suffered an injury/occupational disease or an aggravation.

Prior to the scheduled hearing, the parties agreed that the insurer would accept claimant's hernia condition as an aggravation of the 1988 claim. (Claim number C604-177307). The parties also agreed that the insurer's denial of claimant's August 1990 injury claim would stand. (Claim number C604-288629). Unable to resolve the issue of claimant's entitlement to, and the amount of, an attorney fee, the parties submitted that issue to the Referee.

Thereafter, the Referee concluded that claimant's attorney had been instrumental in obtaining compensation for claimant without a hearing. Consequently, the Referee held that claimant was entitled to an insurer-paid attorney fee under amended ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4), the Referee found that $3,000 was a reasonable insurer-paid attorney fee.

On review, the insurer renews its contention that the Referee lacked "jurisdiction" to award claimant an attorney fee under claim number C604-177307 (the 1988 claim) because claimant's hearing request expressly pertained to claim number C604-288629 (the August 1990 claim) and the parties did not agree to include the 1988 claim number in their dispute. We acknowledge that claimant's hearing request did not include a reference to the 1988 claim number.

Nevertheless, claimant's hearing request expressly raised "Aggravation ORS 656.273" as one of the issues for hearing. Inasmuch as more than 90 days had elapsed since Dr. Cervi-Skinner's medical report (which noted a "recurrent" hernia, as well as a 1988 prior injury) and no denial of claimant's aggravation claim concerning the 1988 accepted hernia condition had been forthcoming, claimant was entitled to seek a hearing regarding the insurer's "de facto" denial of his aggravation claim. See Barr v. EBI Companies, 88 Or App 132, 134 (1987); Euzella Smith, 44 Van Natta 778 (1992).

Under such circumstances, we conclude that the compensability of claimant's current hernia condition, either as an injury claim or as an aggravation claim, was placed in issue by his hearing request and the insurer's response which denied both an injury and an aggravation. Furthermore, since the insurer agreed to accept claimant's condition as an aggravation of his 1988 claim prior to the scheduled hearing regarding that hearing request, we further hold that the Referee had jurisdiction under that hearing request to determine claimant's entitlement to an attorney fee under amended ORS 656.386(1). In effect, the Referee held that claimant's counsel had been instrumental in obtaining the rescission of the insurer's "de facto" denial without a hearing.

In conclusion, the caption for claimant's hearing request, as well as the caption for the Referee's order, should have included a reference to claimant's 1988 claim (C604-177307). However, the omission of this claim number does not prevent the Referee or this Board from exercising their authority to address issues which are timely and properly raised pursuant to ORS 656.283(1) and 656.319(1).

Accordingly, we hold that the Referee had jurisdiction to determine whether claimant's counsel was instrumental in obtaining compensation for claimant without a hearing; i.e., in prompting the rescission of the insurer's "de facto" denial of claimant's aggravation claim. As supplemented and modified herein, we affirm that portion of the Referee's order.

Having concluded that claimant is entitled to an attorney fee award under ORS 656.386(1), we next address the insurer's contention that the Referee's $3,000 attorney fee award was excessive. Following our review of this record, we modify the Referee's attorney fee award.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable attorney fee concerning the insurer's pre-hearing acceptance of claimant's aggravation claim prior to hearing is $2,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record, the parties' stipulation of facts, and claimant's attorney's affidavit), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney might go uncompensated.

Inasmuch as attorney fees are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for services on Board review. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated July 15, 1991 is affirmed with the following modification. In lieu of the Referee's attorney fee award, claimant is awarded a $2,000 reasonable attorney fee, to be paid by the insurer. This attorney fee award is payable by the insurer under claim number C604-177307 for claimant's counsel's services in prompting the rescission of the insurer's "de facto" denial of claimant's aggravation claim.

In the Matter of the Compensation of
ROBERT E. PAYNE, SR., Claimant
WCB Case No. 91-07058
ORDER ON REVIEW (REMANDING)
Merrill Schneider, Claimant Attorney
Kathryn L. Alvey (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Hooton.

Claimant requests review of Referee Davis' order that dismissed claimant's request for hearing on a Determination Order on the grounds that it was untimely. On review, the issue is dismissal. We set aside the Order of Dismissal and remand to the Hearings Division.

FINDINGS OF FACT

In September 1987, claimant twisted his right ankle while working as a garbage collector for the insured. SAIF accepted the claim as a disabling

injury and provided medical benefits and time loss. The claim was closed by a February 17, 1988 Notice of Closure with no permanent disability.

In June 1988, claimant reinjured his right ankle and sought additional compensation. Pursuant to an Opinion and Order dated August 18, 1989, SAIF reopened the claim and provided benefits for a worsening of the original injury. The claim was reclosed by a December 11, 1989 Notice of Closure, which awarded benefits for additional temporary total disability and 2 percent scheduled permanent disability for injury to the right foot.

Meanwhile, claimant had sustained an aggravation due to a right knee and ankle strain in November 1989. The claim was reclosed by an August 31, 1990 Determination Order, which awarded additional benefits for periods of temporary total disability and 10 percent scheduled permanent disability for the loss of the right leg (knee). The Determination Order found claimant's condition medically stationary on July 26, 1990.

On February 25, 1991, claimant filed a request for reconsideration of the Determination Order with the Department of Insurance and Finance. The Department determined that June 4, 1990 was the correct medically stationary date and, on May 29, 1991, dismissed the request for reconsideration for lack of jurisdiction. On June 3, 1991, claimant filed a request for hearing, challenging the award of permanent disability and seeking attorney fees.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's request for hearing on the August 31, 1990 Determination Order was untimely. We disagree.

When a claim is closed by a Determination Order, an objecting party must first request reconsideration of the order with the Department. ORS 656.268(5). ORS 656.268(6)(b) provides:

> "If any party objects to the reconsideration order, the party may request a hearing under ORS 656.283 within 180 days after copies of the notice of closure or the determination order are mailed, which ever is applicable. The time from the request for reconsideration until the time the reconsideration is made shall not be counted in any limitation on the time allowed for the request for hearing."

OAR 436-30-050(3) further provides:

> "The time required to complete the reconsideration proceeding pursuant to this rule shall not be included in the 180 days from the mailing date of the Notice of Closure or Determination Order to request a hearing. The 180 day time frame will be tolled upon receipt of the request for reconsideration until the date the reconsideration order is issued."

In this case, claimant filed his request for reconsideration on February 25, 1991, and the Department issued its order on May 29, 1991. The time from the August 31, 1990 Determination Order to the date the Appellate Unit received the request for reconsideration on February 25, 1991 was 177 days. This calculation was arrived at by excluding the date of the Determination Order and the date the request for reconsideration was received, in accordance with the last sentence of ORS 656.268(6)(b). Therefore, claimant had three more days after the May 29, 1991 Order on Reconsideration (the date of the Order on Reconsideration is also excluded), or until June 1, 1991, to file his request for hearing.

However inasmuch as June 1, 1991 was a Saturday, the last day for filing a hearing request was the next business day on Monday, June 3, 1991. ORCP 10A; ORS 174.120; see also Anita L. Clifton, 43 Van Natta 1921 (1991). Because claimant's request for hearing was filed on June 3, 1991, the request was timely.

Accordingly, claimant's hearing request on the August 31, 1990 Determination was timely filed. The Referee's dismissal order is vacated. Because the Referee dismissed the case without an evidentiary hearing, this matter is remanded to the Hearings Division to convene a hearing.

IT IS SO ORDERED.

In the Matter of the Compensation of
NANCY R. SANTOS, Claimant
WCB Case No. 90-21316
ORDER ON REVIEW
Olson, Rowell & Walsh, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Hooton and Tenenbaum.

The insurer requests review of that portion of Referee Harri's order that set aside its denial of claimant's occupational disease claim for a mental disorder. Claimant cross-requests review of that portion of the order that awarded attorney fees for services rendered in overturning the denial. On review, the issues are compensability and attorney fees.

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

The insurer argues that a mental disorder must be severe, chronic and extraordinary to give rise to a compensable claim. It provides a compendium of prior Board decisions to support its position. While each of those cases may involve events that are more obviously extraordinary than those in the present claim, each claim for the compensability of a mental condition must be established on its own proof. We have not stated, intentionally or otherwise, a burden, or standard of proof not present in ORS 656.802(2).

The insurer also relies heavily on the Referee's statement that: "Some raising of voices, in connection with disciplinary situations, may be generally inherent and reasonable in the work place in some circumstances." (O&O p.5). That reliance is misplaced. The Referee specifically found, and we agree, that:

> "The meeting in Mr. Litzer's office did not involve merely a passing comment -- it involved a period of time exceeding the 5-10 minutes that Dr. Turco acknowledged would be sufficiently discomforting to result in situational stress. The type of comments and the manner in which the meeting was handled resulted in the situation's going beyond the protection that the statute provides for conditions generally inherent in the work place or for reasonable disciplinary, corrective or job performance evaluation actions." (O&O p.8, citations omitted).

Both the treating physician (Ex. 34) and Dr. Turco (Ex. 39 pp. 14-15) opined that the disciplinary actions of Mr. Litzer were unreasonable. Given our

adoption of the Referee's findings on credibility, there is no reliable contrary evidence.

Claimant is entitled to an assessed attorney for prevailing over the insurer's request for 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 attorney services on review is $1250, 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 issues, and the value of the interest involved.

ORDER

The Referee's order dated July 8, 1991 is affirmed. For services on Board review concerning the compensability issue, claimant's attorney is awarded an assessed fee of $1,250, to be paid by the insurer.

April 30, 1992 Cite as 44 Van Natta 898 (1992)

In the Matter of the Compensation of
LEWIS L. SEAL, Claimant
WCB Case No. 90-08065
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Gunn and Tenenbaum.

Claimant requests review of that portion of Referee Menashe's order that upheld the insurer's October 9, 1990 back-up denial of claimant's aggravation claim for a back condition. The insurer cross-requests review of those portions of the order that: (1) directed it to pay claimant an unspecified amount of temporary total disability for the period from October 27, 1989 to October 9, 1990; and (2) assessed a penalty for the insurer's allegedly unreasonable resistance to the payment of compensation. On review, the issues are aggravation, temporary total disability and penalties. We affirm in part, reverse in part, and vacate in part.

FINDINGS OF FACT

On December 7, 1988, claimant suffered a compensable middle and upper back injury while moving freight for the insured. Claimant was treated by Dr. Eubanks, D.O., from December 22, 1988 until he returned to regular work on February 24, 1989. His claim was closed by a June 14, 1989 Determination Order, which awarded temporary total disability, but no permanent disability.

The claim was reopened on August 23, 1989, after claimant had returned to Eubanks with complaints of increased back pain following a long-haul trip. Eubanks reported that he expected no change in the pattern of occasional episodes of recurrent muscle inflammation and rapid response to single visits or very short courses of therapy. The claim was reclosed by an October 10, 1989 Determination Order that awarded additional temporary total disability only.

On October 27, 1989, claimant returned to Eubanks, who provided palliative care and authorized time loss through October 30, 1989. On January 4, 1990, he informed the insurer that he had seen claimant "for palliative manipulative therapy" on five separate occasions since September 1989, including October 27, and noted that the "injury on December 7th * * * was, indeed, a new injury, and the extent to which the present condition might have been related to the prior

accident would be minor." (Ex. 18). The insurer responded to Eubanks' letter as if it were an aggravation claim and issued a denial dated January 24, 1990. Its denial stated:

> "Aggravation is a worsening of one's condition as a result of the original injury and without any intervening accident or incident.
>
> "In reviewing Dr. Eubanks' report of January 4, 1990, it would appear that a new injury occurred on December 7, 1989.
>
> "Therefore, after careful consideration of all information received, we find that we cannot accept responsibility for this aggravation." (Ex. 18A).

On February 19, 1990, Eubanks wrote the insurer and stated that there had been no new injury in December 1989, explaining that "December 7th" meant December 7, 1988, the date of claimant's compensable injury. He further explained that his reference to a "prior accident" referred to an unrelated injury claimant had sustained in April 1988. (Ex. 18B). Eubanks continued to treat claimant and authorized time loss from January 17 to February 5, 1990.

Based on Eubanks' clarification, the insurer sent a letter to claimant "rescinding the Aggravation Denial of January 24, 1990," and indicating that the "claim is now in an accepted status and benefits will be paid accordingly." (Ex. 18C). That same day, March 13, 1990, the insurer wrote Eubanks seeking to determine whether the doctor's reference to particular treatment administered on October 27 and November 20 meant that claimant's medical condition had actually worsened.

In response to the insurer's letter, Eubanks reported that claimant's symptoms on October 27 and November 20 were part of the waxing and waning of his condition. (Ex. 20). Based on that report, the insurer issued a back-up denial of its March 13, 1990 acceptance, indicating that it would "be unable to reopen this claim as an aggravation." (Ex. 21).

From February 5 to August 16, 1990, Eubanks continued to authorize discrete periods of time loss. At the time of hearing, claimant had not received temporary total disability benefits other than that authorized by the Determination Orders.

On October 9, 1990, the insurer issued another aggravation denial on the ground that no claim for an aggravation had been filed and that claimant's condition had not worsened.

CONCLUSIONS OF LAW AND OPINION

Aggravation

Both parties raise numerous procedural issues with regards to the filing and processing of claimant's aggravation claim. The insurer contends that, despite its earlier claims processing, claimant never filed a claim for aggravation. We disagree. In determining whether an injured worker perfects a claim for an aggravation under ORS 656.273, the overriding concern is whether the carrier had sufficient notice that it had to determine whether a worsening had occurred. Krajacic v. Blazing Orchards, 84 Or App 127 (1987), Haret v. SAIF, 72 Or App 688 (1985). While the insurer might have properly found that Eubanks' medical reports were insufficient to constitute a claim for an aggravation, it must have concluded that his reports provided sufficient notice of a worsening because it first denied and then accepted the claim on March 13, 1990. See

Haret v. SAIF, supra, 72 Or App at 672, note 1. Accordingly, we conclude that a claim for an aggravation was filed and litigated and is now properly before us.

Claimant contends that the Referee erred in finding that the October 9, 1990 back-up denial was permissible under the 1990 amendments to ORS 656.262(6). After our review of the record, we conclude that we need not address that issue because, even assuming that the denial was procedurally proper, we find it improper on the merits and set it aside.

The insurer bears the burden of proving, by clear and convincing evidence, that the claim is not compensable. ORS 656.262(6). To carry that burden, it relies on Eubanks' March 20, 1990 letter, which provides that claimant's disability was part of the waxing and waning of his condition. The insurer maintains that such a symptomatic worsening is not sufficient under ORS 656.273(8), which requires a worker to prove that the worsening is more than the waxing or waning of symptoms of the condition contemplated by the previous permanent disability award. The fault with that argument, however, is the fact that claimant has not been awarded any permanent disability. Consequently, no future exacerbations resulting in a loss of earning capacity could have been contemplated, and any subsequent change in claimant's condition resulting in temporary or permanent loss of earning capacity is sufficient to prove increased disability. See Louis A. Duchene, 41 Van Natta 2399 (1989).

The insurer also contends that Eubanks' medical reports indicate that claimant's disability represented only a symptomatic worsening, and evidence of a symptomatic worsening is not sufficient to prove an aggravation. That argument is without merit. For purposes of establishing a compensable aggravation claim, "worsened conditions" may take the form of either a worsening of the underlying condition or a symptomatic worsening. Smith v. SAIF, 302 Or 396 (1986). Because the medical record establishes that claimant's back symptoms became exacerbated since the last award of compensation, resulting in a temporary loss of earning capacity, claimant is entitled to additional compensation under ORS 656.273.

In short, we conclude that the insurer has failed its burden of proving, by clear and convincing evidence, that the claim is not compensable. Accordingly, its back-up denial is set aside and the claim is remanded for further processing according to law.

Temporary Total Disability

At hearing, claimant raised the issue of entitlement to benefits for temporary disability. The Referee noted that there was evidence that claimant was not scheduled to work during some period of time loss authorization, but awarded such benefits nonetheless, concluding that the insurer was obligated to obtain the necessary information to pay claimant the benefits to which he was entitled. Although the insurer challenges that decision on review, we decline to address the issue at this time. Having determined that claimant has sustained a compensable aggravation, we remand this matter to the insurer for claims processing according to law. It would be premature for us to determine claimant's substantive entitlement to such benefits prior to claim closure.

Penalties

A penalty is assessable under ORS 656.262(10) when a carrier "unreasonably delays or unreasonably refuses to pay compensation." The reasonableness of a carrier's denial must be based upon the information available to the carrier at the time of the 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.

The insurer denied claimant's aggravation claim based upon Eubanks' report that claimant's underlying condition had not worsened. Based on that evidence, we conclude that the insurer had a legitimate doubt as to its liability for the claim and, consequently, find the insurer's actions to have been reasonable. Accordingly, no penalty is warranted.

Attorney Fee at Hearing and on Review

The Referee awarded a $1,500 assessed attorney fee for claimant's counsel's efforts in overturning the insurer's April 6, 1990 aggravation denial. Inasmuch as we also are overturning the insurer's October 9, 1990 back-up denial of the same aggravation claim, the attorney fee will be supplemented accordingly. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning both aggravation denials 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 hearing record and appellate briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 25, 1991 is affirmed in part, reversed in part and vacated in part. The insurer's October 9, 1990 aggravation denial is set aside and the claim is remanded to the insurer for further processing according to law. In lieu of the Referee's $1,500 assessed attorney fee, claimant's counsel is awarded a reasonable attorney fee of $2,500, to be paid by the insurer. The Referee's assessed penalty for the insurer's allegedly unreasonable denial is reversed. The Referee's temporary disability award is vacated. The remainder of the order is affirmed.

April 30, 1992 Cite as 44 Van Natta 901 (1992)

In the Matter of the Compensation of
MARY E. SHORES, Claimant
WCB Case No. 90-06677
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Tenenbaum, Kinsley and Gunn.

The insurer requests review of Referee Davis' 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

Claimant sustained a back injury in June 1988, when a patient fell on her during her employment as a psychiatric aide. She treated with Dr. Schubert, chiropractor.

On July 17, 1989, claimant suffered a low back injury, when she lifted a 50 pound bag of dog food at work. By stipulation, the insurer accepted her claim for lumbar-pelvic strain.

Claimant continued working for the employer until October 1989, when she aggravated her back symptoms unloading freight. She treated with Dr. Schubert again.

In April 1990, claimant began working for a nursing home. On July 16, 1990, she suffered a sudden onset of back pain off work, while walking home from the library.

Dr. Quijano, M.D., became claimant's attending physician. The next day, he examined claimant, ordered a CT scan and referred her back to Dr. Schubert for chiropractic treatment. He also referred her to Dr. White, neurosurgeon, who diagnosed a herniated disc at L4-5.

As of July 1990, claimant had suffered from back pain for three and one-half years. During that time, she received chiropractic treatments fairly regularly, often three or four treatments per week, except for a hiatus between mid-November 1989 and July 1990.

Claimant started a new job as a restorative aide at a nursing home in December 1990.

CONCLUSIONS OF LAW AND OPINION

Scope of Review

Claimant contends that the insurer raised a new rationale for its denial on review and that we should confine ourselves to consideration of the "lack of worsening" basis set out in the denial. (See Ex. 25). We are not so persuaded.

Claimant correctly states that the basis for the written denial is an alleged absence of worsening. However, we conclude that the related issue concerning the causal connection between claimant's current condition and the accepted condition was adequately raised before the Referee. Cf. Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991). In reaching this conclusion, we note that at the outset of the hearing, claimant's counsel stated that the issues included the "compensability of an alleged aggravation[.]" (Tr. 3). Prior to the taking of testimony, the insurer stated its position that "the [aggravation] denial should be affirmed, because there's no proof that the condition that has been accepted--the condition that is the claim, has worsened." (Tr. 8). Claimant did not object to the insurer's statement of the issue and causation was fully litigated. Under such circumstances, we find claimant's apparent claim of unfair surprise to be unfounded. Consequently, we address the insurer's causation defense. Cf. Eugene L. Mallory, 43 Van Natta 1317 (1991); also cf. Gunther H. Jacobi, 41 Van Natta 1031 (1989).

Aggravation

In order to establish a compensable aggravation, claimant must prove a worsened condition resulting from the industrial injury. ORS 656.273(1); Perry v. SAIF, 307 Or 654 (1989).

In the present case, there is no real dispute over the worsening element of claimant's aggravation claim. The Referee decided that claimant carried her burden concerning the causation element, because "[t]here is no real evidence that claimant's disc pathology derives from anything other than her on-the-job injury[.]" (O&O, p. 4). We disagree.

Claimant's burden regarding compensability is not carried by simply disproving other possible causal explanations. ORS 656.266. Here, considering the number of potential causal factors, particularly previous back injuries and

other work exposures, the causation issue is a complex medical question. Thus, resolution of this issue requires expert medical evidence. Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

The only medical evidence relating claimant's current back condition to her 1989 injury is the opinion of Dr. Schubert, treating chiropractor. Dr. Schubert opined: "There is no evidence of intervening injury from [claimant's] present employment or any off-the-job activities. Since this patient reported to this office on July 18, 1989, her history of symptoms and activities have been consistent as has her examination findings and the recent CT scan of July 19, 1990, indicating a high medical probability that [claimant] did sustain disc herniation as a result of her on-the-job [injury] of July 17, 1989." (Ex. 23).

Although we generally defer to the opinion of a treating physician, there are persuasive reasons not to do so in this case. See Weiland v. SAIF, 64 Or App 810 (1983). We acknowledge at the outset that Dr. Schubert was in a good position to evaluate claimant after the 1988 and 1989 injuries. However, we are not persuaded by his reasoning, specifically, his statement that claimant's consistent symptoms, activities, and findings support the conclusion that there is a "high medical probability" of a causal connection between claimant's 1989 low back strain and her current herniated disc. This is curiously inconsistent with his comment that he had never tested her for disc herniation earlier because she had responded favorably to treatment addressed to a sprain or strain with joint dysfunction and subluxations. Instead, we find, as we have in the past, that a medical opinion based on such consistency is speculative. See Carol A. Hayes, 43 Van Natta 2696 (1991).

In addition, we note that Dr. Schubert had apparently treated claimant for the June 1988 injury for one and one-half years and that his treatment for the 1988 injury therefore overlapped his treatment for the July 1989 injury. (See Ex. 20a) However, Dr. Schubert does not explain whether or how he was able to distinguish between the two injuries as potential causes for claimant's current herniated disc. A medical opinion which lacks explanation is not persuasive. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980). Moreover, even assuming that the two back injuries were independent of each other, we again note, contrary to Dr. Schubert's reasoning, that a lack of evidence of an "intervening" injury is not sufficient to establish compensability. See ORS 656.266. Finally, we note that Dr. Schubert failed to explain why claimant's herniated disc is related to her 1989 injury, in view of the fat that it was not discovered or did not occur for a year. For these reasons, we conclude that Dr. Schubert's opinion is not well-reasoned. Therefore, we do not rely on it. See Somers v. SAIF, 77 Or App 259 (1986).

Claimant testified that her pain after the most recent exacerbation was the same pain she had suffered after the 1989 injury and that she did not have right leg pain until the 1989 injury. On the other hand, we note that the Independent Chiropractic Consultants (ICC) recorded claimant's history that she felt about the same on January 2, 1990 as she had prior to the July 1989 lifting incident. (Ex. 8-1) Upon examination, the ICC physicians also reported full lumbar range of motion. (Ex. 8-2). They opined that claimant's condition was medically stationary and that she exhibited no evidence of impairment related to the 1989 strain. (Ex. 8-3). Although they recommended that claimant return to restricted work, they stated that their recommendations were "based upon pre-existing lumbarization of S1 . . . unassociated with her recent strain injury." (Id.) Under these circumstances, we conclude that it is as likely as not that claimant's recently discovered disc herniation is related to a cause other than her 1989 strain injury. Therefore, claimant has not carried her burden of proof.

ORDER

The Referee's order dated April 24, 1991 is reversed. The insurer's denial of claimant's aggravation claim is reinstated and upheld. The Referee's award of an attorney fee for prevailing over that denial is also reversed.

Board Member Gunn dissenting.

I must disagree with my respected colleagues. First, contrary to the majority's findings of fact, the insurer did not accept only a lumbar-pelvic strain. The exact words of the stipulation are "an injury to her lumbar spine" (See Ex. 13.1, line 12). The majority misapplies the evidentiary standard for compensability of an injury or disease claim under ORS 656.266 to the evidentiary standard for compensability of an aggravation claim under ORS 656.273. The standard for proving causation under ORS 656.266 is not a legal element of proof required for an aggravation to be compensable, and its application to an aggravation claim is not supported by the clear, unambiguous terms of the statute. The law only requires that the worsened condition result from the original injury. See ORS 656.273(1).

That showing is but one element of compensability of an aggravation claim. Compensability of an aggravation claim requires other elements separate and distinguishable from injury or occupational disease claims.

First, ORS 656.273 was amended in 1990 to set forth new requirements to establish a compensable aggravation under law: (1) the worsening must be established by medical evidence supported by objective findings; and (2) the worsening must be more than a waxing and waning of symptoms of the condition contemplated by the previous award of compensation.

Claimant has satisfied both requirements. There is no dispute that claimant has proven a worsened condition by medical evidence supported by objective findings. There is also no dispute that claimant's herniated disc condition is beyond a mere waxing and waning of symptoms contemplated by the previous award.

The aggravation statute also provides: "[I]f the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable." ORS 656.273(1). I would hold that the clear language of 656.266 only applies to injury or occupational disease claims, and for the reasons stated in my dissent in Elizabeth Bonar-Hanson, 43 Van Natta 2578 (1991), the burden to prove that a non-work injury is the major contributing cause of the worsening rests with the insurer.

In this case there is no evidence that any injury outside the course and scope of employment ever occurred. Therefore, as a matter of law, I would find that claimant has met all of the requirements set forth above for establishing a compensable aggravation claim.

Turning to the question of whether the worsened condition resulted from the original injury, I agree that the issue is a complex medical question. Thus, resolution of this issue requires expert medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

As the majority discussed, Dr. Schubert, the treating chiropractor, relates claimant's current back condition to her 1989 injury. He noted the absence of any evidence of an intervening injury from employment or off-work activities. He also noted that claimant's history of symptoms and activities, her examination findings and CT scan results have all been consistent. He

therefore opined that her disc herniation was the result of her July 17, 1989 injury. (Ex. 23).

We give greater weight to the opinion of claimant's treating doctor, unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). In assessing the persuasiveness of a medical opinion, we consider three basic factors: the source of the opinion, its factual basis and its logical force. Earl M. Brown, 41 Van Natta 2287, 291 (1989). In this case, I do not find any reason to reject the opinion of the claimant's treating doctor. I would also point out that the insurer offered that evidence and waived cross-examination of Dr. Schubert.

Turning to Dr. Schubert's opinion, I find it to be dispositive for the following reasons. As the majority points out, Dr. Schubert was in the best position to evaluate claimant because he has been her treating physician after both her 1988 and 1989 injuries. He also did not concur with the findings of the Independent Chiropractic Consultants' medical report. (See Ex. 18a). This report is mentioned by the majority and seems to infer that claimant had a pre-existing condition before the 1989 injury. I acknowledge the majority's concerns that Dr. Schubert's did not explain the specific mechanism of the 1989 injury and how it relates to the current disc herniation, and that he did not explain how he could distinguish the worsened condition from the 1988 and 1989 injuries and why he did not order certain diagnostic test or find the disc herniation sooner.

Those are excellent questions, but they were not asked. The failure of the record to answer those questions should neither diminish the persuasiveness of the evidence offered nor constitute a failure of proof by claimant.

For these reasons, I respectfully dissent.

May 6, 1992 Cite as 44 Van Natta 905 (1992)

In the Matter of the Compensation of
GLADYS M. THEODORE, Claimant
WCB Case No. 90-20641
CORRECTED ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by the Board en banc.

The self-insured employer requests review of those portions of Referee Mills' order that: (1) set aside its partial denial of allegedly palliative medical services provided since July 1990; and (2) assessed penalties and attorney fees for an allegedly unreasonable denial. Claimant cross-requests review of the portion of the order that upheld the employer's denial of her aggravation claim. On review, the issues are aggravation, medical services and penalties and attorney fees. We affirm in part, reverse in part and vacate in part.

FINDINGS OF FACT

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

The second sentence in the second full paragraph on page two is replaced with: Claimant complained that she was having a new problem with her knee, that being "give way" of the knee, which caused her to fall without warning.

CONCLUSIONS OF LAW AND OPINION

Applicable law

Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Accordingly, this matter is properly analyzed under the Workers' Compensation Law as amended, effective July 1, 1990. Or Laws 1990 (Special Session), ch. 2, 54; Ida M. Walker, 43 Van Natta 1402 (1991).

Aggravation

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury. ORS 656.273(1). Worsened symptoms may be sufficient to carry claimant's burden, if claimant proves that she is more disabled, temporarily or permanently, since the last arrangement of compensation. Smith v. SAIF, 302 Or 396, 401 (1986). Because this claim involves the knee, a scheduled body part, "more disabled" means increased loss of use or function of the knee. ORS 656.214; International Paper Co. v. Turner, 304 Or 354 (1987), on rem 91 Or App 91 (1988); see Jeffry D. Morgan, 43 Van Natta 2348 (1991). Further, the worsened condition must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

In the present case, a November 13, 1989 Determination Order awarded temporary, but not permanent, disability compensation and found claimant's condition medically stationary on September 18, 1989. (Ex. 11). Claimant requested a hearing, raising the issue of the extent of her scheduled permanent partial disability. The request was dismissed pursuant to a March 22, 1990 Stipulation and Order, which awarded claimant 5 percent scheduled permanent partial disability for her right knee condition. The Stipulation was the last arrangement of compensation prior to the claimed worsening.

Claimant has suffered from continuing right knee pain since she was declared medically stationary as of September 18, 1989. She reported that she had some "locking" of her right knee following her May 11, 1989 surgery and that her knee sometimes felt as though it would give way. (Exs. 4-3, 4-6, 9). However, claimant testified that those problems "stopped," for almost a year. (Tr. 10). She again sought treatment in the summer of 1990, because of knee "give way" which resulted in falls. Id. She contends that her knee "give way" constitutes a new symptom which establishes a worsening under ORS 656.273, and further, that her claim is supported by objective findings, i.e., her falls. We disagree.

Although increased symptoms of a compensable condition may be sufficient to establish a compensable worsening, claimant's testimony regarding her symptoms is not sufficient to carry her burden in the present case. Our conclusion in this regard is based on the medical evidence, which does not contain objective findings supporting the claim of worsened condition resulting from the original injury.

The medical evidence concerning claimant's current right knee problems comes primarily from Dr. Baskin, orthopedist. In July 1990, Baskin reported claimant's history that "since her surgery she has continued to have difficulty with her knee, intermittent catching with flexion-extension and feeling weak." Due to her "persistent symptoms," claimant requested Baskin's evaluation. (Ex. 13-1). Although Baskin reported claimant's history that her right knee occasionally gave out from under her, he was not sure that she suffered "any significant worsening." (Ex. 24A). Instead, he opined that "[i]t is just that it has never gotten better." Id. In December 1990, Baskin stated that he could not "clinically pick up any aspects of worsening; however, she feels that she is worse and more limited." (Ex. 26).

Dr. Kaesche examined claimant in January 1991 and acknowledged that claimant has "persistent symptoms," but opined that her complaints were disproportionate with her objective findings. (Ex. 28-3). Kaesche also stated that claimant had "remained" medically stationary. (Ex. 28-4).

In the present case, claimant's current "give way" symptoms may or may not be "new." Although, both Drs. Baskin and Kaesche acknowledged claimant's complaints, neither opined that claimant suffered a worsening of symptoms or the underlying condition supported by objective findings. Cf. Suzanne Robertson, 43 Van Natta 1505 (1991); Robert Leatherman, 43 Van Natta 1678 (1991). Accordingly, we agree with the Referee that claimant has failed to establish a compensable aggravation claim.

Medical Services

A threshold issue not raised by either party is whether, in light of the 1990 amendments to the workers' compensation statutes, this forum has jurisdiction to resolve this dispute over medical services that the employer contends are palliative and, therefore, not compensable under ORS 656.245 and the relevant administrative rules. We conclude that original jurisdiction over this dispute lies with the Director and vacate that portion of the Referee's order.

As a general matter, the Board, and thus our Hearings Division, has jurisdiction over matters concerning a claim, which is defined as those matters wherein a claimant's right to receive compensation, or the amount thereof, is directly at issue. ORS 656.704(3); ORS 656.726(2); see Ashley v. University of Oregon, 100 Or App 588 (1990). However, under the 1990 amendments to the workers' compensation law, "matters concerning a claim" do not include any dispute regarding medical treatment or fees "for which a resolution procedure is otherwise provided" in ORS Chapter 656. ORS 656.704(3). In this regard, ORS 656.327 provides, in part:

> "(1)(a) If an injured worker, an insurer or self-insured employer or 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, self-insured employer shall so notify the parties and the director."

The phrase "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services" is not statutorily defined and the scope of its plain meaning is significant. Thus, in construing the provision, we have relied on legislative history, which indicated that the purpose of ORS 656.327 was to remove questions concerning the appropriateness of medical treatment from the litigation process and allow such decisions to be made by a physician rather than a referee. See Minutes, Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 3, Side A at 75. Accordingly, we have concluded that ORS 656.327 provides a resolution procedure for those medical treatment disputes that are appropriate for review by a medical panel, such as the reasonableness and necessity of medical treatment for a compensable condition. See Stanley Meyers, 43 Van Natta 2643 (1991). For the same reason, we have also concluded that ORS 656.327 does not govern medical treatment disputes that primarily involve legal analysis, such as the causal relationship between the need for the treatment and the compensable injury. See Michael A. Jaquay, 44 Van Natta 173 (1992).

The dispute at issue here involves the question of whether claimant's medical treatments are palliative, rather than curative. If found palliative, such

care is generally not compensable without prior approval from the carrier or Director. ORS 656.245(1)(b). We find that such a dispute generally concerns the effectiveness and appropriateness of the medical treatment at issue and, therefore, believe that it lies within those matters the legislature intended to be resolved by a physician, rather than a referee. Accordingly, because a proceeding for resolving this medical treatment is otherwise provided in ORS 656.327, we hold that original jurisdiction lies exclusively with the Director.

We vacate the Referee's decision insofar as it purports to set aside the employer's denial of claimant's medical service claim, for the denial did not raise a matter concerning a claim within the jurisdiction of the Hearings Division. We also vacate the Referee attorney fee award for prevailing against the denial.

Penalties and Attorney Fee

Given the novelty of this issue, and the possible interplay with ORS 656.704, we conclude that the employer's action in denying the claim was not unreasonable. Consequently, no penalty or related fee is assessable. ORS 656.262(10).

ORDER

The Referee's order dated February 7, 1991 is affirmed in part, reversed in part and vacated in part. Those portions that set aside the employer's denial of medical services and awarded an assessed fee for prevailing against that denial are vacated. Claimant's request for hearing regarding that medical services denial is dismissed for lack of jurisdiction. The Referee's assessments of a penalty and a $250 attorney fee award for an unreasonable denial are reversed. The remainder of the order is affirmed.

Board Members Tenenbaum, Kinsley and Hooton dissenting.

We write to dissent from the majority on the medical services issue, as we conclude that the Board, and thus the Hearings Division, does have jurisdiction over the issue of whether the care in question was curative or palliative.

The majority accurately states the law, as decided in Stanley Meyers, 43 Van Natta 2643 (1991), from which we also dissented. Under amended ORS 656.704(3), "matters concerning a claim" do not include any dispute regarding medical treatment or fees "for which a resolution procedure is otherwise provided" in ORS Chapter 656. See Stanley Meyers, supra.

The question of whether the treatment in question is curative or palliative does not involve the reasonableness or necessity of the care. No allegation has been made that the treatment is excessive, inappropriate or was performed in violation of a rule for providing the particular service. We find, accordingly, that no "procedure" has been "otherwise provided" to resolve a dispute as to whether certain medical services are palliative or curative. Therefore, we would conclude that the Board has jurisdiction over this issue.

In the Matter of the Compensation of
MICHELE M. TIENHAARA, Claimant
Own Motion No. 92-0012M
OWN MOTION ORDER
Westmoreland & Shebley, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's claim for an alleged worsening of her August 9, 1979 compensable back, neck and right knee injury. Claimant's aggravation rights expired on August 7, 1985. SAIF has accepted the compensability of claimant's current condition. However, it opposes the reopening of her claim for payment of temporary disability compensation, contending that she has removed herself from the work force.

We may exercise our own motion authority to reopen claimant's claim for additional temporary disability compensation if she has sustained a worsening of her compensable injury requiring either inpatient or outpatient surgery, or other treatment requiring hospitalization. ORS 656.278(1)(a). Dr. Smith, claimant's attending physician, opined that claimant's current lumbar and lower extremity symptoms are sequelae of the lumbar surgeries of 1986 and 1987, which were due to a disk herniation related to the 1979 injury. The progressive development of foraminal stenosis is a natural sequela of the 1979 injury and surgeries. (Report of December 30, 1991). Dr. Nash, claimant's treating surgeon, requested a decompressive lumbar laminotomy at L5-S1 with subtotal facetectomy, foraminotomy and neurolysis, left. (Letter of October 8, 1991). Thus, we conclude that claimant has sustained a worsening of her compensable injury requiring surgery.

However, in order to qualify for the payment of temporary disability compensation, claimant must have been in the work force at the time of the worsening. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Cutright v. Weyerhaeuser Company, 229 Or 290 (1985).

SAIF contends that claimant had withdrawn from the work force, based on a December 22, 1987 Stipulation and Disputed Claim Settlement in which claimant stipulated that she had voluntarily withdrawn from the labor market and was no longer a worker within the meaning of Dawkins and Cutright, supra. That order has no res judicata effect, nor is it factually determinative here.

Claimant submitted a January 17, 1992 deposition by Dr. Nash, in which he states that, currently, it would be futile for claimant to attempt to work. To be entitled to benefits for temporary disability, a claimant must show that she is willing to work, even though efforts to obtain employment would be futile due to the work-related injury. Id. Here, claimant needed to submit evidence sufficient to overcome her prior statement that she has left the workforce. However, she has provided no evidence to establish that she has been willing to work at any time after her voluntary withdrawal from the work force in 1987. See Wausau Insurance Companies v. Morris, 103 Or App 270 (1990); Lyle L. Smith, 43 Van Natta 169 (1991). Because we lack such evidence, we are unable to find that claimant is willing to work. Thus, we conclude that she has withdrawn from the workforce. Accordingly, we deny claimant's request for temporary disability compensation.

Claimant's entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
BUDDY J. WILLIS, JR., Claimant
WCB Case No. 90-16494
ORDER ON RECONSIDERATION
Popick & Merkel, Claimant Attorneys
Roberts, et al., Defense Attorneys

Claimant has requested reconsideration of our April 8, 1992 Order on Review. Specifically, claimant contends that Exhibit 45 was not addressed in our order and as a claim for medical services it is properly analyzed separately from the aggravation issue. Therefore, claimant asserts that the Referee's opinion regarding the medical services denial should be reinstated.

Exhibit 45 is a September 11, 1990 letter to claimant's counsel from the insurer. It recites that:

> "PER YOUR LETTER OF 8/29/90, WE WILL PAY FOR RELATED SERVICES FROM THE 10/31/89 CLAIM. WE WILL NOT PROCESS MEDICALS RELATED TO THIS AGGRAVATION. IT APPEARS THE LATEST BILLS RELATE TO THE AGGRAVATION." (Ex. 45).

In Evans v. SAIF, 62 Or App 182, 186 (1983), the court held that "the fact that a claimant has not suffered an aggravation of his previous injury does not affect his entitlement to further medical services as provided in ORS 656.245." The question, therefore, is whether claimant's current need for medical services is causally related to his industrial injury.

Dr. Browning, claimant's treating physician, reported that claimant has been medically stationary without impairment and capable of his regular work since February 1, 1990. Dr. Browning noted that medical testing performed in June, July and August of 1990 did not document any objective findings of impairment. (Ex. 51). Moreover, Dr. Browning reported that the cause of claimant's ongoing complaints were of an unknown etiology. (Ex. 35).

Under the circumstances, we find that claimant has failed to establish that his current need for medical services is causally related to his industrial injury. Therefore, on this basis, we reinstate and uphold the September 11, 1990 denial. (Ex. 45). Accordingly, we withdraw our April 8, 1992 order. On reconsideration, as supplemented herein, we republish our April 8, 1992 order. The parties rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
PATRICIA V. STANDARD, Claimant
WCB Case No. 91-00163
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of Referee Harri's order that: (1) set aside its denial of claimant's aggravation claim for her low back condition; and (2) set aside its "de facto" denial of claimant's medical services claim. On review, the issues are aggravation and medical services. We affirm in part and vacate in part.

FINDINGS OF FACT

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

The September 28, 1990 Determination Order is claimant's last award or arrangement of compensation.

CONCLUSIONS OF LAW AND OPINION

Aggravation

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

We find that the last arrangement of compensation is the September 28, 1990 Determination Order. Notwithstanding our decision in regard to the date of the last award of compensation, we agree with the Referee that claimant has proven a worsened condition since September 1990. Moreover, we agree that claimant's symptomatic increase resulted in diminished earning capacity. We further agree with the Referee that claimant's previous permanent disability award did not contemplate future periods of increased symptoms accompanied by diminished earning capacity. See ORS 656.273(8).

The insurer asserts that the Referee's conclusion regarding future contemplated waxing and waning is "incredible" and "blatantly incorrect." We do not agree. Although claimant has experienced "ongoing" back difficulties and a "regular pattern" of continuing back pain for a number of years, the record does not establish that future periods of waxing and waning were contemplated by the previous award.

In Lucas v. Clark, 106 Or App 687 (1991), the record established that claimant had experienced several flare-ups before his award of permanent disability. However, the award made no reference to the prognosis for claimant's condition and made no additional award for that condition. Similarly, prior to the award, no doctor had predicted future or chronic flare-ups of the condition. Under these circumstances, the court concluded that there was not substantial evidence to support a finding that future periods of waxing and waning were contemplated by the award of permanent disability.

Here, the record also discloses that claimant has continuing low back symptoms. However, the record does not establish that claimant's award of permanent disability contemplated future waxing and waning of symptoms. In this regard, we reject the insurer's contention that ORS 656.273(8) contains a "built-in" presumption that an award of permanent disability contemplates "a certain amount of waxing and waning." An award of unscheduled permanent

disability compensates an injured worker for the permanent loss of earning capacity due to a compensable injury. ORS 656.214(5). Such a loss of earning capacity may be caused by limitations resulting from continuing unabated symptoms or symptoms that change over time. No presumption exists that all permanent disability awards anticipate a waxing and waning of symptoms.

Accordingly, we affirm the Referee on the issue of aggravation.

Medical services

The Referee concluded that the insurer's letter of January 9, 1991 constituted a "de facto" denial of palliative care. The parties have not disagreed with the Referee's characterization of the letter as a denial. A threshold issue, however, is whether the Hearings Division has jurisdiction over such matters.

We agree with the Referee that claimant is entitled to medical services for her compensable aggravation. However, to the extent that the Referee's order purported to set aside a "de facto" denial of palliative care and determined that claimant's care was also curative, we vacate that portion of the order. See Gladys M. Theodore, 44 Van Natta 905 (1992)(Jurisdiction over the issue of whether medical treatment is palliative rests exclusively with the Director). Moreover, we find that the issue of whether Dr. Kitchel was claimant's attending physician for purposes of prescribing palliative care, is also an issue over which we are without jurisdiction. See Tracy Johnson, 43 Van Natta 2546 (1991). Accordingly, we also vacate that portion of the Referee's order.

The Referee's attorney fee award was based upon claimant's prevailing over the insurer's aggravation and medical services denials. After considering the factors set forth in OAR 438-15-010(4) and the time devoted to the issue of the "de facto" denial of medical services, we find that $500 of the $1,750 attorney fee awarded for services at hearing is attributable to the issue of medical services. Because we have vacated the portion of the Referee's order that set aside the "de facto" denial of medical services, we correspondingly modify the attorney fee award at hearing.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable attorney fee for claimant's counsel's services on review concerning the issue of aggravation is $850, to be paid by the insurer. In reaching this conclusion, we have considered the time devoted to the issue (as represented by claimant's appellate brief), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated June 12, 1991 is affirmed in part and vacated in part. That portion of the Referee's order that set aside the "de facto" denial of medical services is vacated. The Referee's $1,750 attorney fee award is modified. In lieu of the Referee's attorney fee award, claimant's counsel is awarded $2,100 for services at hearing and on review on the issue of aggravation. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
DANELL L. SWEISBERGER, Claimant
WCB Case No. 90-15324
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Bethlahmy's order that found that claimant was not entitled to temporary total disability benefits because she had voluntarily withdrawn from the work force at the time of the aggravation. On review, the sole issue is entitlement to temporary total disability benefits. We affirm.

FINDINGS OF FACT

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

Claimant compensably injured her low back on November 11, 1983. On August 13, 1984, she underwent surgery for a L4-5 lumbar discectomy. On January 25, 1985, Dr. Brett, treating surgeon, released claimant for work with restrictions of no lifting over 25 pounds and no excessive bending. (Ex. 5-1). Claimant experienced an increase in her symptoms in February 1985. After this exacerbation, she was returned to light duty status. (Ex. 15-2).

Claimant's initial claim was closed by Determination Order on August 26, 1985 which awarded 25 percent unscheduled permanent partial disability and temporary total disability from December 28, 1983 through June 28, 1985. (Ex. 8).

In December 1985, a return to work assistance program was terminated due to claimant's lack of cooperation and participation. (Exs. 12, 13). Ms. Ingram, vocational counselor, noted that claimant's testing indicated excellent clerical skills but her behavior indicated "a sincere lack of commitment to returning to work." (Ex. 13-2).

On February 21, 1986, Dr. Brett turned claimant's care over to Dr. Lee, M.D., noting that perhaps Dr. Lee would be able to help claimant with her pain syndrome and "her motivational attitude towards work." (Ex. 14).

In April 1986, Dr. Utterback, orthopedist, examined claimant and noted that her physical findings indicated an ability to work with minimal restriction. (Ex. 15-3). In May 1986, Dr. Klein, psychiatrist, examined claimant. She found her to be quite overfocused on her physical problems and entrenched in a disabled role. (Ex. 16-3).

On December 12, 1986, claimant entered into a Stipulation and Disputed Claim Settlement, whereby the insurer agreed to reopen claimant's low back claim retroactive to April 1986. (Exs 19, 28C-2). This aggravation claim was closed by a March 10, 1987 Determination Order which awarded temporary total disability from April 30, 1986 through November 14, 1986. (Ex. 23).

Between the time she left her at injury job in January 1984 and January 1989, claimant did not return to work. (Tr. 16, 17). Claimant testified that, during that time, she "applied at different places." (Tr. 17).

Claimant's father had passed away and claimant and her siblings helped run their mother's tire store pending a decision to sell it. Claimant helped in

this tire store from January 1989 through October 16, 1989. (Tr. 11). This help included training her sister in bookkeeping, doing statements, taking payments from customers, and writing up sales tickets. (Tr. 16). No records were kept regarding claimant's hours; however, she estimated that she worked 20 hours per week. (Tr. 12). Claimant was not paid for this help. (Tr. 11, 18). However, she received lunches and tire service. (Tr. 11). During this same time, claimant's sister was a full-time employee at the tire store and received wages. (Tr. 18).

Claimant testified that she did not know if she would have gone back to work if it had not been for the fact that this was her mother's tire store. (Tr. 17). Claimant did not look for gainful employment during the period from January 1989 through October 16, 1989. (Tr. 17). Claimant's mother sold the tire store in December 1989. (Tr. 18).

Dr. Lee authorized time loss from October 16, 1989 to August 3, 1990. (Ex. 37). As of December 17, 1990, the date of the hearing, claimant had not sought employment since she last treated with Dr. Lee in August 1990. (Tr. 25; Ex. 38-1).

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, although claimant had established a compensable aggravation, she was not entitled to temporary disability benefits because she had voluntarily removed herself from the labor market. We agree.

In Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989), the Court listed three situations where a claimant is deemed to be in the work force: (1) the claimant is engaged in regular gainful employment; (2) the claimant, although not employed at the time, is willing to work and is making reasonable efforts to obtain employment; or (3) the claimant is willing to work, although not employed at the time and not making reasonable efforts to obtain employment because of a work related injury, where such efforts would be futile.

A worker who has voluntarily withdrawn from the work force at the time of an aggravation of a compensable injury is not entitled to temporary total disability. Cutright v. Weyerhaeuser, 299 Or 290, 293 (1985).

The record establishes that claimant had voluntarily withdrawn from the work force before January 1989 when she began helping in her mother's tire store. During the period from the time she left her at injury job in January 1984 until January 1989, claimant did not return to work and made no reasonable effort to find work, although such efforts would not have been futile. Claimant testified that she had applied to "different" places during the period before January 1989. However, this testimony does not overcome the evidence that claimant had voluntarily withdrawn from the work force before January 1989.

In December 1985, a return to work program was terminated due to claimant's lack of cooperation and participation. (Exs. 12, 13). She did not keep in contact with the vocational counselor and did not follow through on job leads. Furthermore, her vocational counselor found that she lacked commitment to return to work.

Dr. Brett, treating surgeon, noted that claimant had problems with her motivational attitude towards work. Dr. Klein, psychiatrist, noted that she was entrenched in a disabled role. Yet the medical evidence establishes that, outside of the period of her compensable aggravation, claimant was at least able to perform light work with restrictions. (Exs. 5-1, 15-2, 15-3). On this record,

we find that claimant was not willing to work and had voluntarily withdrawn from the work force before January 1989.

However, withdrawal from the work force is not a permanent state. A worker can return to the work force after voluntarily withdrawing. Furthermore, the critical time for determining whether claimant has withdrawn from the work force is at the time of her disability. Weyerhaeuser Co. v. Kepford, 100 Or App 410, 414 (1990).

Therefore, the question presented here is whether claimant returned to the work force when she began helping in her mother's tire store. Applying the factors in Dawkins, supra, we find that she had not returned to the work force.

First, claimant was not engaged in gainful employment. She was not paid for her help at her mother's tire store. We do not find that lunches and tire service rise to the level of gainful employment. In contrast, claimant's sister was a full time employee and was paid wages.

Second, although claimant was willing to help her mother out, we do not find that she was willing to work at gainful employment. Claimant testified that she did not know if she would have returned to work during this period if not for the fact that it was her mother's tire store. (Tr. 17). From January 1989 through October 16, 1989, claimant made no effort to obtain gainful employment. Thus, even if claimant had been willing to work, she did not make reasonable efforts to obtain gainful employment.

Finally, the work injury did not prevent claimant from making reasonable efforts to obtain employment, and such efforts would not have been futile. Outside the periods of her compensable aggravation, the medical evidence establishes that claimant was at least able to perform light work with restrictions. (Exs. 5-1, 15-2, 15-3). Dr. Lee did authorize additional restrictions on claimant's ability to work when he released her to return to work. (Ex. 37). The record contains no medical evidence that efforts to obtain gainful employment would be futile.

Although claimant testified that she was not able to work full time because of her low back pain, regular part time work is considered gainful employment. John R. Huffman, 42 Van Natta (1990). Also, the very fact that claimant was able to help in her mother's tire shop for 20 hours a week demonstrates that it would not be futile for claimant to seek gainful employment.

The fact that claimant did not seek gainful employment when her family obligations ended provides further evidence that claimant had not returned to the work force in January 1989. Claimant's mother sold the tire store in December 1989. Furthermore, claimant was released to return to work as of August 4, 1990. (Ex. 37). Yet, as of the date of the hearing, claimant had not looked for work. (Tr. 25).

In addition to the above Dawkins analysis, we find that claimant's work for her mother did not constitute a return to the work force because it was not an employment relationship. Where the existence of an employment relationship is in question, the first focus is on claimant's perspective of the employment relationship. Newport Seafood v. Shine, 71 Or App 119, 124 (1984). Because ORS 656.005(28) provides that "worker" means any person who engages to furnish services for a remuneration, one of the crucial factors is whether claimant expected to be paid by her mother. Claimant was not paid and the record provides no indication that she expected to be paid by her mother. (Tr. 11, 18). Claimant did receive tire service and was taken to lunch. (Tr. 11). However, this does not rise to the level of "remuneration."

Claimant worked as a volunteer for her mother and, as such, was not a subject worker earning remuneration within the definition of ORS 656.005(28). See Hix v. SAIF, 34 Or App 819 (1978); Michael P. Cortinas, 42 Van Natta 2719 (1990); John Dayton, 37 Van Natta 210 (1985).

Accordingly, we conclude that claimant had voluntarily withdrawn from the work force at the time of her aggravation. Therefore, she is not entitled to temporary disability benefits.

ORDER

The Referee's order dated May 28, 1991 is affirmed.

In the Matter of the Compensation of
JOHN M. AMES, Claimant
WCB Case No. 90-17571
ORDER ON RECONSIDERATION
Black, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Claimant requests reconsideration of that portion of our April 7, 1992 Order on Review that excluded Exhibit 49, a post-hearing medical report from Dr. Grant. Claimant contends that the admissibility of the report was not properly before us, because the insurer at no time objected to the report and did not raise it as an issue in the appellant's brief. The insurer has filed a response to claimant's request.

The insurer's appellant's brief provides, in part:

> "The employer objects to the referee's exclusive reliance on Exhibit 49 (the post-hearing medical report solicited by the referee). OAR 438-07-005(5) was not intended to 'correct' an attending physician. Rather, the rule allows the referee to seek out a fresh and objective third party perspective on the existing record. Furthermore, by relying exclusively upon the solicited report, the referee completely discounted Dr. Grant's numerous earlier consistent reports supporting a much lower award of permanent disability." (App. brief at 3).

Based on those arguments and others, the brief concludes:

> "Exhibit 49 should therefore be disregarded, and the claimant's permanent disability rated on the existing record only." (App. brief at 4).

Contrary to claimant's assertion, the issue was expressly raised by the insurer on review. Accordingly, we withdraw our April 7, 1992 order. On reconsideration, as supplemented herein, we adhere to and republish our April 7, 1992 order effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT W. BRIGHT, JR., Claimant
WCB Case No. 91-06659
ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Brazeau's order which: (1) awarded additional temporary disability; and (2) assessed a penalty and related fee for the insurer's allegedly unreasonable unilateral termination of claimant's temporary disability benefits. On review, the issues are temporary disability and penalties and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Reasoning that claimant's aggravation claim was in open status and none of the circumstances justifying the termination of temporary disability compensation (TTD) under ORS 656.268(3) had occurred, the Referee concluded that the insurer's unilateral termination of claimant's TTD was unlawful. Consequently, the Referee decided that claimant was entitled to additional TTD as well as penalties and attorney fees. The Referee awarded temporary disability payable from July 19, 1990 through "the next proper closure of [claimant's] open claim."

We adopt the Referee's reasoning and conclusions as to the temporary disability and the penalty and attorney fee issues. We modify the time period for which the temporary disability benefits are due.

On review, the insurer requests that our April 1, 1992 Order on Review in Robert W. Bright, 44 Van Natta 657 (1992) be "taken into account in the Board's deliberations" of the current case on review in order to "achieve a consistent set of orders." In our previous order, we concluded that this claimant's aggravation claim was not compensable and reversed the Referee's order which had found compensability. However, the fact that claimant's aggravation claim has ultimately been found noncompensable does not make the insurer's unilateral termination proper and does not extinguish its responsibility to process the claim in the interim and pay claimant the temporary disability benefits required by law. See A.G. McCullough, 39 Van Natta 135, 137 (1987), affirmed Weyerhaeuser v. McCullough, 92 Or App 204, 208 (1988).

On the other hand, our decision that claimant's aggravation claim was not compensable does lead us to modify the Referee's award of temporary disability benefits to the extent that, if the claim was still open at the time of the Board's April 1, 1992 order, the insurer's claim processing obligation ended on that date by virtue of the order.

Inasmuch as we have reduced claimant's temporary disability award and claimant is not entitled to an attorney fee award for defending on the penalty and attorney fee issue, an attorney fee for claimant's counsel's services on review is not warranted. ORS 656.382(1); Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated September 25, 1991 is affirmed in part and modified in part. In lieu of the Referee's temporary disability award, claimant is awarded temporary total disability from the insurer's July 19, 1990 unilateral termination until such benefits could be lawfully terminated or April 1, 1992, whichever occurred first. The remainder of the order is affirmed.

May 6, 1992 Cite as 44 Van Natta 918 (1992)

In the Matter of the Compensation of
LOREN L. HARNAR, Claimant
WCB Case Nos. 91-07472 & 91-03477
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Hooton.

The SAIF Corporation requests review of Referee Davis' order that directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree. On review, the issue is the rate of scheduled permanent disability.

We affirm and adopt the Referee's order.

Because SAIF initiated the request for review and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel may be entitled to a carrier-paid attorney fee under ORS 656.382(2). Claimant filed no respondent's brief on review, however. Instead, his attorney directed a letter to the Board, acknowledging SAIF's request for review and indicating that claimant relies on the record.

In Shirley M. Brown, 40 Van Natta 879, 882 (1988), we noted that ORS 656.382(2) provides for a carrier-paid attorney fee for "legal representation" by an attorney for the claimant, and concluded that there was no evidence of such representation to base a fee where an attorney fails to file a brief on review. We recognized, however, that an attorney might provide some "legal representation" short of filing a brief that would support a fee. See Dan W. Hedrick, 38 Van Natta 208 (1986), aff'd mem 83 Or App 275 (1987). We find such efforts documented in the record here, and conclude that the aforementioned letter qualifies as "legal representation" for the claimant. Accordingly, claimant's counsel is entitled to an insurer-paid attorney fee on review.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the rate of permanent disability issue is $100, 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 response), the complexity of the issue, and the value to claimant of the interest involved.

ORDER

The Referee's order dated September 30, 1991 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $100, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
STAN J. MANSER, Claimant
WCB Case No. 90-19595
ORDER ON RECONSIDERATION
Cooney, et al., Defense Attorneys

The self-insured employer has requested reconsideration of our April 10, 1992 Order on Review. Specifically, the employer contends that remand is necessary to clarify the basis of the Referee's credibility finding. In its motion, the employer cites the portions of the Opinion and Order which refer to claimant's testimony being "thoroughly impeached," (O&O p. 4), and stating that claimant was "not a credible witness," while two of its witnesses were "very credible" (O&O p. 2). Considering these references, the employer argues that the Referee's negative credibility finding may be demeanor-based and that the Referee should have an opportunity to explain his finding. We disagree.

As we indicated in our order, the finding was based on the record. We continue to reach that conclusion, noting that the Referee found that "[c]laimant's lack of credibility was based on his statements to both Melva Holmes and Anita Wallace, which were completely contrary to his statements at hearing." (O&O p. 3). Considering this clear pronouncement, we find that the Referee explained the basis of his credibility finding. Therefore, assuming without deciding that a lack of such explanation could lead to an insufficiently developed record, we conclude that this is not such a case. See ORS 656.295(5). Accordingly, the employer's motion to remand is denied.

With this clarification and supplementation, we conclude that our Order on Review adequately addresses the contentions contained in claimant's motion. Our April 10, 1992 order is abated and withdrawn. As supplemented and clarified herein, we republish our April 10, 1992 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
KENNETH W. McDONALD, Claimant
WCB Case No. 90-08924
ORDER OF ABATEMENT
Roger D. Wallingford, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

The insurer requests reconsideration of that portion of our April 7, 1990 Order on Review that affirmed the Referee's conclusion that claimant had established the compensability of his psychological condition. The insurer contends that our order is legally insufficient under Garcia v. Boise Cascade Corp., 309 Or 292 (1990), and Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498 (1990).

In order to allow sufficient time to consider the motion, the above noted Board order is withdrawn and claimant 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
KATHERINE F. TAYLOR, Claimant
WCB Case No. 89-18102
ORDER ON REVIEW
Francesconi, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Gunn and Kinsley.

Claimant requests review of that portion of Referee Lipton's order that upheld the insurer's denial of her occupational disease claim for a mental disorder. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "FINDINGS OF FACT" with the following modification. Instead of the Referee's finding that claimant's production activities for a 30-second commercial ad consumed 10 to 12 hours, we find that it took 10 to 12 hours to film the ad. The remaining production activities for that ad, including script writing, audio, editing, casting and manual insertion into programming, took a considerably longer period of time.

CONCLUSIONS OF LAW AND OPINION

The Referee applied the law in effect before the 1990 amendments (Oregon Laws 1990 (Special Session), chapter 2). Claimant filed her hearing request before May 1, 1990, and the hearing was convened before July 1, 1990. Accordingly, we too analyze this matter under the law in effect before the 1990 amendments. See Or Laws 1990 (Special Session), ch. 2, 54(2).

In order to establish a compensable mental disorder, claimant must prove: (1) she has a mental or emotional disorder which is generally recognized in the medical or psychological community; (2) the employment conditions producing the mental disorder exist in a real and objective sense; (3) they are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective, or job performance evaluation actions by the employer, or cessation of employment; and (4) there is clear and convincing evidence that the mental disorder arose out of and in the course of employment. Former ORS 656.802(2).

It is undisputed that claimant has a mental disorder which is generally recognized in the medical or psychological community. Dr. Colistro, treating psychologist, diagnosed major depression, while Dr. Turco, examining psychiatrist, diagnosed adjustment disorder with mixed emotional features. (Exs. 7-8, 8-5). We therefore find that claimant has proved this element of her claim.

The Referee was not persuaded that claimant's mental disorder was produced by employment conditions which existed in a real and objective sense. The Referee reasoned that claimant's activities of producing commercials for her employer were not conditions of her employment, because she was hired to sell advertising time for the employer and the employer did not promote, acquiesce in, or benefit from claimant's production activities. We disagree.

In January 1988, the employer hired claimant as its advertising sales representative. Claimant was primarily responsible for selling advertising time on several channels to prospective clients. (Tr. 126). However, she was also expected to serve as a "production liaison," responsible for coordination between clients and the video production companies that produced commercials. (Tr. 130, 251). This "production liaison" position was new, because the employer had not

previously been involved in the production of commercials for insertion in its programming. (Tr. 130).

Claimant attempted to work with several video production companies, but their work was too expensive or otherwise unsatisfactory. (Tr. 131, 143, 204, 384-85). She therefore assumed the responsibilities of producing the commercials herself in January 1989. (Tr. 129-31). These responsibilities included writing the scripts, selecting the music, casting talent, supervising the taping and editing, and manually inserting the commercials into programming. (Tr. 131-35). She produced about 20 commercials for the employer. (Tr. 153). Although the employer did not specifically direct her to produce the commercials herself, it was her understanding that she was to "do the job and get it done and keep them on the air." (Tr. 139-40).

Claimant's production activities frequently required her to work late at night and on weekends, leaving her little time to make sales contacts with prospective clients. (Tr. 32-33). Her supervisor, Steve Lee, was aware that she was working overtime on production activities. (Tr. 368-69). Lee directed her to make more sales contacts and stop her production activities. (Tr. 252-54). Feeling overworked, claimant sought psychological treatment in May 1989 for an acute stress reaction. (Ex. 2).

We conclude that the conditions of claimant's employment arose from her dual role as advertising sales representative and production liaison. It was her perception that, as production liaison, she was expected to "get the job done" and keep the employer "on the air." When she could not find a satisfactory production company to produce the commercials, she understood that it was her responsibility to produce them herself.

Although claimant's perception may have been incorrect, we find there was a real and objective basis for it. See Duran v. SAIF, 87 Or App 509 (1987). That basis was the lack of a clear distinction between claimant's responsibilities as production liaison and the production activities she should not have performed. The employer had not previously been involved in producing commercials, and did not have a clear description of the production liaison position. Moreover, when claimant was hired for the job, her training included viewing a sales representative actually producing a commercial. (Tr. 498). In addition, the employer had other sales representatives who were producing commercials in addition to their sales work. (Tr. 363-64).

Under these circumstances, we conclude that claimant's perception that she was overworked was based on "real and objective" conditions of her employment. See id. Therefore, we find that the conditions producing claimant's mental disorder were real and objective.

We agree with and adopt the Referee's findings that: (1) the employment conditions producing the mental disorder were not conditions generally inherent in every working situation; and (2) the employer's program of progressive discipline, including the threat of dismissal, was a reasonable disciplinary action. In adopting the latter finding, we are persuaded that, in light of the clearly defined standards and practices that the employer put in writing (Ex. 3B), claimant had ample opportunity to conform her conduct to the employer's expectations.

Finally, we must determine whether there is clear and convincing evidence that the mental disorder arose out of and in the course of employment. To establish this element, claimant must prove by clear and convincing evidence that work-related stressors, not otherwise excluded under former ORS 656.802(2), are the major cause of the mental disorder. See Aetna Casualty Co. v.

Aschbacher, 107 Or App 494, rev den 312 Or 150 (1991). In order to be clear and convincing, the evidence must be "free from confusion, fully intelligible, distinct" and "the truth of the facts asserted must be highly probable." Riley Hill General Contractor v. Tandy Corp., 303 Or 390, 407 (1987). Because we have found that the employer's disciplinary actions were reasonable, those actions are excluded under former ORS 656.802(2)(b) and may not be considered in the analysis of the major cause of her psychological disability and need for treatment.

We find that the causation issue is a complex medical question, resolution of which turns largely on the medical evidence. See Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986). Where medical evidence is in conflict, we tend to give greater weight to the opinions of claimant's treating doctors, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983).

Dr. Colistro, claimant's treating psychologist, had seen claimant numerous times by the time he offered his opinion (Ex. 8-1). He diagnosed claimant as suffering from severe, single episode major depression. (Ex. 8-5). He identified work stress involving a combination of excessive work, lack of training, poor support from superiors and co-workers, and the company's disorganization as the sole cause of claimant's psychological problems. (Ex. 8-3, 8-5). The employer's disciplinary actions, which we have previously found to be reasonable, were not among the factors Dr. Colistro cited as contributing to claimant's depression. Thus, we find that it is Dr. Colistro's opinion that work stress, apart from any of the employer's disciplinary measures, is the sole cause of claimant's psychological condition.

Dr. DeWitt, claimant's longtime treating medical doctor, corroborates Dr. Colistro's opinion. He treated claimant several times for symptoms of stress and anxiety beginning in May 1989 until he referred her to Dr. Colistro for psychological treatment, and he was aware that her supervisors had taken some disciplinary measures (claimant said she was "jumped on by her supervisors"). (Ex. 12-2). It was Dr. DeWitt's opinion that most of claimant's problems arose from her work for the employer; specifically, from working long hours without any secretarial help, and from financial problems with the employer. (Ex. 14). Significantly, Dr. DeWitt did not cite the employer's disciplinary measures as among the factors that caused claimant's job stress.

Thus, we conclude, relying on the opinions of claimant's treating doctors Colistro and DeWitt, that there is clear and convincing evidence that claimant's work conditions (excluding the employer's disciplinary actions) were the major contributing cause of her psychological condition.

Dr. Turco, a psychiatrist who conducted an independent medical examination, opined that work-related stressors, when compared to non-work-related stressors, were the major cause of claimant's mental disorder, contributing more than 50 percent to claimant's stress. (Tr. 329-30). He recommended that claimant not return to her employer at injury. (Ex. 7-8). In forming his opinion, he considered the employer's disciplinary actions as a work-related stressor, to which he assigned a contribution of "more than 25 percent." (Tr. 330). Other work-related factors that Dr. Turco cited as contributing to claimant's psychological condition included insufficient support staff in a highly pressured job, increased job responsibilities, working long hours, and financial disputes (Tr. 328-30). However, he did not indicate whether, if the employer's disciplinary actions were excluded from consideration, the remaining work-related stressors were the major cause of the disorder.

To the extent that Dr. Turco's opinion may conflict with the opinions of Drs. Colistro and DeWitt, we give greater weight to the treating doctors' opinions. Both Drs. Colistro and DeWitt had the opportunity to observe claimant over an extended period of time in treating her psychological condition and its medical symptoms, while Dr. Turco saw her only once. Dr. DeWitt treated claimant for other medical problems over a 20 year period, and, thus, has the advantage of being familiar with claimant's condition before the onset of her psychological problems.

We conclude that claimant has sustained her burden of proving by clear and convincing evidence that work-related stressors, not otherwise excluded under former ORS 656.802(2), were the major cause of her mental disorder. Accordingly, claimant's mental disorder claim is compensable.

Claimant is entitled to an assessed attorney fee for her counsel's services at hearing and on review concerning this matter. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $12,500 is a reasonable fee, 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 attorney's statement of services submitted at hearing, the value of the interest involved, the complexity of the issues, and the risk that claimant's attorney may go uncompensated.

ORDER

The Referee's order dated November 6, 1990, is reversed. The insurer's denial is set aside, and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of $12,500, payable by the insurer.

May 8, 1992 Cite as 44 Van Natta 923 (1992)

In the Matter of the Compensation of
TERRY A. SORVIK, Claimant
WCB Case No. 90-19448
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
David O. Horne, Defense Attorney

Reviewed by Board Members Moller and Neidig.

The insurer requests review of that portion of Referee Peterson's order that set aside its partial denial of claimant's left knee injury claim. In his brief, claimant contends that the insurer failed to timely deny his knee injury claim. On review, the issues are compensability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

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

In the present case, claimant seeks compensation for a condition he alleges arose directly from the January 29, 1990 incident in which he slipped on a board at work, as distinguished from a "consequence" arising from the injuries he sustained on that date. Accordingly, claimant's condition is properly characterized as a primary consequence of an industrial accident. Therefore, in order to establish compensability, claimant must show that the January 29, 1990 accident was a material contributing cause of his left knee injury and need for medical services. See ORS 656.005(7)(a)(A); Julie K. Gasperino, 43 Van Natta 1151 (1991).

Here, we agree with the Referee that claimant has established compensability of his left knee condition and we affirm the Referee on that issue.

Untimely denial

At hearing, the issues litigated before the Referee were compensability and penalties and attorney fees, based upon an allegedly unreasonable denial. The Referee found that, considering the medical records and the 801 form, the insurer's denial was not unreasonable.

We conclude that the issue of timeliness of the denial was not litigated at hearing. Accordingly, it is not appropriately raised for the first time on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991); Mavis v. SAIF, 45 Or App 1059 (1980). Therefore, we do not address claimant's contention that the insurer's denial was untimely.

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 issue of compensability is $850, 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 August 8, 1991 is affirmed. For services on review concerning the issue of compensability, claimant's counsel is awarded an attorney fee of $850, to be paid by the insurer.

In the Matter of the Compensation of
CATHERINE E. GREEN, Claimant
WCB Case Nos. 90-12498, 90-02289 & 90-11980
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Phillip Nyburg, Defense Attorney

Reviewed by Board Members Tenenbaum and Hooton.

The insurer requests review of that portion of Referee Black's order that set aside its denial of claimant's occupational disease claim for a myofascial pain syndrome condition. Claimant cross-requests review of that portion of the order that failed to award her additional scheduled permanent disability. On review, the issues are compensability and extent of permanent disability. We affirm the Referee's compensability determination and conclude that claimant has failed to establish an entitlement to an award of scheduled permanent disability under the standards.

FINDINGS OF FACT

Claimant began work with the insured in December 1987. She initially worked on the haulback, where she sorted wood scraps from a plywood production line. After working haulback for approximately one month, she began work on a fishtail saw. That job involved pulling wood off a table onto a saw deck. Both positions required repetitive movement of the arms, pushing, pulling and some twisting.

In January 1988, claimant began to experience soreness and sharp pain in both wrists. She later sought medical treatment in July 1988, complaining of numbness and tingling in her left hand. Dr. Freeman, M.D., diagnosed bilateral carpal tunnel syndrome and, on August 23, 1988, performed left-sided carpal tunnel release surgery.

Claimant returned to work. By January 1989, she was again complaining of progressively worse pain in her shoulders, neck and right forearm. She returned to Freeman, who performed right-sided carpal tunnel release surgery on March 15, 1989.

Claimant returned to regular work for a short period after the second surgery, but left on maternity leave in August for the birth of her fourth child. Meanwhile, her claim was closed pursuant to an August 17, 1989 Determination Order, which awarded temporary total disability but no permanent disability.

Following her return to work from maternity leave, claimant was placed on a schedule of rotating shifts. Her work assignments would rotate every six weeks and alternated between day, night and relief shifts. In December 1989, she reported upper body pain, fatigue and soreness, and began to experience mental difficulties. She returned to Freeman, who diagnosed myofascial pain dysfunction and referred her to Dr. Wheeler, M.D. Claimant was also examined by Dr. Becker, M.D., and by physicians at the Northwest Pain Center.

On February 15, 1990, claimant filed a claim for "fibrositis-mood disturbance-sleep disorder." (Ex. 38). She also submitted a petition requesting the insured to reopen her claim and commence the payment of temporary disability. On April 12, 1990, the insurer denied the claim, asserting that claimant's condition had not worsened since the claim was closed and that her current need for treatment was unrelated to her work with the insured.

CONCLUSIONS OF LAW AND OPINION

Compensability - Myofascial Pain Syndrome

The Referee concluded that there was sufficient medical evidence to establish that claimant's myofascial pain syndrome, or fibrositis, was compensable as an occupational disease under ORS 656.802. We agree and adopt his conclusions and reasoning. McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986).

Extent of Permanent Disability

At hearing, claimant alleged that she was entitled to an award of permanent disability as a result of her compensable bilateral carpal tunnel syndrome condition. The Referee failed to address the issue, and claimant renews her argument on cross-review.

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 June 8, 1989, and her claim was closed by Determination Order on August 17, 1989, we apply the "standards" in effect at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-010 through 436-35-260 apply to the rating of claimant's scheduled permanent disability.

Sensory Loss

Claimant first contends that she is entitled to an award for loss of sensation under former OAR 436-35-110(3)(a). She relies on Dr. Freeman's December 1989 report that sensation was "decreased remarkably to pin from the wrists on up to the shoulders[.]" (Ex. 30). There is no evidence in that report, however, that the noted sensory loss is due to nerve impairment caused by claimant's compensable carpal tunnel syndrome condition.

Claimant also relies on Dr. Becker's depositional testimony, in which he noted that claimant had "some loss of pinprick perception" related to her carpal tunnel syndrome, and that the loss "was localized to the median nerve distribution." (Ex. 48A). Those comments, however, do not establish with reasonable certainty the extent of that sensory loss and, therefore, are insufficient for purposes of awarding permanent disability under the "standards." In fact, the only evidence Becker gave as to the extent of the impairment was that it was somewhere "in between" severe or very slight. (Ex. 48A at 10). Without more detailed and specific sensory findings, we decline to assign what would be a purely arbitrary impairment value for sensory loss under former OAR 436-35-110(3)(a).

Grip Strength

Claimant next contends that she is entitled to an award for loss of grip strength and relies on a December 1989 physical capacities evaluation. That evaluation, however, does not relate the strength loss to claimant's compensable carpal tunnel syndrome condition. Moreover, it does not attribute the loss to atrophy, anatomical changes or nerve damage. Accordingly, claimant has failed to establish entitlement to an award for loss of grip strength under the standards. See former OAR 436-35-110(3)(a), (d).

Chronic Conditions

Claimant last contends that she is entitled to an award for a chronic condition limiting the repetitive use of each forearm. She relies on her testimony, as well as that of her coworkers, that she is unable to engage in repetitive lifting or gripping activities.

Former OAR 436-35-010(7) allows an award of 5 percent for chronic conditions that limit the repetitive use of a scheduled body part. Lay testimony, however, cannot by itself establish the existence of a chronic condition. See Ruben Carlos, 43 Van Natta 605 (1991). There must be medical evidence to support such a finding. Claimant contends that her testimony is corroborated by the medical records; however, she cites no specific evidence. After our review of the medical record, we find no evidence that claimant suffers from a chronic condition limiting the repetitive use of her forearms as a result of her compensable condition. Accordingly, we conclude that claimant has failed to establish entitlement to an award of permanent disability.

Attorney Fee on Review

Because the insurer initiated the request for review concerning the compensability issue and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an assessed 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 attorney's services on review is $1,000, 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 April 15, 1991 is affirmed. The August 17, 1990 Determination Order award of no scheduled permanent disability is affirmed. For services on Board review concerning the compensability issue, claimant's counsel is awarded a reasonable fee of $1,000, to be paid by the insurer.

April 30, 1992 Cite as 44 Van Natta 927 (1992)

In the Matter of the Compensation of
HAROLD R. HOPKINS, Claimant
Own Motion No. 92-0205M
ORDER POSTPONING ACTION ON OWN MOTION REQUEST
Emmons, et al., Claimant Attorneys

The insurer voluntarily reopened the above claim for the payment of temporary total disability compensation pursuant to ORS 656.278(4). Claimant's aggravation rights expired on October 23, 1989. The insurer accepted the compensability of claimant's October 2, 1990 cervical surgery. The employer now requests authorization for reimbursement from the Reopened Claims Reserve.

We may authorize reimbursement from the Reopened Claims Reserve for amounts of compensation which are properly paid pursuant to our authority under ORS 656.278. ORS 656.625. Under ORS 656.278(1)(a), we may authorize, on our own motion, the payment of temporary disability compensation 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). In

such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. Id.

If there is litigation pending on issues which may affect our own motion jurisdiction, it is our policy to postpone action until the pending litigation has been resolved. Here, claimant has a pending request for hearing concerning a Determination Order dated October 24, 1989. (WCB Case No. 89-23900). Our records show that claimant is contending the Determination Order prematurely closed his claim. If claimant prevails at hearing and the Determination Order is set aside, claimant's claim would be processed as an open aggravation claim. In that event, inasmuch as our own motion jurisdiction to award temporary disability compensation does not begin until claimant's aggravation rights have expired, see Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988), we would lack own motion jurisdiction to authorize reimbursement of any temporary disability compensation paid by the insurer.

Therefore, we defer action on this request for own motion action and request that Referee 1Baker, who is scheduled to conduct the hearing in WCB Case No. 89-23900 submit a copy of his order to the Board. After issuance of that order, the parties should advise the Board of their respective positions regarding this request for reimbursement.

Parenthetically, if the October 24, 1989 Determination Order is not found to be premature, inasmuch as claimant's aggravation rights expired on October 23, 1989, we would have own motion jurisdiction to award any additional amounts of temporary disability compensation. The record shows that the insurer reopened claimant's claim for the payment of temporary disability compensation before the date of the October 2, 1990 surgery. As we discussed above, we would have own motion authority to reimburse only those amounts of temporary disability compensation that were paid from the date of surgery or hospitalization. Additionally, any further closures of the claim would be subject to our own motion jurisdiction; that is, claim closure would have to be accomplished by issuing a Notice of Closure (Form 2066) under OAR 438-12-055 (own motion claim closure procedure), not by issuing a Determination Order under ORS 656.268 (regular claim closure procedure).

Thus, if the October 24, 1989 Determination Order is not found to be premature, because the claim was subsequently reopened after the expiration of claimant's aggravation rights, it appears that the Determination Order issued on July 5, 1991, as corrected on October 23, 1991, and the Order on Reconsideration dated January 28, 1992, were issued without authority.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN J. RICE, Claimant
WCB Case Nos. 90-14069 & 90-12474
ORDER ON REVIEW
John C. O'Brien, Jr., Claimant Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Tenenbaum and Kinsley.

The insurer requests review of Referee Mills' order which set aside its denial of claimant's claim for back surgery at L5-S1. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the "Findings of Fact," except for the "Findings of Ultimate Fact," contained in the Referee's Opinion and Order and the Opinion and Order on Reconsideration, with the following exceptions.

We make no findings regarding the reasonableness and necessity of L3-5 or L5-S1 surgery.

We do not find that claimant suffered an April 1990 pratfall; nor do we find that Dr. Nash's November 26, 1990 surgery repaired post-traumatic, rather than congenital or degenerative, problems.

CONCLUSIONS OF LAW AND OPINION

We note at the outset that claimant's L3-5 condition, a chronic back strain, resulted from an occupational disease. See John J. Rice, 42 Van Natta 2513 (1990), aff'd mem Connecticut Indemnity v. SAIF, 109 Or App 329 (1991). The law of the case involving the L3-5 condition is that the condition was compensable as of an Arbitrator's Order dated April 17, 1990. See id.

The issues raised prior to the November 1990 hearing arose out of the insurer's denial of claimant's aggravation and medical services claims, including his request for authorization for repeat surgery at L3-5. The Referee upheld the insurer's denial of the medical services claim on reasonable and necessary grounds. Subsequent to the Referee's order, Dr. Nash operated at L5-S1 and the parties agreed that their dispute is limited to the compensability of that surgery. Consequently, the Referee abated his November 8, 1990 Opinion and Order, reopened the record, and issued an Opinion and Order on Reconsideration setting aside the insurer's denial of claimant's medical services claim for the November 26, 1990 L5-S1 surgery.

In the Order on Reconsideration, the Referee stated that the only issue before him was "whether the surgery at L5-S1 was reasonable and necessary and related to claimant's compensable claim." (O&O p.2). We reframe and restate the issues, for the following reasons. First, the reasonableness and necessity of surgery ceased to be at issue when the parties asked the Referee to abate his initial order. Second, claimant presents alternative arguments. He contends that: (1) the L5-S1 medical services are compensable as related to an alleged April 1989 pratfall at work; or (2) they are compensable as related to the accepted L3-5 condition, because the L3-5 surgery caused the need for treatment at L5-S1. Although the Referee stated that the treatment was claimed as related to the compensable condition, he relied on Dr. Nash's opinion and decided the case on the theory that the L5-S1 surgery is compensably related to an April 1989 work incident, which had not previously been found compensable. In so doing, the Referee found that an April 1989 compensable event occurred at work. We disagree.

In order for a medical services claim to be compensable, the claimed treatment must be related to a compensable condition. ORS 656.245(1). Here, under claimant's second theory, the condition at L5-S1 is claimed to be a consequence of the accepted condition at L3-5, as a result of intrusive surgery to remove scarring at L3-5. However, the work activities which caused the L3-5 problems were not the direct cause of the need for treatment at L5-S1. Under these circumstances, we conclude that the L5-S1 condition is claimed as a "consequential condition," rather than a direct or primary consequence of the L3-5 occupational disease. See Julie K. Gasparino, 43 Van Natta 1151, 1153 (1991). Therefore, to prevail concerning the claimed L5-S1 treatment, claimant

must prove that the L3-5 condition was the major contributing cause of the L5-S1 consequential condition. See ORS 656.005(7)(a)(A).

The only evidence arguably relating claimant's need for L5-S1 surgery to his treatment for the L3-5 condition is the opinion of Dr. Zivin, an independent examiner. On August 15, 1990, Dr. Zivin opined that, given claimant's potential for instability due to his congenital pars defect, repeated surgical intrusions could only be expected to increase the likelihood of instability at the L5-S1 level. (Ex. 81-11). Noting that the October 1989 surgery at L3-5 did not materially benefit claimant, Zivin also stated that "without doubt some of [claimant's] current problems are the residuals of and are attributable to that surgery." (Ex. 81-12). After the November 1990 surgery, Dr. Zivin stated: "The surgery itself was performed at a site of congenital spinal malformation, whereas expected hypertrophic changes in the facets and encroachment upon nerve roots is expected. This condition was not caused by [claimant's] employment." (Ex. 90-2). Dr. Zivin's August 1990 opinion raises the possibility that the then-anticipated L3-5 surgery may have caused problems at L5-S1. Although Dr. Zivin clearly opined that "some" of claimant's "problems" are due to his prior surgery, we are unable to determine whether those problems included the condition requiring treatment at L5-S1. Moreover, in light of Dr. Zivin's later opinion explaining that changes in spinal facets and nerve root encroachment are expected with a preexisting defect such as claimant's, we conclude that Dr. Zivin's opinion does not support claimant's second theory that the surgery at L3-5 was the major contributing cause of the worsened spondylosis at L5-S1.

Claimant also advances the theory that the worsened L5-S1 condition is related to an alleged April 1989 pratfall at work. In order to prevail under this theory, claimant must prove that the work incident occurred as he alleges.

The evidence on this question is conflicting. Dr. Finch, then-treating chiropractor, reported on May 10, 1989 that claimant was taken off work on May 4, 1989, after he sought treatment on April 21, 1989. Finch reported, "Patient states there was no injury involved." (Ex. 33). On June 29, 1989, Western Medical Consultants reported claimant's history that he had experienced a flare-up in April, noting that claimant "recalls no specific event that caused this flare-up . . . [and] cannot recall any specific or dramatic incident which caused his present increase in symptoms[.]" (Ex. 36-2). On August 29, 1989, Independent Chiropractic Consultants examined claimant, reviewed his history, and commented that claimant did not report a triggering traumatic event. (Ex. 46-3).

On the other hand, claimant and his wife testified that claimant tripped over a cable at work in April 1989 and fell backward to the ground. The first medical reference to a suspected work incident is Western Medical Consultants' November 1989 report that stated that claimant "probably" suffered a new incident in April 1989, although their report contained no history of a new incident. (Ex. 48-1). Dr. Nash, treating surgeon, first reported an April 1989 pratfall on May 24, 1990. (Ex. 75-2). After claimant's November 1990 surgery, Dr. Nash opined that an April 1989 pratfall "heralded the development of symptoms, that eventually led to the necessity of his surgeries." (Ex. 89). On July 23, 1990, Dr. Berkeley described a March 1989 pratfall. (Ex. 80-1).

Considering the complete lack of contemporaneous evidence of an April 1989 injurious event and claimant's failure to explain why he didn't recall such an event then, but does now, we find claimant's reporting to be materially unreliable. Moreover, because Dr. Nash based his opinion concerning causation on claimant's unreliable history, Dr. Nash's opinion is unreliable as well. In the absence of reliable evidence supporting claimant's "new injury" theory, he has not carried his burden of proving that he suffered a compensable injury in April

1989. For these reasons, we conclude that the medical services claim is not compensable.

ORDER

The Referee's order dated November 8, 1990, as reconsidered on July 3, 1991, is reversed. The insurer's denial of claimant's claim for surgery at L5-S1 is reinstated and upheld. The Referee's award of an assessed attorney fee is also reversed.

May 12, 1992 Cite as 44 Van Natta 931 (1992)

In the Matter of the Compensation of
AL S. DAVIS, Claimant
WCB Case No. 91-04560
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of those portions of Referee Knapp's order which: (1) found that the Director did not have jurisdiction over the reasonableness and necessity of claimant's proposed back surgery; and (2) set aside SAIF's "de facto" denial of the proposed surgery. The Department of Insurance and Finance has filed a motion requesting that it be joined as a party to this proceeding and has filed appellate briefs. On review, the issues are motion for joinder and jurisdiction. We deny the joinder motion, conclude that the Director had jurisdiction over this dispute pursuant to ORS 656.327(1)(a), and reviewing the Director's order for substantial evidence under ORS 656.327(2), affirm the Director's order.

FINDINGS OF FACT

We adopt the Referee's findings of fact, but do not adopt the Referee's "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Motion for Joinder

The Department of Insurance and Finance (Department) has moved to be joined as a party to this proceeding and has filed appellate briefs concerning this matter.

Inasmuch as the Department was not a party at hearing and this matter did not arise from a hearing request filed by the Director, we conclude that the Department is not a party to this proceeding. ORS 656.005(20); 656.283(1). In support of its contention that it has standing, the Department cites John A. Tallant, 42 Van Natta 939 (1990). In Tallant, the Board concluded that because the Department had a stake in the outcome of a case involving a noncomplying employer, it had standing. Here, by contrast, the Department does not have a stake in the outcome of this particular case, but rather has a general interest in the interpretation of ORS 656.327.

We conclude, based on the foregoing reasoning, that the Department does not have standing in this proceeding. Consequently, we deny the Department's motion for joinder. Nevertheless, the briefs submitted by the Department will be considered as amicus curiae briefs.

Jurisdiction

In the present case, SAIF contended that claimant's proposed surgery was inappropriate and it initiated the Director's review of the surgery pursuant to ORS 656.327. On April 4, 1991, the Department of Insurance and Finance issued a proposed and final order concerning a bona fide medical services dispute, which concluded that the proposed treatment was not appropriate. Claimant filed a hearing request asserting that the Director did not have jurisdiction over this matter.

The Referee concluded that the Hearings Division, and not the Director, had original jurisdiction over this dispute concerning the reasonableness and necessity of claimant's proposed back surgery. The Referee reasoned that ORS 656.327 did not apply because the surgery was proposed treatment, rather than treatment claimant was "receiving", that was excessive, inappropriate or ineffectual as provided in ORS 656.327(1)(a). We disagree.

Under amended ORS 656.704(3), "matters concerning a claim" do not include any dispute regarding medical treatment or fees for which a resolution procedure is otherwise provided in ORS Chapter 656. ORS 656.327 provides a procedure for the resolution of disputes between the insurer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services."

Subsequent to the Referee's order, we concluded that original jurisdiction over such disputes is no longer shared by the Director and the Hearings Division. Stanley Meyers, 43 Van Natta 2643 (1991). Rather, because such disputes do not constitute matters concerning a claim, original jurisdiction lies exclusively with the Director. See Stanley Meyers, supra. Furthermore, we have also held that disputes regarding proposed medical services, as well as those regarding current medical services, are within the Director's original jurisdiction pursuant to ORS 656.327. Kevin S. Keller, 44 Van Natta 225 (1992).

Accordingly, the Referee was in error when he concluded that the Director did not have jurisdiction to decide this medical services dispute. However, the Hearings Division does have jurisdiction to review the Director's order if a claimant requests such review. Consequently, the Referee had jurisdiction to review the Director's order pursuant to ORS 656.327(2).

ORS 656.327(2) provides in pertinent part: " * * * Review of a Director's order shall be as provided in ORS 656.283 in accordance with expedited hearing procedures established by the Board, except that the order of the Director may be modified only if the order is not supported by substantial evidence in the record." Substantial evidence exists to support a finding when the record, reviewed as a whole, would permit a reasonable person to make that finding. Armstrong v. Asten-Hill Co., 90 Or App 200 (1988).

We find that the record is fully developed on the issue of the reasonableness and necessity of claimant's proposed surgery, and we proceed to review the Director's order for substantial evidence.

The only physician who concludes that surgery is appropriate is Dr. Misko, neurosurgeon. Dr. Misko has performed four prior surgeries on claimant's back which have not resulted in lasting relief of claimant's pain. Drs. Seres and Ploss of the Northwest Pain Center concluded that claimant was not a good surgical candidate. Finally, Dr. Matteri served as medical reviewer for the Director. He concluded that not enough motion is present at the L3-4 segment to warrant additional surgical intervention. Dr. Matteri felt that because the surgery would represent a fifth surgical procedure for claimant, the likelihood

of significant relief would be miniscule and would not warrant the risks inherent in the procedure.

Based on this record, we hold that the Director's findings were based on substantial evidence and support the Director's conclusion that the proposed surgery was not appropriate. Accordingly, the Director's order is affirmed. ORS 656.327(2).

ORDER

The Referee's order dated July 30, 1991 is reversed. The Director's order dated April 4, 1991 is affirmed. The Referee's $1,800 attorney fee is reversed.

May 12, 1992 Cite as 44 Van Natta 933 (1992)

In the Matter of the Compensation of
PAMELA J. PANEK, Claimant
WCB Case No. 91-01720
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Moller and Westerband.

The SAIF Corporation requests review of Referee Mills' order which: (1) held that the Hearings Division had jurisdiction in this case; (2) set aside SAIF's denial of psychological treatment; (3) assessed a penalty and attorney fee for unreasonable denial of psychological treatment; (4) set aside SAIF's "de facto" denial of a proposed swimming program; (5) assessed a penalty and attorney fee for an allegedly unreasonable denial of the swimming program; and (6) assessed an attorney fee for an allegedly unreasonable resistance to the payment of compensation due to SAIF's requirement that claimant undergo monthly weigh-ins to monitor her weight loss. SAIF moves to strike a supplemental memorandum filed by claimant with the Board after the briefing schedule was completed. On review, the issues are motion to strike, jurisdiction, medical services, and penalties and attorney fees. We vacate in part and reverse in part.

FINDINGS OF FACT

Claimant suffered a compensable injury to her right foot on May 18, 1983 when she tripped while exiting an elevator. Claimant had a preexisting psychological condition which became disabling as a result of the on-the-job injury and claimant's inability to get back to work. In addition, following her injury, claimant had an extreme weight gain.

Two Referee orders, dated April 2, 1986 and May 31, 1988, found claimant's psychological condition and need for treatment as well as her problem with weight to be compensably related to the industrial injury. Two stipulations, dated July 27, 1987 and January 12, 1990, have also reflected that causal relationship. The January 12, 1990 Stipulation found SAIF to be responsible for claimant's foot claim, bulimia, Pickwickian's syndrome, congestive heart failure, morbid obesity, eating disorder, depression, anxiety, and her general psychological and psychiatric condition.

Claimant has been treating with Virginia Terhaar since the fall of 1987. Ms. Terhaar obtained her MS in counseling in 1978 and is a licensed professional counselor with the State of Oregon. Ms. Terhaar's specialty is sexual assault victims. Claimant was an early childhood sexual assault victim.

Claimant has also treated with Dr. Dewey, a licensed psychologist, since 1985. Dr. Dewey has diagnosed claimant as having, at present, three to four adult personalities.

Dr. Friedman, psychiatrist, began treating claimant in February 1988. Dr. Friedman has assisted in co-admissions for claimant's hospitalizations when necessary, and also monitors claimant's medications.

In the summer of 1990, Dr. Friedman became claimant's principal attending physician. A treatment team was established with Dr. Dewey as claimant's therapist, Ms. Terhaar as her counselor, and Dr. Friedman as her attending psychiatrist.

In September 1990, SAIF indicated that it would no longer pay for claimant's counseling with Ms. Terhaar. SAIF's basis for the denial was that the counseling was not being conducted under the direct control and supervision of claimant's attending physician. Claimant has continued to treat with Ms. Terhaar and pay for the visits on her own.

Claimant currently weighs approximately 440 pounds. Her ultimate goal, established by the treatment team, is a weight loss of 150 pounds. Claimant has undergone numerous weight control programs without reaching her goal. To help with weight loss, the treatment team recommended claimant begin swimming.

On November 13, 1990, SAIF's claims adjustor sent a letter to Dr. Friedman advising that it was SAIF's expectation that claimant lose between 2 to 3 pounds per week or 8 to 13 pounds per month. The letter requested claimant attend a weigh-in once per month. SAIF's letter also suggested that claimant ought to swim 3 to 4 times per week or the swimming would be viewed as recreational and would not be paid for. The letter also stated that Ms. Terhaar's bills would not be paid.

FINDINGS OF ULTIMATE FACT

The Hearings Division does not have jurisdiction to determine the issue concerning the treatment provided by Ms. Terhaar.

The Hearings Division does not have jurisdiction to determine the reasonableness or appropriateness of the proposed swimming program.

SAIF has no authority to require claimant to attend a weigh-in once per month.

There has been no claim for treatment from Dr. Dewey in excess of the two times per week authorized by SAIF.

Copies of discovery materials were sent to claimant during the course of her claim. This was a mistake, but it was not unreasonable.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant's supplemental memorandum, filed on December 3, 1991, was submitted after the briefing schedule in this case was completed. OAR 438-11-020(2). Claimant has not filed for an extension of time for the filing of briefs, nor has she offered any statement of extraordinary circumstances for which an extension may be considered. Therefore, we grant SAIF's motion to strike the supplemental memorandum. Accordingly, we do not consider the supplemental memorandum on Board review.

Jurisdiction

SAIF asserts that the Hearings Division does not have jurisdiction over the present case because: "ORS 656.327(1)(a) provides that the director has exclusive jurisdiction to review cases where an injured worker 'is receiving medical treatment that is excessive, inappropriate, ineffectual, or in violation of the rules.'" We agree in part.

Treatment provided by Ms. Terhaar

The basis for SAIF's denial was that claimant's treatment provided by Ms. Terhaar is in violation of OAR 436-10-050(2) and 436-10-005(9). We agree that this dispute involves medical services that are allegedly in violation of rules within the meaning of amended ORS 656.327(1). Under the circumstances, we conclude that the Hearings Division does not have original jurisdiction over this dispute, as the matter is within the purview of the Director in the first instance. See Julie M. Harper, 44 Van Natta 820 (1992); Stanley Meyers, 43 Van Natta 2643 (1991).

We, therefore, vacate the Referee's order insofar as it purports to set aside the denial, for the denial did not raise a matter concerning a claim within the jurisdiction of the Hearings Division. We also vacate the Referee's attorney fee award of $2,500 for prevailing against the denial, and the assessment of penalties and related attorney fees.

Swimming Program

SAIF asserts that claimant's proposed swimming program is "not properly at issue here because SAIF has never received anything that constitutes a claim for any compensation related to a swimming program." We do not necessarily agree that SAIF has never received a claim for claimant's swimming program; however, we conclude that we are without jurisdiction to address this medical services issue. Original jurisdiction over this dispute lies within the Director's original jurisdiction pursuant to ORS 656.327. See Kevin S. Keller, 44 Van Natta 225 (1992).

Accordingly, we vacate the Referee's decision insofar as it purports to set aside a "de facto" denial of a swimming program, for the purported denial does not raise a matter concerning a claim within the jurisdiction of the Hearings Division. We also vacate the Referee's assessed attorney fee award of $500 and penalty related fee of $250 for claimant's counsel's services for prevailing against the denial.

Monthly Weigh-in Requirement

The Referee concluded that:

> "The insurer's actions in connection with the weight loss and weigh-ins have not resulted in the denial of any medical care or other compensation to claimant. Those actions were unreasonable and unwarranted and were, in the insurer's own words, designed to tie claimant's ongoing weight loss to the further provision of medical services. I therefore conclude that those actions were unreasonable resistance to the payment of compensation, are disallowed, and entitle claimant's attorney to a fee under ORS 656.382."

We agree with the Referee that SAIF's request was unreasonable. SAIF has no authority to prescribe procedures as part of claimant's medical treatment. Such prescriptions are the province of claimant's treating physician. Rather,

SAIF has three options to deal with medical services being provided to claimant. It may: (1) pay the bill; (2) deny the treatment as being unrelated to the compensable injury; or (3) request review by the Director in the event SAIF believes that the treatment is not reasonable and appropriate for the compensable condition.

However, inasmuch as SAIF's actions did not result in denied medical services or medical bills, we have no choice but to disagree with the Referee that SAIF's actions amounted to an unreasonable resistance to the payment of compensation. Therefore, although we find SAIF's conduct to have been unreasonable, we conclude that there is no basis for an award of a penalty-related attorney fee. Accordingly, we reverse that portion of the Referee's decision which assessed an attorney fee for an unreasonable resistance to the payment of compensation.

ORDER

The Referee's order dated June 27, 1991 is vacated in part and reversed in part. That portion which set aside the SAIF Corporation's denial of treatment provided by Ms. Terhaar is vacated. The assessed attorney fee of $2,500 and penalty of 25 percent of the unpaid bills, with one-half of the penalty as an attorney fee for the denial of treatment provided by Ms. Terhaar, are vacated. That portion of the Referee's order that set aside SAIF's "de facto" denial of the proposed swimming program is also vacated. The assessed penalty of $250 and attorney fee of $500 for the denial of the swimming program are vacated. Claimant's request for hearing on those denials is dismissed for lack of jurisdiction. The Referee's attorney fee award of $1,250 for unreasonable resistance to the payment of compensation is reversed.

May 12, 1992 Cite as 44 Van Natta 936 (1992)

In the Matter of the Compensation of
MADLYN PIETILA, Claimant
WCB Case No. 91-04622
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Sandra K. Haynes, Defense Attorney

Reviewed by Board Members Moller and Westerband.

The self-insured employer requests review of those portions of Referee Schultz' order which: (1) awarded a $2,000 assessed attorney fee for prevailing on the temporary disability issue; and (2) awarded a $1,500 assessed attorney fee for prevailing on a "de facto" denial of medical services. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee awarded claimant an assessed fee for prevailing on the temporary disability compensation issue. We, instead, conclude that claimant is entitled to an approved fee, payable out of increased compensation.

A claimant is entitled to an assessed fee under ORS 656.386(1) if he prevails at hearing over a denial of a claim for compensation. 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. Esther C. Albertson, 44 Van Natta 523 (1992); Mona L. Allison, 43 Van Natta 1749 (1991); James R. Jones, Jr., 42 Van Natta 238 (1990).

The employer contends that the Referee's award of a $1,500 assessed attorney fee for prevailing on the "de facto" denial of a $26.71 prescription is excessive. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing concerning the medical services issue is $500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issue, and the value of the interest involved (reimbursement of a $26.71 prescription).

ORDER

The Referee's order dated August 2, 1991 is modified. In lieu of the Referee's award of an insurer-paid attorney fee of $2,000, we approve an out-of-compensation attorney fee of 25 percent of the increased temporary disability compensation awarded by the Referee's order, not to exceed $1,050. In lieu of the Referee's award of a $1,500 assessed attorney fee for prevailing on the medical services issue, claimant is awarded an assessed attorney fee of $500 payable by the self-insured employer.

May 12, 1992 Cite as 44 Van Natta 937 (1992)

In the Matter of the Compensation of
WILLIAM K. PORTER, Claimant
WCB Case No. 90-07029
ORDER ON REVIEW
Grover C. Dahn, Claimant Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Westerband and Moller.

The insurer requests review of those portions of Referee Mills' order that: (1) set aside its denial of claimant's cervical injury claim; (2) set aside its denial of claimant's medical services claim for cervical and lumbar surgery as not related to his compensable 1987 injury; (3) found the cervical and lumbar surgeries to be reasonable and necessary; and (4) found that claimant's back injury claim was prematurely closed. On review, the insurer argues that: (1) claimant has not established an aggravation claim for a lumbar condition; and (2) the 34 percent (108.8 degrees) unscheduled permanent disability awarded by a January 25, 1990 Determination Order should be reduced. On review, claimant argues that: (1) the unscheduled permanent disability awarded by a Determination Order should be increased; and (2) he should be awarded penalties and attorney fees for the insurer's allegedly unreasonable denial of his current lumbar and cervical conditions, the requests for surgery for those conditions, and his aggravation claim. With his respondent's brief, claimant has enclosed a copy of a letter from his treating neurosurgeon. We treat this submission as a motion to remand for the taking of further evidence. Judy A. Britton, 37 Van Natta 1262 (1985). The issues on review are remand, compensability, premature closure, medical services, aggravation, extent of unscheduled permanent disability, penalties, and attorney fees. We deny the motion to remand, reverse in part, affirm in part, and vacate in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exceptions, corrections and supplementation. We do not adopt the Referee's findings of ultimate fact.

Claimant first reported neck pain relating to the November 30, 1987 injury on August 30, 1989, during an examination by Dr. Bussanich, consulting chiropractor. (Ex. 35-1). Prior to that examination, claimant had been examined by seven physicians and had not reported a history to any of them of neck pain dating from the injury.

On December 7, 1987, claimant was examined by Dr. Duff, consulting orthopedist, and reported no neck pain. (Ex. 2). On December 8, 1987, claimant began chiropractic treatments with Dr. MacDonald and reported no neck pain. (Exs. 3, 4). On January 19, 1988, claimant was examined by Dr. Peterson, consulting chiropractor, and reported no neck pain. (Ex. 5). On January 27, 1988, claimant began treating with Dr. Struckman, orthopedist. At no time during his eight visits did claimant mention any neck problems. (Exs. 7, 73). On February 23, 1988, claimant was examined by Dr. Spady, examining orthopedist, and reported no neck complaints or neck injury. (Exs. 9, 75). Dr. Spady noted no abnormalities in the neck on physical examination. (Ex. 75). On October 25, 1988, claimant was examined by Dr. Segur, consulting chiropractor, and reported no neck pain. (Ex. 12).

In December 1988, Dr. Steinhauer, M.D., examined claimant as part of a Workers' Rehabilitation Evaluation with the Emanuel Pain Center. (Exs. 19, 55). At that time, claimant reported only problems with his low back and did not report neck pain. (Exs. 73a-1, -2). On admission to the Pain Center in November 1989, claimant reported neck pain in addition to low back pain. (Ex. 73a-12).

CONCLUSIONS OF LAW AND OPINION

Remand

With his respondent's brief, claimant enclosed a copy of a letter from his treating neurosurgeon. We treat this submission as a motion to remand for the taking of further evidence. Judy A. Britton, supra.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Keinow's Food Stores v. Lyster, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986).

Here, the May 21, 1991 letter from Dr. Nash relates to: (1) claimant's worsened condition as of Dr. Nash's May 14, 1991 examination of claimant; and (2) the reasonableness and necessity of the proposed lumbar surgery. We do not find the record to be insufficiently developed without this letter for the following reasons. As to the first aspect of the letter, we make our decision as to whether claimant has established an aggravation claim based on the facts at the time of the alleged aggravation; therefore, claimant's condition more than a year after the alleged aggravation is not relevant to this issue. As to the second aspect, the Director has original jurisdiction over the issue of the reasonableness and necessity of medical services; therefore, this information is not relevant to our decision. Stanley Meyers, 43 Van Natta 2643 (1991). Accordingly, we deny the motion for remand and do not consider this letter on review.

Compensability of Cervical Condition - Injury Claim

The Referee found claimant credible based on his demeanor. Claimant testified that he had neck pain immediately following the November 30, 1987 injury and reported that pain but felt that it was related to the pain from the low back injury. In 1989, claimant began to report a history of cervical pain due to the 1987 injury. The Referee found that the scant cervical findings before 1989 were sufficient to support claimant's account of his injury. On that basis, the Referee found that the 1987 work incident injured claimant's cervical spine.

We will ordinarily defer to a Referee's demeanor credibility finding. However, given claimant's cervical degenerative disc disease, the issue of whether the 1987 work incident injured claimant's cervical spine is a very complex medical question even without any dispute concerning the factual histories upon which the medical opinions offered were based. Because of the unusually marked discrepancy between what claimant alleges he reported to the physicians and what those reports state were his complaints, we will not defer to the Referee's demeanor credibility finding, but instead, make an independent assessment of the evidence.

The December 1987 and January 1988 chart notes of Dr. MacDonald, treating chiropractor, provide the most support to claimant's argument that he reported cervical pain contemporaneous with the work incident. (Ex. 1A). However, these chart notes are not self-explanatory and Dr. MacDonald provided no explanation of them. On the other hand, Dr. Steinhauer, treating M.D., reviewed these chart notes and opined that the notations of "pain in mid back," "numbness back," "upper back," "bilateral cervical paraspinal M.S.," and "multiple thoracic" did not indicate that claimant was complaining about a cervical problem at the time or was experiencing complaints directly attributable to his neck. (Ex. 73a-1).

Furthermore, Dr. Struckman, orthopedist, treated claimant early in 1988 and stated that at no time during claimant's eight visits did he mention any neck problems. (Exs. 7, 73). Dr. Spady, orthopedist, performed a thorough examination of claimant on February 23, 1988. (Ex. 9). After reviewing his records, Dr. Spady stated that there were no abnormalities in the neck on physical examination, including range of motion, tenderness, deformity, muscle spasm, and neurological changes. (Ex. 75).

In addition, claimant did not report a history of cervical problems dating from the work incident during examinations in 1987 and 1988 with Dr. Duff, treating orthopedist, Dr. Peterson, consulting chiropractor, Dr. Segur, consulting chiropractor, and Dr. Steinhauer. (Exs. 2, 5, 12, 55, 73a). On this record, we find that claimant did not report a history of cervical pain until August 30, 1989 when he was examined by Dr. Bussanich, consulting chiropractor. (Ex. 35-1). During that examination, claimant reported that he had experienced neck pain and headaches since the November 1987 injury.

Dr. Steinhauer treated claimant while he was at the Emanuel Pain Center. Steinhauer first evaluated claimant in December 1988, at which time claimant reported problems only in his low back. In November 1989, claimant returned to the Pain Center and at that time reported complaints of neck pain, headaches, and bilateral arm pain in addition to low back pain. (Exs. 55, 73a-1). Steinhauer noted that he routinely asks patients about any pain problems in addition to the major area of pain and, in spite of this query, claimant did not complain of neck symptoms when Steinhauer first examined him in December 1988. (Ex. 73a-2). In addition, Steinhauer checked his records and those of Dr. MacDonald, the treating chiropractor immediately following the injury. After reviewing these records, Steinhauer stated that he found no evidence that claimant complained of any neck problems following the 1987 injury until 1989.

(Ex. 73a-1). As a result, Steinhauer concluded that claimant's neck problems were not related to the November 1987 injury.

In contrast, Dr. Nash, treating neurosurgeon, and Dr. Berkeley, consulting neurosurgeon, both opined that the 1987 injury caused claimant's neck problems. (Exs. 65-4, 76). However, Dr. Nash first saw claimant on January 25, 1990 and Dr. Berkeley first saw him on February 19, 1990. Claimant reported to both surgeons that he had neck and left arm pain from the date of the 1987 injury. (Exs. 58-1, 65-1).

On the basis of claimant's lack of reports of cervical pain to the physicians contemporaneous to the injury and Dr. Steinhauer's well-reasoned report regarding the relationship between the 1987 injury and claimant's cervical condition, we find that Drs. Nash and Berkeley had an inaccurate history regarding claimant's cervical complaints. Therefore, we do not find their opinions that the 1987 injury caused the cervical condition persuasive. Instead, we find Steinhauer's well-reasoned report persuasive. We conclude that claimant has not established that he injured his cervical spine in the 1987 incident.

Compensability of Cervical Condition - Occupational Disease Claim

In the alternative, claimant argues that Dr. Steinhauer's report establishes that claimant's work activities caused his cervical degenerative disc disease. We disagree.

Claimant's work activities as a heavy equipment mechanic included lifting, manipulating, and carrying tools, parts, and equipment. Because the facts preclude compensability under ORS 656.802(1)(a) or (b), claimant's cervical condition is compensable, if at all, under ORS 656.802(1)(c).

There is no evidence that claimant's cervical condition preexisted the 1987 injury. Therefore, to establish the compensability of his current cervical condition under ORS 656.802(1)(c) & (2), claimant must prove that employment conditions in the form of a series of traumatic events or occurrences were the major contributing cause of the cervical degenerative disc disease. Claimant must also prove the existence of the cervical disc disease by medical evidence supported by objective findings. ORS 656.802(2).

The existence of claimant's cervical degenerative disc disease is objectively supported by radiological tests. Dr. Steinhauer presents the only medical opinion regarding whether the cervical condition is an occupational disease.

First, Dr. Steinhauer concluded that claimant's return to work for four months in 1989 as an "oiler" could have worsened his cervical complaints but found it unlikely that that short period of work aggravated a neck condition that did not exist in November 1987. (Ex. 73a-2). Furthermore, Steinhauer noted that claimant's neck degeneration occurred over many years, not just during the four months he worked as an "oiler." Id.

Second, Dr. Steinhauer noted that claimant's general work activities "could theoretically produce cervical degeneration leading to the kind of neck symptoms he now experiences." (Ex. 73a-1). He also noted that it could not be proved that claimant's neck problems would not have occurred without his work activities. Id. Without further explanation, Steinhauer concluded that claimant's employment significantly contributed to, if not actually caused, the cervical complaints and cervical radiculopathy. (Ex. 73a-3).

We do not find that Steinhauer's final statement satisfies claimant's burden of proof. Unlike his opinion regarding the work injury theory, his opinion

regarding the occupational disease theory is conclusory, without any supporting reasoning. His report, as a whole, merely states that claimant's work activities could have caused his cervical condition. A "possibility" is not sufficient to satisfy the major contributing cause standard. Furthermore, Steinhauer does not explain his change of opinion from a possibility of claimant's work causing his cervical degeneration to a certainty that the work significantly contributed, if not actually caused, the neck condition. This unexplained change of opinion is not persuasive. Moe v. Ceiling Systems, 44 Or App 429 (1980); Raul A. Herrera, 40 Van Natta 1281 (1988). Thus, on this record, claimant has not established that his work activities were the major contributing cause of his cervical condition or its worsening.

Compensability of Cervical Condition - Failure to Cross-Appeal a Determination Order

Claimant also argues that because the insurer did not cross-appeal the January 25, 1990 Determination Order, which included an impairment award for cervical findings, the July 16, 1990 denial denying the cervical condition was a back-up denial. As such, claimant argues, the insurer must establish by clear and convincing evidence that the cervical conditions were not part of the original injury. We disagree. Failure to cross-request an appeal of the Determination Order does not constitute an acceptance of the cervical condition. See Johnson v. Spectra Physics, 303 Or 49 (1987). Without a prior acceptance, the January 1990 denial cannot be considered a back-up denial.

Medical Services

Because we find that claimant has not proven that his cervical condition is related either to the 1987 injury or his work activities, we find that medical services regarding the cervical condition are not compensable.

Causal Relationship of the Proposed Lumbar Surgery

The Referee found that the requested lumbar surgery was causally related to the 1987 injury. We agree.

At the outset, we note that, although the issue in the present case involves medical services, we have jurisdiction over this matter. In Michael A. Jaquay, 44 Van Natta 173 (1992), we held that there is no other procedure provided by ORS Chapter 656 for resolving disputes concerning the causal relationship between an injury and a need for medical services. Accordingly, where a denial is based on the ground that the need for medical services is not causally related to the compensable injury, the Board has jurisdiction. Jaquay, supra.

An injured worker is entitled to medical services "for such period as the nature of the injury or the process of recovery requires, including such medical services as may be required after a determination of permanent disability." ORS 656.245(1)(a). In order to establish compensability of medical services, claimant must show that his compensable lumbar condition is materially related to his current need for treatment.

The insurer argues that the 1987 injury combined with a preexisting condition. Therefore, the insurer contends, pursuant to ORS 656.005(7)(a)(B), claimant must prove that the injury remains the major contributing cause of his disability or need for treatment. However, claimant had no back problems prior to the work injury, and there is no medical evidence that the injury "combined" with a preexisting degenerative condition. See Janice M. Brodek, 43 Van Natta 1931 (1991). Therefore, we question the insurer's contention that claimant need prove that the injury was the major contributing cause of any disability or need

for treatment. However, regardless as to whether the standard of proof is "the major" or "a material" contributing cause, we conclude that claimant has sustained his burden.

Dr. Hazel, orthopedist and clinical instructor at Oregon Health Science University, performed an independent medical examination of claimant on December 13, 1989. (Ex. 47). Dr. Hazel stated that he had very inadequate medical records upon which to base an opinion. Nevertheless, he speculated that claimant's current lumbar condition was degenerative in nature. (Ex. 47-5). After receiving additional records, Dr. Hazel continued to opine that claimant's lumbar condition was related to a degenerative process and not to back strain or stress. (Ex. 74-2, Tr. 16).

Dr. Steinhauer concurred with Dr. Hazel's initial report which was admittedly speculation based on inadequate information. (Ex. 50). Later, without explanation, Dr. Steinhauer opined that claimant's lumbar complaints, including the radiculopathy, were attributable to his work activity. (Ex. 73a-2). We do not find this unexplained change of opinion persuasive. Moe v. Ceiling Systems, supra; Raul A. Herrera, supra.

Although Dr. Berkeley recommended lumbar surgery, his reports give no opinion as to the cause of the need for this surgery. Dr. Nash opined that the L4-5 disc prolapse and the L5-S1 spondylopathy were not the product of degenerative change but were caused by the 1987 injury based on the fact that these were focalized conditions. (Ex. 76-2). Dr. Nash had an accurate history as to the effect that the 1987 injury had on claimant's lumbar spine. Although Dr. Nash did not use the term "the major" contributing cause, it is apparent from his opinion that he believed claimant's compensable injury was the sole cause of his need for surgery. See McClendon v. Nabisco Brands, 77 Or App 412 (1986).

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, where Dr. Nash's opinion is based on an accurate history, there are no persuasive reasons not to defer to Dr. Nash on this issue. Therefore, we find claimant's lumbar surgery to be causally related to claimant's compensable injury.

Reasonableness and Necessity of Lumbar Surgery

The Referee found that the proposed lumbar surgery was reasonable and necessary. We find that the Referee lacked jurisdiction over this issue. Under amended ORS 656.704(3), "matters concerning a claim" do not include any dispute regarding medical treatment or fees for which a resolution procedure is otherwise provided in ORS Chapter 656. ORS 656.327(1) provides a procedure for the resolution of disputes between the insurer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services."

Here, at hearing and on review, the insurer argued that the proposed lumbar surgery was not reasonable and necessary in that claimant was not a good candidate for surgery and that the surgery was unlikely to lead to any improvement in his condition. These arguments are contentions that the proposed medical services are excessive and ineffectual. Original jurisdiction over such disputes is no longer shared by the Director and the Hearings Division. See Stanley Meyers, supra. Rather, because such disputes do not constitute matters concerning a claim, original jurisdiction lies exclusively with the Director. Id.; Kevin S. Keller, 44 Van Natta 225 (1992). Accordingly, we vacate the

Referee's order insofar as he found that the proposed lumbar surgery was reasonable and necessary.

Premature Closure

The Referee found that claimant's claim was prematurely closed based on Dr. Steinhauer's opinion that: (1) conservative treatment had not improved claimant's condition since claim closure; and (2) there was a possibility that surgery would improve his condition. We disagree.

A claim may be closed if claimant's compensable condition is medically stationary, i.e., no further material improvement would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17). In deciding whether a claim was prematurely closed, we determine whether the claimant's condition was medically stationary on the date of closure, without considering subsequent changes in his condition. Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). However, medical reports authored after closure may be considered if they address claimant's condition at the time of closure. For example, post-closure reports can be considered if there is no post-closure change in claimant's condition and the only question is whether claimant was medically stationary at the time of closure. Scheuning v. J.R. Simplot & Co., 84 Or App 622, 625, rev den 303 Or 590 (1987). It is claimant's burden to establish that he was not medically stationary when the claim was closed. Brad T. Gribble, 37 Van Natta 92 (1985).

Dr. Steinhauer found claimant medically stationary upon discharge from the Pain Center on November 22, 1989. (Ex. 42-3). At that time, Steinhauer was of the opinion that claimant's lumbar condition was not surgically treatable. (Ex. 73a-11). On December 13, 1989, Dr. Hazel examined claimant and found him medically stationary. The Determination Order found December 13, 1989 as the medically stationary date. The Determination Order was issued on January 25, 1990.

No medical report after that date addresses the issue of whether claimant was medically stationary as of January 25, 1990. On June 8, 1990, Dr. Steinhauer examined claimant and noted that: (1) his lumbar condition had not significantly improved or worsened since the November 1989 Pain Center treatment; and (2) the November 1989 medical testing indicated pathology which can produce pain. (Exs. 70-3, 70-4). On those bases, Dr. Steinhauer recommended authorization for surgery as recommended by Dr. Berkeley. (Exs. 70-3, 70-4).

Dr. Steinhauer gives no opinion as to claimant's medically stationary status. Although he finds no post-closure change in claimant's condition, he does not address the question of whether claimant was medically stationary at claim closure. In effect, Steinhauer merely changed his opinion regarding the proper course of treatment. On this record, we find that claimant has not established that his claim was prematurely closed.

Aggravation of Lumbar Condition

Because the Referee found that claimant's claim had been prematurely closed, he did not address the aggravation issue.

Although we have found that the condition for which Drs. Nash and Berkeley propose surgery to be causally related to claimant's 1987 work injury, a dispute continues to remain concerning whether the proposed surgery is reasonable and necessary. As previously discussed, this dispute is under the Director's jurisdiction pursuant to ORS 656.327(1). Kevin S. Keller, supra.

In Gary L. Waldrupe, 44 Van Natta 702 (1992), we held that where a decision regarding reopening a claim is contingent on a matter that is within the original jurisdiction of the Director, litigation regarding reopening the claim

must be deferred pending Director resolution of that matter. We also held that the Board and its Hearings Division may proceed to consider an aggravation issue based on a theory that a claimant's current condition (irrespective of a proposed surgery) constitutes a worsening of a compensable injury since the last award or arrangement of compensation. Gary L. Waldrupe, supra; Suzanne A. Holland, 44 Van Natta 804 (1992).

In the present case, claimant's aggravation claim is contingent on whether the proposed surgery is reasonable and necessary, a matter that is within the original jurisdiction of the Director. Consequently, it follows that consideration of any claim reopening issue must await the Director's determination as to whether the proposed surgery is reasonable and necessary. Gary L. Waldrupe, supra.

Therefore, litigation of that portion of the employer's denial which pertained to an aggravation claim based on the proposed surgery must be deferred pending Director resolution of the "reasonable and necessary" dispute. As an administrative matter, when, as here, a Referee is required to consider issues that are encompassed within one WCB Case Number in a manner that will finally resolve some issues and defer others for resolution at a future date, the following procedure is recommended. The Referee should direct the Central Files Section of the Hearings Division to create a new WCB Case Number to which the Referee will then assign the deferred issue(s). Gary L. Waldrupe, supra.

To return the "aggravation/surgery" issue to its appropriate status of "deferral" and to avoid any potential administrative confusion, the Central Files Section of the Hearings Division is directed to assign a new WCB Case Number to the "aggravation/surgery" issue. Litigation of this new case will then be deferred pending the Director's decision concerning the proposed surgery. The parties are requested to keep the Docketing Section fully apprised of further developments regarding the aggravation/surgery issue.

Extent of Unscheduled Permanent Disability

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). Stephen A. Roberts, 43 Van Natta 1815 (1991).

Claimant argues that the insurer's failure to cross-appeal the January 1990 Determination Order precludes it from first raising at hearing the issue of reduction of the permanent disability award by the amounts relating to cervical impairment. We disagree.

By appealing the January 1990 Determination Order, claimant put the extent of unscheduled permanent disability at issue. OAR 438-06-031 provides that if, at hearing, evidence supports an issue not previously raised, the referee may allow the issue to be raised. If the adverse party is surprised and prejudiced as a result, the Referee may continue the hearing upon a motion of the adverse party. Thus, claimant's remedy, in the event of surprise, was to request a continuance at hearing. Claimant made no showing of prejudice and made no motion for a continuance. Therefore, we conclude that the issue of reduction of extent of permanent disability was properly before the Referee.

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

the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010.

Because claimant's condition became medically stationary on December 13, 1989, and his or her claim was closed by Determination Order on January 25, 1990, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. WCD Admin. Order 1-1989. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent disability.

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

The parties do not dispute the values assigned by the evaluator for claimant's age (1), education (0), training (0), and skills (1). Therefore, we address only the values for adaptability and impairment.

Adaptability

The adaptability value for a claimant who is not working as a result of his compensable injury is determined by the claimant's residual physical capacity, without regard to that claimant's physical capacity prior to the injury. Former OAR 436-35-310(4).

Here, claimant is not working as a result of his compensable injury and no offer of employment has been made. Claimant's physical capacity is in the light category. (Exs. 40-2, 42-3, 77-3). Therefore, the appropriate adaptability value is 4. Former OAR 436-35-310(4)(c).

Impairment

Relying on an August 30, 1989 report from Dr. Bussanich, D.C., claimant argues that he is entitled to a 9 percent impairment value for loss of range of motion. (Ex. 35-3). However, we do not rely on this report because it measures claimant's loss of range of motion before he became medically stationary. Instead, we rely on Dr. Berkeley's February 19, 1990 examination. (Ex. 65-2). We do so because that examination was made after claimant was medically stationary, and it contains the most complete measurements of range of motion closest to the hearing date.

Dr. Berkeley's examination establishes that claimant had 50 degrees of flexion, which is rated at 4 percent impairment, and no extension, which is rated at 3 percent impairment. Former OAR 436-35-360(6) and (7). These values are added for a total loss of range of motion value of 7 percent. Former OAR 436-35-360(10).

Based on the radiculopathy into his legs, claimant argues that he is entitled to a 15 percent impairment value for loss of strength due to lumbosacral plexus nerve injury. Former OAR 436-35-350(4) provides for a rating of "[i]njuries to [the] spinal nerve plexus with resultant loss of strength." However, the medical record contains no evidence of such a nerve injury. The only evidence in the medical record regarding nerve injury states "[t]he EMG was negative for acute nerve injury." (Ex. 23-2). On this record, claimant has not established that he has an injury to his spinal nerve plexus.

Claimant is entitled to an 8 percent impairment value for the unoperated disc bulges at L4-5 and L5-S1. (Exs. 65-3, 73a-16). Former OAR 436-35-350(2). These multiple residuals are combined, not added, for a total impairment value of 14 percent.

Computation of Unscheduled Permanent Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value 1 is added to his education value 1, the sum is 2. When that value is multiplied by claimant's adaptability value 4, the product is 8. When that value is added to claimant's impairment value 14, the result is 22 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 22 percent.

Penalties and Attorney Fees

The Referee found no unreasonable resistance to payment of compensation by the insurer regarding the issuance of the denial. We agree. On review, claimant raises the issue of attorney fees and penalties relating to the employer's alleged unreasonable denial. However, he makes no argument regarding this issue.

The standard for determining an unreasonable denial is whether the carrier has a legitimate doubt as to its liability. Unreasonableness and "legitimate doubt" are to be considered in the light of all the evidence available at the time. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988), citing Norgard v. Rawlinsons, 30 Or App 999, 1003 (1977); see Carol J. Knapp, 41 Van Natta 851, 854 (1989).

The denial denied claimant's claims for bilateral carpal tunnel syndrome and depression. Claimant did not appeal those denials. It also denied that claimant's cervical condition and his need for cervical surgery were related to the compensable injury. We have found that claimant's cervical condition is not related to the compensable injury. The denial also denied an aggravation claim regarding claimant's lumbar condition. At the time of the denial, the insurer had Dr. Steinhauer's report which noted no objective worsening of claimant's condition since the November 1989 examination. (Ex. 72-3). In light of Dr. Steinhauer's opinion, we do not find that the insurer's denial of the aggravation claim was unreasonable. Finally, the denial also denied the proposed lumbar surgery. At the time of the denial, the insurer had medical reports from Drs. Duff, Spady and Hazel indicating that changes in claimant's spine were degenerative in nature. In light of these reports, we do not find that the insurer's denial of the proposed lumbar surgery was unreasonable. Therefore, we decline to assess a penalty or attorney fee for an allegedly unreasonable denial.

Attorney Fees at Hearing and on Review

In light of our conclusions, we modify the Referee's $2,250 attorney fee award for prevailing against the denial. As a result of our decision, claimant is entitled to an attorney fee for prevailing against the insurer's denial of a causal relationship between the current condition/proposed lumbar surgery and claimant's compensable condition. ORS 656.386(1). In addition, claimant is entitled to an attorney fee for services on Board review concerning his successful defense of that portion of the Referee's order.

After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable attorney fee for claimant's counsel's services at the hearing level and on Board review concerning the "causal relationship" issue is $1,500, to be

paid by the insurer. This fee is in lieu of, rather than in addition to, the Referee's $2,250 attorney fee award. In reaching this conclusion, we have considered the time devoted to the issues (as represented by the record and claimant's appellate briefs), the complexity of the issues, and the value of the interest involved. We further note that the primary focus of this dispute at both the hearings level and on Board review was the compensability of the cervical condition, a condition which we found was not compensable.

ORDER

The Referee's order dated March 19, 1991 is reversed in part, affirmed in part, and vacated in part. That portion of the order that set aside the January 25, 1990 Determination Order as being prematurely issued is reversed. In lieu of the January 25, 1990 Determination Order 34 percent (108.8 degrees) award and in addition to the 13 percent (41.6 degrees) unscheduled permanent disability awarded by the December 15, 1988 Determination Order, claimant is awarded 9 percent (28.8 degrees) unscheduled permanent disability, giving him a total award to date of 22 percent (70.4 degrees) unscheduled permanent disability for a low back injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. The insurer's partial denial of the cervical condition and the proposed surgery for that condition is reinstated and upheld. That portion of the order regarding the reasonableness and necessity of the proposed lumbar surgery is vacated, and claimant's hearing request regarding that issue is dismissed for lack of jurisdiction. In lieu of the Referee's award of $2,250 assessed attorney fees, claimant's attorney is awarded an assessed fee of $1,500 for services at hearing and on review, to be paid by the insurer. The remainder of the Referee's order is affirmed. Central Files is directed to assign a new WCB case number to the "aggravation/surgery" issue, for which further action will be deferred pending the Director's decision concerning the proposed surgery.

May 12, 1992 Cite as 44 Van Natta 947 (1992)

In the Matter of the Compensation of
OPAL L. SCARRIOFFINI, Claimant
WCB Case No. 88-07137
ORDER ON REMAND
Sherwood & Coon, Claimant Attorneys
Cummins, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Scarrioffini v. Marriott Corporation, 111 Or App 208 (1992). The court reversed our prior order, Opal L. Scarrioffini, 42 Van Natta 1937 (1990), that declined to grant claimant permanent total disability. In reaching that conclusion, we found that claimant had transferable skills. Nevertheless, in awarding claimant increased permanent partial disability, we concluded that she completely lacked transferable skills. Reasoning that our order was internally inconsistent regarding an important fact, the court has remanded for reconsideration.

After conducting our reconsideration, we find that claimant has transferable skills. In reaching this conclusion, we rely on the opinion offered by Mr. Skillings, a vocational counselor. Based on claimant's physical limitations and her work history, Skillings identified a variety of positions which were within claimant's physical and vocational capacity. (Exs. 24B & 28, Tr. 108-114). Under such circumstances, Skillings concluded that claimant was currently employable.

In light of our finding that claimant has transferable skills, as well as our prior conclusions that claimant had not made reasonable efforts to obtain

employment and had not established that it would be futile for her to make such efforts, we continue to hold that claimant is not entitled to permanent total disability benefits. Finally, notwithstanding our "transferable skills" finding, we adhere to our previous determination that, considering claimant's moderate permanent impairment, limited physical capacity, age, and limited education, she is entitled to an 80 percent unscheduled permanent disability award under the Director's guidelines (former OAR 436-30-380, et seq).

Accordingly, as supplemented and clarified herein, we adhere to and republish our September 5, 1990 order.

IT IS SO ORDERED.

May 12, 1992 Cite as 44 Van Natta 948 (1992)

In the Matter of the Compensation of
JOSEPH SWEET, Claimant
WCB Case No. 90-18447
ORDER ON REVIEW
Reynolds & Bendixsen, Claimant Attorneys
Carol Taaffe (Saif), Defense Attorney

Reviewed by Board Members Westerband and Moller.

Claimant requests review of Referee Menashe's order which: (1) upheld the SAIF Corporation's partial denial of claimant's right knee condition; and (2) awarded claimant 14 percent (18.9 degrees) scheduled permanent disability for loss of use or function of claimant's left foot, whereas a Determination Order had not awarded any permanent scheduled disability. On review, the issues are compensability and extent of scheduled permanent disability.

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

On review, claimant argues that his right knee condition was found compensable by prior order of the Board and, therefore, relitigation of its compensability is barred by the doctrine of res judicata. We disagree.

Res judicata is comprised of two doctrines, claim preclusion and issue preclusion. Issue preclusion bars future litigation between the same parties concerning an issue that was "actually litigated and determined" in a setting where "its determination was essential to" the final decision reached. North Clackamus School District v. White, 305 Or 48, 53, modified 305 Or 468 (1988). Claim preclusion, on the other hand, does not require actual litigation of an issue or that the determination of the issue be essential to the final decision reached. Rather, a claim is barred if it is based on the same factual transaction that was at issue in a prior action between the same parties. Drews v. EBI Companies, 310 Or 134, 140 (1990). Moreover, there must be a prior opportunity to litigate the claim, whether or not used, and there must be a final judgment. Id.

Here, claimant was involved in a compensable 1986 motor vehicle accident, wherein his left leg was crushed while his right leg received only multiple small bruises and abrasions. (Exs. 1-5 and 1A-4). In 1988, claimant requested a hearing regarding the noncomplying employer's "de facto" denial and the referee upheld the employer's denial. However, the referee made a finding of fact in his March 10, 1988 order that both of claimant's legs had been injured in the accident. (Ex. 3A). SAIF did not represent the employer at the 1988 hearing.

(Id.). The Board's November 2, 1989 Order on Review reversed the referee, finding claimant's "bilateral leg injury" compensable. (Ex. 3B).

While our de novo review of these orders indicates that claimant's injury was termed a "bilateral leg injury," there is no indication that there was any "actual litigation" of claimant's right knee condition at that time. We, therefore, find that issue preclusion is not applicable to this case.

We also find that claim preclusion does not apply. Although claimant alleges that his left leg condition and his right knee condition were both caused by the compensable 1986 motor vehicle accident, the parties had no prior opportunity to litigate the compensability of claimant's right knee condition because claimant did not even seek treatment for his right knee condition until November 5, 1990. (Ex. 13).

Claimant also contends that SAIF's stipulation during his June 4, 1991 hearing that both of claimant's legs were involved in the 1986 motor vehicle accident constituted a stipulation that his right knee condition is compensable. (See Tr. 8 and 21). We disagree. SAIF's stipulation constituted only agreement to the facts of the 1986 accident but not to the compensability of claimant's current right knee condition.

Consequently, we conclude that neither the 1989 order of the Board nor SAIF's stipulation during claimant's June 4, 1991 hearing precluded the current litigation concerning the compensability of claimant's right knee condition. See Drews v. EBI Companies, supra; North Clackamus School District v. White, supra. Accordingly, we affirm the Referee's decision.

ORDER

The Referee's order dated June 14, 1991, as corrected on June 24, 1991, is affirmed.

May 13, 1992 Cite as 44 Van Natta 949 (1992)

In the Matter of the Compensation of
TRUMAN B. GOODENOUGH, Claimant
WCB Case No. 90-11720
ORDER ON REVIEW
Max Rae, Claimant Attorney
Daryl Nelson, Defense Attorney

Reviewed by Board Members Neidig and Moller.

The insurer requests review of that portion of Referee Harri's order that awarded claimant permanent total disability. In its brief, the insurer also contends that claimant's out-of-state injury precludes an award of permanent total disability. On review, the issue is extent of scheduled and unscheduled permanent disability, up to and including permanent total disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Washington claim

The Referee concluded that, in regard to his Oregon claim, claimant became stationary in April 1990, several months prior to his injury in Washington. The Referee also found that the Washington injury had little effect on claimant's condition and the parties agreed that claimant's disability could be rated, as claimant had previously been found medically stationary as to his Oregon injury.

On review, the insurer contends that, because claimant filed an out-of-state claim upon which compensation was awarded, it is not responsible for claimant's condition. We disagree.

There is no evidence that the insurer raised the issue of responsibility at hearing. Accordingly, we conclude that the insurer may not contend, on review, that it is not responsible for claimant's condition. Mavis v. SAIF, 45 Or App 1059 (1980).

Permanent total disability

We adopt the Referee's Conclusions and Opinion on the issue of permanent total disability, with the following supplementation.

The insurer contends that the present case is distinguishable from the Kobayashi case cited by the Referee because, in Kobayashi, there was no malingering on the part of the claimant. Kobayashi v. Suislaw Care Center, 76 Or App 320 (1985). However, in a January 21, 1991 report, Dr. Davies stated that claimant was convinced that he is "disabled" and his belief that he "'is hurt beyond repair' is clearly 'real' to (claimant)." Dr. Davies found that claimant's perception was "not a conscious fabrication or a byproduct of malingering." Under the circumstances, we do not agree with the insurer that the Kobayashi case is distinguishable on such a basis.

The insurer also contends that claimant's somatoform disorder should not be considered in determining whether he is permanently totally disabled. We disagree. Dr. Davies stated that "the injury or the pain...set the disabling aspect of the somatoform disorder into action." As noted by the Referee, Dr. Davies has provided the only medical opinion on claimant's psychological condition. Accordingly, we agree with the Referee that the condition may be considered in determining entitlement to permanent total disability.

Claimant is entitled to an assessed attorney fee for successfully defending against the insurer's request for review on the issue of permanent total disability. 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 $1,600, to be paid by the insurer. In reaching this conclusion, we have particularly considered the complexity of the issue, the time devoted to the issue (as represented by claimant's respondent's brief) and the value of the interest involved.

ORDER

The Referee's order dated June 19, 1991 is affirmed. For services on review concerning the issue of permanent total disability, claimant's counsel is awarded an assessed attorney fee of $1,600, payable by the insurer.

In the Matter of the Compensation of
WAYNE B. PALMER, Claimant
WCB Case No. 91-01512
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Podnar's order that upheld the insurer's "de facto" denial of his medical services claim for a weight loss program. On review, the issue is medical services. We affirm in part and vacate in part.

FINDINGS OF FACT

We adopt the "FINDINGS" section of the Referee's order, except for the last paragraph.

CONCLUSIONS OF LAW AND OPINION

There are two separate issues concerning the weight loss program: (1) whether the program is palliative or curative treatment for the compensable condition; and (2) whether claimant's need for weight loss resulted from medication prescribed for treatment of the compensable condition.

The Referee found that the weight loss program was palliative treatment and not compensable under ORS 656.245(1)(b). On review, claimant argues that the program was curative, while the insurer argues that it was palliative.

We have held that a dispute regarding whether medical treatment is palliative or curative, or otherwise reasonable and necessary, is not a matter concerning a claim, over which the Hearings Division has original jurisdiction. Gladys M. Theodore, 44 Van Natta 905 (1992); Stanley Meyers, 43 Van Natta 2643 (1991). We held that ORS 656.327 (Director's medical review of the appropriateness of treatment) provides a procedure for resolving such a dispute and, therefore, concluded that original jurisdiction lies exclusively with the Director. Id. Accordingly, we vacate that portion of the Referee's order that addressed whether the weight loss program was palliative or curative treatment, and whether it was reasonable and necessary.

On the other hand, we have held that the Hearings Division has original jurisdiction of a dispute regarding whether the need for treatment is causally related to the compensable injury. Michael A. Jaquay, 44 Van Natta 173 (1992). Here, claimant argues that the medication Amitriptyline, which was prescribed for his back condition, caused his weight gain and, hence, his need for the weight loss program. We disagree.

Because claimant is alleging that his weight problems arose as a consequence of the compensable back condition, he has the burden of proving that the compensable condition was the major contributing cause of those problems. See ORS 656.005(7)(a)(A); Julie K. Gasperino, 43 Van Natta 1151, 1153 (1991). Because this is a complex medical issue; the resolution of this issue turns largely on the medical evidence. See Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

Claimant relies on Dr. Becker's January 2, 1990 chart note that "[t]he amitriptyline appears to have caused some degree of persisting weight gain." (Ex. 1G) (Emphasis added). Because Dr. Becker's note merely raises the possibility of a causal connection, it is not sufficient medical proof. Gormley v.

SAIF, 52 Or App 1055, 1060 (1981). Moreover, it is not consistent with the uncontroverted evidence that claimant continued to gain weight for months after he had stopped taking Amitriptyline. (Tr. 7; Ex. 6aa). We conclude that claimant has not sustained his burden of proving a causal connection between his weight gain and treatment for the compensable condition.

Parenthetically, we emphasize that our decision regarding the causation issue has no bearing on the issue of whether a weight loss program is reasonable and necessary treatment for the compensable condition. That issue would be for the Director under ORS 656.327(1).

ORDER

The Referee's order dated May 10, 1991 is affirmed in part and vacated in part. Insofar as the Referee's order upheld the insurer's denial of the reasonableness and necessity of the weight loss program, it is vacated. Claimant's hearing request on that denial is dismissed. The remainder of the Referee's order that upheld the insurer's denial of a causal connection between the weight loss and the compensable condition is affirmed.

In the Matter of the Compensation of
LOIS M. POTTKER, Claimant
Own Motion No. 91-0358M
OWN MOTION ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
EBI Companies, Insurance Carrier

Claimant requests reconsideration of the Board's April 13, 1992 Own Motion Order in which we declined to authorize reimbursement to the insurer for its voluntary reopening of her claim for temporary total disability compensation.

Claimant contends that the insurer did not provide us with full discovery, specifically a copy of a September 24, 1991 letter from his attorney to Dr. Hacker, claimant's treating neurosurgeon, and his September 30, 1991 narrative response. Claimant is correct and has now provided us with this evidence.

In that response, Dr. Hacker opines that claimant suffered an injury in 1983 to the disc capsule at L5-S1, which is related to the current herniation and radiculopathy for which Dr. Hacker performed an L5-S1 microdiskectomy. We find that claimant's current condition is a worsening of her 1983 injury.

We are persuaded that claimant's compensable injury has worsened requiring surgery. We, therefore, have the authority to award temporary disability compensation commencing on August 9, 1991, the date of claimant's surgery. See ORS 656.278(1)(a). Accordingly, reimbursement of these monies to the insurer is appropriate. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-12-055.

Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45.

IT IS SO ORDERED.

In the Matter of the Compensation of
CLARA A. FENNER, Claimant
WCB Case No. 90-12812
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of Referee Livesley's order which found that claimant's reflex symphathetic dystrophy claim was prematurely closed. In its brief, the insurer also challenges the Referee's post-hearing ruling granting claimant's motion to submit an additional exhibit. On review, the issues are evidence and premature closure.

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

Claimant's meniscectomy was performed on May 20, 1988.

The insurer objects to the Referee's admission of an exhibit that was offered by claimant after the hearing.

The Referee may "reopen the record and reconsider his or her decision before a request for review is filed" based on the discovery of new material. OAR 438-07-025(1). However, the motion to reconsider must state the "nature of the new evidence" and contain "an explanation why the evidence could not reasonably have been discovered and produced at the hearing." OAR 438-07-025(2). We review the Referee's ruling to reopen the record based on newly discovered evidence for abuse of discretion. See e.g. Mark G. Smith, 43 Van Natta 315 (1991).

The exhibit in dispute here was prepared by claimant's treating physician in response to a request by claimant's attorney. The request was prepared on October 12, 1990 with the hearing set for October 29, 1990. On October 23, 1990, claimant's counsel's office contacted the physician's office and was told that the report would be mailed that day. However, the report was not received until November 5, 1990.

The Referee found that the physician's failure to mail the report, along with claimant's counsel's efforts to procure the report before hearing, constituted sufficient explanation as to why the evidence could not reasonably have been discovered and produced at the hearing. Under such circumstances, we conclude that the Referee did not abuse his discretion in admitting the exhibit.

The insurer requested review, and the Board did not disallow or reduce the compensation awarded to claimant. Therefore, 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 a reasonable fee for claimant's counsel's services on review is $1,350, 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 June 27, 1991 is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of $1,350, to be paid by the insurer.

In the Matter of the Compensation of
CLIFFORD S. BRUSH, Claimant
WCB Case No. TP-92002
THIRD PARTY DISTRIBUTION ORDER
Burt, et al., Claimant Attorneys
Liberty Northwest Insurance Corporation, Insurance Carrier

Claimant has petitioned the Board to resolve a dispute concerning the distribution of proceeds from a third party judgment. ORS 656.593(1). Asserting that his $41,680.33 third party judgment was recovered for compensable injuries (wrist and knee) for which Liberty Northwest expended a minimal amount of its approximately $22,000 in claim costs, claimant contends that Liberty's share of the judgment should be limited to its costs attributable to the wrist and knee injuries ($1,680.33). We agree.

FINDINGS OF FACT

In June 1988, claimant sustained a compensable injury while performing his work activities. Specifically, while walking in a crosswalk, he was struck by U. S. Postal Service truck. Claimant suffered a right wrist fracture (which required surgery) and a left knee strain/sprain.

Liberty Northwest (Liberty), the workers' compensation insurer for claimant's employer, accepted the claim and has provided compensation. Its lien is approximately $22,000, which includes claim expenses for the wrist and knee injuries, as well as a low back condition (and resultant disc surgery) which arose subsequent to the accident.

Claimant engaged legal representation to pursue a cause of action for negligence against the postal service. He sought damages for injuries to his right wrist, left leg/knee, and back totalling $300,000.

Following a trial before a Federal District Court Judge, claimant was awarded $41,680.33. This December 1991 judgment was composed of $1,680.33 in economic damages (medical expenses) and $40,000 for non-economic damages. Both awards were for claimant's wrist and knee injuries. The judge expressly concluded that claimant had failed to establish that the "ruptured disc, and the resultant medical procedures and expenses, were caused by the accident." This judgment was not appealed.

After the judgment, Liberty contended that its entire $22,000 lien (including costs attributable to claimant's back and surgery) was reimbursable from the third party judgment. Claimant agreed that Liberty was entitled to recover its actual claim costs resulting from the wrist and knee injuries. However, since his judgment did not include damages for his back condition, claimant argued that Liberty was not entitled to receive reimbursement for its costs related to that condition.

Unable to resolve their dispute, claimant petitioned the Board for resolution. Despite several opportunities to present justification of its specific lien demands and to provide argument regarding its position, no response from Liberty has been received.

CONCLUSIONS OF LAW

Pursuant to ORS 656.578, 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 the third person. The proceeds of any damages recovered from a third person by the worker or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.693(1).

The statutory scheme for the allocation of damages is precise. Robert B. Williams, 38 Van Natta 119, 123 (1986), aff'd Estate of Troy Vance v. Williams, 84 Or App 616 (1987). ORS 656.593(1) provides in exact detail how, and in what order, the proceeds of any damages shall be distributed. Pursuant to ORS 656.593(1)(a) costs and attorney fees incurred shall be initially disbursed. Then, the worker 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). Any remaining balance shall be paid to the worker. ORS 656.593(1)(d).

Here, since claimant elected to seek recovery from a third party for damages resulting from his compensable injury, his cause of action became subject to Liberty's lien as a paying agency. ORS 656.580(2); 656.593(1); Kenneth Owens, 40 Van Natta 1049 (1988). This lien attaches to general damages, as well as to special damages. Kenneth Owens, supra, at pages 1050-51.

As previously discussed, following distribution of claimant's attorney fee, litigation costs, and claimant's 1/3 statutory share, Liberty is entitled to retain the balance of the third party recovery "to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794." ORS 656.593(1)(c). "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).

In addition to providing compensation for claimant's wrist and knee conditions, Liberty has paid benefits for his back condition. These benefits for claimant's back condition have apparently been provided without objection from claimant. Since these benefits were paid in conjunction with claimant's June 1988 compensable injury, they constitute "compensation." See Mark S. Randolph, 43 Van Natta 1770 (1991).

Nevertheless, claimant's third party recovery was expressly confined to damages related to his wrist and knee injuries. Under such circumstances, we conclude that Liberty's lien should be similarly limited to its claim costs attributable to those injuries. Such an approach will permit Liberty to retain the balance of the third party recovery "to the extent that it is compensated for its expenditures for compensation" resulting from the compensable injuries for which claimant has received damages from the third party. See ORS 656.593(1)(c).

Liberty has not contested claimant's contention that its lien for his wrist and knee injuries is $1,680.33. Consequently, we find that Liberty's third party lien equals $1,680.33. Claimant requests that this amount be reduced by "one-quarter allowed for attorney fees for recovery." He provides no support for such a request. Moreover, we have previously held that the third party statutes do not provide authorization for an attorney fee award other than that disbursed from the third party recovery. Theresa J. Lester, 43 Van Natta 338 (1991). Consequently, we decline to further reduce Liberty's lien as claimant requests.

Accordingly, we hold that Liberty Northwest is entitled to recover $1,680.33 from the third party judgment. Therefore, claimant's attorney is directed to distribute the proceeds in accordance with ORS 656.593(1). Specifically, following allocation for claimant's attorney fee and litigation costs, claimant shall receive 1/3 of the remaining balance. ORS 656.593(1)(a), (b). Thereafter, Liberty Northwest shall receive $1,680.33. ORS 656.593(1)(c). The remaining balance shall be paid to claimant. ORS 656.593(1)(d).

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT F. CURTIS, Claimant
WCB Case Nos. 90-19714 & 89-09574
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Davis' order which: (1) upheld the self-insured employer's September 27, 1990 denial of claimant's aggravation claim for low back injury; (2) found that Dr. Kendrick's October 18, 1990 report did not constitute an aggravation claim and consequently that the employer's failure to respond to it did not constitute a "de facto" denial; (3) declined to assess a penalty or related attorney fee for the employer's allegedly unreasonable failure to process the claim; and (4) declined to assess a penalty or related attorney fee for the employer's allegedly unreasonable failure to pay interim compensation. Additionally, claimant moves the Board to remand the case for receipt of further evidence. On review, the issues are remand, aggravation 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.

The record closed on April 16, 1991. Thereafter, it was reopened in order to receive Exhibits 63A and 63B, consisting of correspondence between the employer and claimant's counsel regarding the alleged aggravation claim filed by Dr. Kendrick. The record was reclosed on May 28, 1991 upon receipt of the two exhibits. On May 30, 1991, the Referee issued his order on the merits of claimant's claims, and thereafter, claimant timely requested Board review.

On February 17, 1992, claimant filed with the Board a motion to remand claimant's case to consider the following: (1) additional medical evidence (two additional reports from Dr. Kendrick, concerning claimant's subsequent back fusion surgery);(2) the Director's August 26, 1991 order finding that claimant's back fusion surgery is appropriate medical treatment; and (3) Referee Nichols' December 11, 1991 order affirming the Director's order.

CONCLUSIONS OF LAW AND OPINION

After the briefs were filed on Board review, claimant submitted a supplemental memorandum of authorities. The employer objects to this submission. Supplemental briefs are generally not allowed; however, parties may submit supplemental authorities advising of recent changes in the law that are relevant to

the decision. Betty L. Juneau, 38 Van Natta 553 (1986). Here, claimant cites to a recent Board decision relevant to the issues at hand. Accordingly, we allow claimant's submission, but consider it only to the extent that it advises us of a recent development in the law. See Debra A. West, 43 Van Natta 2299 (1991).

Remand

On review, claimant requests that we remand his case to the Referee to consider additional evidence. Claimant contends that remand is appropriate because this evidence is relevant, was not available at hearing and would likely affect the outcome of claimant's aggravation claim. We deny the motion for remand.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be 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. Olsen, 37 Van Natta 1054, 1055 (1986), aff'd mem, 80 Or App 152 (1986). We consider the additional evidence offered by claimant on review only for purposes of addressing claimant's remand motion.

The proffered evidence consists of the Director's August 26, 1991 order finding that claimant's back fusion surgery is appropriate, Referee Nichols' December 11, 1991 order affirming the Director's order and two additional medical reports from Dr. Kendrick concerning claimant's subsequent back fusion surgery. While we agree that these orders and reports were unavailable at hearing, we find that the record is not insufficiently developed without them.

First, the Director's order and Referee Nichols' order affirming the Director's order have no relevance to the legal issue litigated at hearing. The primary issue at hearing was whether claimant's aggravation claim was properly filed and whether it was compensable. The issue before the Director and Referee Nichols was whether claimant's requested fusion surgery was appropriate medical treatment. See ORS 656.327. The fact that the Director found the surgery appropriate for the worker's current condition does not establish that claimant's condition had worsened since his September 12, 1990 Determination Order.

Additionally, Dr. Kendrick's medical and surgical reports likewise have no relevance to the issue of whether claimant's condition had worsened. Those reports merely reiterate claimant's medical history and outline the procedure followed for his back fusion surgery. While they do establish that claimant had subsequent surgery, they do not relate the surgery or the need for surgery to a worsened condition. Consequently, the reports are not materially relevant to claimant's aggravation claim.

After considering claimant's proffered evidence for purposes of determining whether remand should be granted, we conclude that the current record concerning claimant's aggravation claim is not improperly, incompletely or otherwise insufficiently developed without this evidence. Accordingly, we deny claimant's remand motion. Mark A. Ostermiller, 42 Van Natta 2873 (1990).

September 27, 1990 Aggravation Denial

We adopt the Referee's reasoning and conclusions concerning the employer's September 27, 1990 denial of claimant's aggravation claim with the following supplementation.

Claimant argues on review that the Referee erred in finding that claimant's exacerbation was no more than waxing and waning of the symptoms contemplated by the 1990 Determination Order. He contends that, by definition, "a need for surgery is more than a waxing and waning of previous symptoms." We disagree.

Here, the record contains the medical opinions of Dr. Rosenbaum and Dr. Kendrick. Dr. Rosenbaum opined that that there was no medical evidence to show that claimant's condition had worsened. He also opined that claimant's current condition was consistent with "periodic exacerbations and remissions" and that claimant would not benefit from the proposed fusion surgery because of claimant's age, his historical symptomatology and his other degenerative changes. (Ex. 64-4). In response, Dr. Kendrick stated that he recommended the fusion surgery because the probability of the surgery alleviating claimant's mechanical low back pain was higher now with the newer "fixation methods." (Ex. 66). He said that, while he and Dr. Rosenbaum differed in their treatment approach, they did not differ in their assessment of claimant's problem. (Ex. 66). After our de novo review of the medical record, we conclude that claimant's need for surgery was not a result of a worsened condition but rather a change in treatment approach.

"De Facto" Denial

We adopt the Referee's reasoning and conclusions concerning the employer's de facto denial with the following comments.

In his supplemental brief, claimant cites Juan F. Carrizales, 43 Van Natta 2811 (1991), for the proposition that "a claimant perfects an aggravation claim when the insurer receives a medical report which describes claimant's compensable condition and concludes that he continues to have intermittent pain." (Supplemental brief, p. 3). Claimant misreads our holding in Carrizales. There, the issue was whether the claimant had perfected his right to make an aggravation claim within the statutory five-year aggravation claim period. Here, the issue is not whether claimant had made an aggravation claim before expiration of the five-year bar, because claimant clearly filed a timely aggravation claim.

As the Referee found, Dr. Dowling's September 21, 1990 note which authorized time loss due to the alleged worsening of claimant's condition constituted the aggravation claim. On the other hand, Dr. Kendrick's subsequent correspondence in which he proposed fusion surgery for the alleged worsening noted by Dr. Dowling provided further support for the claim Dowling made, but did not constitute a new separate claim which the employer had an obligation to accept or deny. Furthermore, certain language the Board used in Carrizales has been read out of context. Without reciting all the medical reports, we simply noted in Carrizales our agreement with the Referee's finding that those reports not only constituted a timely aggravation claim, they established a compensable worsening on the merits. Here, we agree with the Referee that Dr. Kendrick's October 18, 1990 report in which he suggested fusion surgery as additional treatment, did not establish that claimant's condition had worsened since the last arrangement of compensation.

Claimant also argues on review that, even if Kendrick's letter does not constitute or establish a new aggravation claim, his attorney's November 27, 1990 letter to the employer constituted a new claim which the employer had a duty to accept or deny, and based upon which, interim compensation had to be paid pending acceptance or denial. We disagree.

It is true that a physician's report is not the only mechanism for making an aggravation claim. A claimant may make a claim for aggravation under ORS

656.273(2) or, alternatively, a physician may submit a report which is a claim for an aggravation under ORS 656.273(3). Stevens v. Champion International, 44 Or App 587 (1980); Richard J. Stevenson, 43 Van Natta 1883 (1991); Herman M. Carlson, 43 Van Natta 963, 964 n. 1 (1991). However, although a letter from claimant or his attorney may constitute a claim, thereby serving to preserve claimant's right to seek additional compensation for an aggravation, it would not entitle claimant to interim compensation or any other benefits. To obtain interim compensation, claimant must submit a physician's report which is sufficient to constitute prima facie evidence in the form of objective findings that claimant's compensable condition has worsened, as a result of which, claimant is unable to work. Jimmie L. Martin, 44 Van Natta 520 (1992). In any event, we have held that claimant had already made his aggravation claim for the alleged worsening through Dr. Dowling's September 21, 1990 report. That claim was properly denied. The employer had no duty to issue another denial in response to the letter from claimant's attorney. Accordingly, we affirm the Referee's decision.

Penalties and Related Attorney Fees

We adopt the Referee's reasoning and conclusions concerning penalties and related attorney fees for the employer's allegedly unreasonable failure to process claimant's claim and for the employer's allegedly unreasonable failure to pay interim compensation.

ORDER

The Referee's order dated May 30, 1991 is affirmed.

May 15, 1992 Cite as 44 Van Natta 959 (1992)

In the Matter of the Compensation of
MARY M. HALEY, Claimant
WCB Case No. 90-11347
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Westerband, Moller, and Gunn.

Claimant requests review of Referee Podnar's order that upheld the self-insured employer's partial denials of claimant's torn anterior cruciate ligament, torn medial meniscus, and the resulting arthroscopy for those conditions. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Because claimant requested a hearing after May 1, 1990 and 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).

The Referee upheld the employer's partial denials of claimant's torn anterior cruciate ligament, torn medial meniscus, and the resulting arthroscopy for those conditions. We agree.

In Julie K. Gasperino, 43 Van Natta 1151 (1991), we held that ORS 656.005(7)(a)(A) does not affect the standard of compensability for conditions intrinsically related to the underlying industrial injury as opposed to secondary consequences of a compensable injury. Here, there is no allegation by claimant or indication in the medical record that the knee injury of February 17, 1990 caused her to fall while skiing on March 8, 1990. Furthermore, the medical record establishes that claimant does not have a torn medial meniscus. Thus, the question presented here is whether the February 17, 1990 work injury was a material contributing cause of claimant's cruciate ligament tear and subsequent need for surgery.

On February 17, 1990, claimant injured her left knee while apprehending a shoplifting suspect in the course of her work activities. She immediately sought medical treatment and was released from work for three days. This injury was diagnosed and accepted as a left knee sprain. While walking on March 7, 1990, claimant's left knee "gave out" without causing her to fall. On March 8, 1990, less than three weeks after the work injury, claimant went downhill skiing for five hours and fell three times. During the last fall, she felt extreme pain and a "popping" sensation in her left knee. She was examined in the Emergency Room that same day and eventually diagnosed with a cruciate ligament tear in her left knee.

Thus, claimant sustained possible injuries to her left knee both during the February 17, 1990 work injury and the March 8, 1990 noncompensable skiing accident. Therefore, the issue of whether her cruciate ligament tear and the subsequent surgery is compensably related to her industrial injury is a complex medical question. Thus, although claimant's testimony is probative, the resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

The record contains two medical opinions regarding causation. Dr. Battalia, internist, examined claimant on February 17, 1990, the day of the work injury. (Exs. 2, 23). Based on his findings during that examination and the findings three days later during a follow-up examination, he concluded that claimant did not sustain a cruciate ligament tear or any significant internal derangement of her left knee as a result of the work injury. (Exs. 21A, 23-7, -8, -16, -17). He noted that key factors to any internal derangement of the knee are "the presence of effusion, jointline tenderness, or laxity of the knee." (Ex. 23-7). None of these factors were present during either the initial examination after the work injury or the follow-up examination. (Exs. 23-7, -8). Dr. Battalia noted that additional symptoms were present during the Emergency Room examination following the skiing accident which were not present in the examinations following the work injury. (Ex. 23-8). These included medial jointline pain, an indication of an internal derangement of the knee.

Dr. Graham, orthopedic surgeon, first examined claimant on March 12, 1990, after the skiing accident. (Ex. 9). He continued to treat claimant and eventually performed an arthroscopy, although he made no repair. Based in part on his understanding that claimant experienced swelling and required a knee immobilizer as a result of the work injury, he initially opined that the cruciate ligament tear occurred at the time of the work injury. (Ex. 20). However, this is an inaccurate history. Claimant neither had swelling following the work injury, nor did she require a knee immobilizer until after the skiing accident. (Exs. 2, 23-13).

After Dr. Graham obtained an accurate history, he opined that it was equally possible that the cruciate ligament tear occurred during the original injury on February 17, 1990 or during the skiing accident on March 8, 1990.

(Ex. 24-2). Even after further inquiry from claimant's attorney, Dr. Graham maintained his position that either incident was equally possible to be the cause of the cruciate ligament tear. (Exs. 26-1, 26-3). Claimant cannot carry her burden of proof by establishing only a possibility of a causal relationship with work activities. Gormley v. SAIF, 52 Van Natta 1055 (1981).

Therefore, we conclude that claimant has not carried her burden of proving that the compensable work injury was a material contributing cause of her cruciate ligament tear and the subsequent surgery. In the alternative, claimant argues that, even if the surgery is found not compensable in its own right, it is compensable as a diagnostic test. We disagree.

ORS 656.245 extends to payment for diagnostic procedures performed as a result of an industrial injury even when the procedures ultimately reveal that claimant's condition is not compensable. Brooks v. D & R Timber, 55 Or App 688 (1982); Myrtle L. Thomas, 35 Van Natta 1093 (1983). An insurer must pay for diagnostic testing which is reasonable and necessary to determine a causal relationship, if any, between a compensable condition and a disease process. Katherine J. Hunter, 43 Van Natta 1488 (1991); Kenneth M. Simons, 41 Van Natta 378, recon 41 Van Natta 646 (1989); Clifford D. Howerton, 38 Van Natta 1425 (1986).

On March 13, 1990, an MRI revealed a probable torn anterior cruciate ligament and a possible torn medial meniscus. (Ex. 15-1). Dr. Graham stated that claimant would have an "arthroscopic exam on April 13 and [a] partial meniscectomy if the MRI findings are confirmed." (Ex. 14). During the arthroscopic exam, Dr. Graham confirmed that the anterior cruciate ligament was torn and determined that the medial meniscus was not torn. Based upon the results of the examination, no repairs were made during the arthroscopy.

On this record, there is no indication that the arthroscopy was performed to determine if a causal relationship existed between the compensable injury and the disease process. Instead, Dr. Graham's statement indicates that the arthroscopy was performed for treatment purposes. Therefore, the arthroscopy is not a compensable medical service.

ORDER

The Referee's order dated June 4, 1991 is affirmed.

Board Member Gunn dissenting.

The majority disregards the persuasive opinion of the treating surgeon, Dr. Graham. His opinion is sufficient to meet claimant's burden to prove that the work incident was a material contributing cause of the left knee condition. It is Dr. Graham's opinion that:

> "Because of the February 17 injury which did lead the patient to seek medical care and because of the findings at arthroscopic examination on 4-13-90, my opinion is that the injury to her anterior cruciate occurred 2-17-90 and may or may not have been compounded by subsequent injury occurring 3-8-90." (Ex. 26-1). (Emphasis added).

Dr. Graham bases his opinion on his examination of claimant and on his arthroscopic findings. We normally give greater weight to the opinion of claimant's treating doctor absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, there are no persuasive reasons not to defer to the treating surgeon. The majority ignores Graham's opinion because he

cannot give us absolute certainty or magic words. However, all that is required is an opinion which indicates that the work injury is a material contributing cause of claimant's injuries. Because I would defer to the treating surgeon's opinion regarding causation, I dissent.

In the Matter of the Compensation of
MICHAEL C. HOLT, Claimant
WCB Case No. 90-19425
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Westerband and Moller.

Claimant requests review of Referee Davis' order which upheld the self-insured employer's denial of claimant's back condition. On review, claimant argues that the denial was premature or, in the alternative, that he withdrew the claim at hearing.

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

The Board's decision in Dorothy Jackson-Duncan, 42 Van Natta 1122 (1990), essentially states that if no "claim" for compensation has been made by the claimant as that term is defined by ORS 656.005(6), the issuance of a denial would be premature, and thus, the Board will set aside any denial issued on that ground, upon an affirmation by the claimant at the outset of the hearing that in fact, he or she had not made a claim. Here, however, claimant's treating physician obviously made a "claim" under ORS 656.005(6), which the employer had a legal duty to accept or deny, and claimant requested a hearing on the denial. The Referee, therefore, correctly declined to set aside the employer's denial based on an assertion by claimant's attorney at hearing that the claim was not a claim, or that the claim, if legally constituted, was being withdrawn.

ORDER

The Referee's order dated April 17, 1991 is affirmed.

In the Matter of the Compensation of
LYLE J. JOHNSON, Claimant
WCB Case No. 91-17457
ORDER OF DISMISSAL
Bonnie Laux (Saif), Defense Attorney

Claimant, pro se, has requested Board review of Referee Myers' March 2, 1992 order. We have reviewed the request to determine whether we have authority to consider the matter. Because we conclude that the request is untimely, we dismiss.

FINDINGS OF FACT

On March 2, 1992, the Referee issued his Opinion and Order. On April 17, 1992, the Board received claimant's May 15, 1992 letter in which he requested a hearing. Specifically, claimant expressed dissatisfaction with his permanent disability award, which was the issue at hearing before the Referee.

Claimant's letter, which was not mailed by registered or certified mail, included the phrase "2nd copy." No other copy of this letter is in the record.

On May 13, 1992, the Board mailed its computer-generated letter to all parties acknowledging claimant's request for review.

CONCLUSIONS OF LAW AND OPINION

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

Assuming that claimant's letter constitutes a request for Board review of the Referee's order, we conclude that it was untimely filed. We base our conclusion on the following reasoning.

The 30th day after the Referee's March 2, 1992 order was April 1, 1992. Claimant's request for review, which was dated March 15, 1992, was neither mailed by registered nor certified mail. Since claimant's request was received by the Board on April 17, 1992, more than 30 days after the Referee's March 2, 1992 order, it is presumed to be untimely until claimant establishes that the mailing was timely. OAR 438-05-046(1)(b). In the past, such proof has taken the form of an affidavit attesting to the fact that a request was mailed to the Board on a certain date. Greg Carpenter, 40 Van Natta 100, 349 (1988). Furthermore, an uncontested statement from a party that a request was mailed to the Board on a particular date would likewise be sufficient.

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

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES E. LOTT, Claimant
WCB Case No. 91-16008
ORDER DENYING MOTION TO DISMISS
Coons, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney

Claimant has moved the Board for an order dismissing the insurer's request for Board review on the ground that a copy of the request was not served on all parties. We deny the motion.

FINDINGS OF FACT

The Referee's order issued March 23, 1992. On March 31, 1992, the insurer mailed a request for Board review. The request did not include an acknowledgment of service or a certificate of personal service by mail upon claimant. See OAR 438-05-046(2)(b); 438-11--005(3). However, the request did include such a certificate indicating that a copy of the request had been mailed to claimant's attorney.

On April 3, 1992, the Board mailed a computer-generated letter to all parties acknowledging the request.

CONCLUSIONS OF LAW

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

"Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(20). Attorneys are not included within the statutory definition of "party." Robert Casperson, 38 Van Natta 420, 421 (1986). Yet, in the absence of a showing of prejudice to a party, timely service of a request for Board review on the attorney for a party is adequate compliance with ORS 656.295(2) to vest jurisdiction in the Board. Argonaut Insurance v. King, supra, page 850-51; Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976); Robert C. Jaques, 39 Van Natta 299 (1987).

Here, the insurer's certificate of personal service by mail upon claimant's attorney is uncontested. Furthermore, no contention has been made that claimant has been prejudiced by not directly receiving a copy of the insurer's request for review. In the absence of such a finding, we hold that the insurer's timely service by mail upon claimant's attorney is adequate compliance with ORS 656.295(2). Denise M. Bowman, 40 Van Natta 363 (1988).

In any event, since the Board's April 3, 1992 acknowledgment letter was mailed to all parties 11 days after the Referee's March 23, 1992 order, we conclude that it is more probable than not that all parties to the hearing received actual notice the insurer's request for review within the statutory 30-day period. See Denise M. Bowman, supra. Under such circumstances, the Board has jurisdiction to consider the insurer's request for review. Argonaut Insurance Co. v. King, supra; Denise M. Bowman, supra.

Accordingly, claimant'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.

May 15, 1992 Cite as 44 Van Natta 965 (1992)

In the Matter of the Compensation of
NANCY A. MITTLEMAN, Claimant
WCB Case No. 91-04884
ORDER ON REVIEW
Guy B. Greco, Claimant Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Nichols' order which upheld the insurer's denial of her medical services claim for diagnostic services. On review, the issue is medical services. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Medical Services - Jurisdiction

This medical services dispute concerns whether or not claimant's diagnostic procedures are causally related to her compensable injury. The insurer denied the diagnostic procedure at issue on the ground that the need for the procedure was not related to the compensable injury. In this regard, ORS 656.245(1) requires that an insurer or self-insured employer provide medical services "for conditions resulting from the [compensable] injury." (Emphasis supplied.) Thus, this dispute concerns the question whether, pursuant to ORS 656.245(1), the need for the proposed diagnostic service is causally related to the compensable injury.

We have held that inasmuch as there is no other procedure provided by ORS Chapter 656 for resolving disputes concerning the causal relationship issue, such disputes are "matters concerning a claim" over which we have original jurisdiction. Michael A. Jaquay, 44 Van Natta 173 (1992). Consequently, we conclude we have jurisdiction over this matter.

Medical Services - The Merits

Claimant underwent diagnostic tests to determine whether her back pain resulted from a suspected noncompensable ovarian cyst rather than from her compensable injury. That question had to be answered in order for the doctor to know what would constitute the appropriate treatment for claimant. It was ultimately found that the back pain resulted from claimant's compensable back injury. Reasoning that the treating physician referred claimant for the tests because he suspected a new condition unrelated to the compensable back condition, the Referee concluded that the diagnostic services were not compensable. We disagree.

An injured worker is entitled to medical services "for such period as the nature of the injury or the process of recovery requires, including such medical services as may be required after a determination of permanent disability." ORS 656.245(1)(a). A diagnostic service is compensable if the need for the service is related to the compensable injury. Brooks v. D & R Timber, 55 Or App 688, 692 (1982); Priscilla J. Bosley, 43 Van Natta 380 (1991). ORS 656.245 extends to payment for diagnostic procedures even when the procedures ultimately reveal that claimant's condition is not compensable. Brooks v. D & R Timber, supra; Kenneth M. Simons, 41 Van Natta 378 (1989).

Were it not for the symptoms related to the compensable back condition, the tentative diagnosis of an ovarian cyst would not have been made and the diagnostic procedures would not have been required. Under these circumstances, we hold that the diagnostic procedures were directly related to the compensable condition and are compensable medical services as contemplated by ORS 656.245(1).

Claimant is entitled to an assessed attorney fee for prevailing on the medical services issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the medical services issue is $2,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by appellant's brief and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 12, 1991 is reversed. The insurer's denial is set aside to the extent it denies the diagnostic services and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's counsel is awarded $2,000 to be paid by the insurer.

In the Matter of the Compensation of
CHESTER S. OSTROWSKI, Claimant
WCB Case No. 90-18875
ORDER ON RECONSIDERATION (REMANDING)
Foss, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

On April 27, 1992, we vacated Referee Livesley's order that had upheld the self-insured employer's denial of claimant's aggravation claim for a back condition and awarded claimant 10 percent (32 degrees) unscheduled permanent disability for a back injury. In addition, we remanded this case to the Referee with instructions to consider two medical reports (Exhibits 36 & 37) which the Referee had previously refused to admit into evidence. Finally, we directed the Referee to allow the employer an opportunity to cross-examine or rebut the aforementioned evidence.

Claimant has submitted a "Statement of Services" concerning his counsel's efforts at hearing and on review. We treat such a submission as a motion for reconsideration.

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 for the claimant's attorney. ORS 656.386(1). 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. Id. In cases in which a claimant finally prevails after remand from the Supreme Court, Court of Appeals or board, then the referee, board or appellate court shall approve or allow a reasonable attorney fee for services before every prior forum. ORS 656.388(1).

Here, as a result of our April 27, 1992 order, claimant has not "finally prevailed" from an order or decision denying his claim for compensation. See ORS 656.386(1). Instead, we have vacated the Referee's order and remanded the case to the Referee for further proceedings in light of additional evidence. Consequently, claimant is not presently entitled to an attorney fee award. Nevertheless, should he finally prevail after the Referee conducts the remand proceedings, the Referee shall award a reasonable attorney fee for services rendered at the initial hearing, on Board review, and after remand. ORS 656.388(1); Iris J. Werth, 42 Van Natta 1243 (1990).

Accordingly, our April 27, 1992 order is withdrawn. On reconsideration, as supplemented herein, we republish our April 27, 1992 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

May 15, 1992 Cite as 44 Van Natta 967 (1992)

In the Matter of the Compensation of
DARRELL W. VINSON, Claimant
WCB Case Nos. 91-05363, 91-08114, 91-08115 & 91-04982
ORDER ON REVIEW (REMANDING)
Vick & Gutzler, Claimant Attorneys
Mitchell, et al., Defense Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Arbitrator Nichols' decision which: (1) set aside Crawford and Company's (Crawford) denial of claimant's aggravation claim for a low back condition; (2) upheld the SAIF Corporation's "new injury" claim for the same condition; and (3) declined to assess an attorney fee for claimant's counsel's services. Crawford cross-requests contending that the Arbitrator applied the wrong standard in determining whether claimant sustained a "new injury." On review, the issues are responsibility and attorney fees. We review for questions of law, ORS 656.307(2), and remand.

The Arbitrator found that claimant's accepted 1986 injury with Crawford's insured constituted a preexisting condition under ORS 656.005(7)(a)(B) and concluded that Crawford failed to prove that the 1991 incident while working for SAIF's insured was the major contributing cause of claimant's current disability and need for medical treatment. Consequently, the Arbitrator determined that Crawford remained the responsible carrier. We disagree.

Subsequent to the Arbitrator's decision, we held that ORS 656.005(7(a)(B) is not applicable in the responsibility context. Rosalie s. Drews, 44 Van Natta 36 (1992). We reasoned that ORS 656.005(7)(a)(B) does not determine compensability of the initial injury, but rather limits a carrier's liability for continuing disability or need for medical services. Rosalie S. Drews, supra;

Bahman M. Nazari, 43 Van Natta 2368 (1991). Only after initial compensability has been favorably decided do we inquire, pursuant to ORS 656.005(7)(a)(B), whether the compensable injury has combined with a preexisting disease or condition. Rosalie S. Drews, supra. Thus, compensability for further disability or need for treatment is a separate issue, the resolution of which is not relevant to the assignment of responsibility. Ronald L. Rushton, 44 Van Natta 124 (1992).

Consequently, we have interpreted Section 49 of the amended law (codified in ORS 656.308) to mean that, in cases such as this one, where 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. Ricardo Vasquez, 43 Van Natta 1678 (1991). Thus, here, Crawford, as the last carrier against which claimant had an accepted low back injury, remains presumptively responsible. In order to avoid responsibility, Crawford has the burden of proving that the work incident with SAIF's insured was a material contributing cause of claimant's current disability and need for medical treatment.

Therefore, because the Arbitrator required Crawford to prove that the work incident with SAIF's insured was the major contributing cause of claimant's current condition, the Arbitrator's order is inconsistent with the applicable law. Accordingly, because our review is limited to questions of law, we remand this matter to the Arbitrator for proper application of law. ORS 656.307(2). In doing so, we note that, inasmuch as we are remanding the Arbitrator's order, we do not reach the attorney fee issue.

ORDER

The Arbitrator's order dated August 5, 1991 is vacated. This matter is remanded to Arbitrator Nichols for a determination of the responsible carrier. Arbitrator Nichols may make that determination with or without further proceedings in any manner that will achieve substantial justice.

May 15, 1992 Cite as 44 Van Natta 968 (1992)

In the Matter of the Compensation of
SYNDEE S. WEST, Claimant
WCB Case No. 91-04971
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Brown's order that: (1) upheld the self-insured employer's "de facto" denial of her proposed carpal tunnel surgery; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial of medical services. In its brief, the employer requests review of that portion of the Referee's order that awarded claimant an attorney fee for prevailing over the employer's "de facto" denial of mileage expenses. In her brief, claimant contends that the employer has failed to formally cross-request review on the attorney fee issue. On review, the issues are jurisdiction, medical services and attorney fees. We vacate in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Applicable law

In the present case, claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation saving 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. sec. 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.

Jurisdiction

The Referee concluded that claimant's proposed carpal tunnel surgery was not reasonable or necessary. We find that the Referee lacked jurisdiction over the issue of the employer's "de facto" denial of the proposed surgery.

Subsequent to the Referee's order, we concluded that, under amended ORS 656.704(3), "matters concerning a claim" do not include any dispute regarding medical treatment or fees for which a resolution procedure is otherwise provided in ORS Chapter 656. Stanley Meyers, 43 Van Natta 2643 (1991). ORS 656.327 provides a procedure for the resolution of disputes between an insurer and an injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services."

Moreover, we recently held that disputes regarding proposed medical services, as well as those regarding current medical services, are within the Director's original jurisdiction pursuant to ORS 656.327. Kevin S. Keller, 44 Van Natta 225 (1992). Thus, the fact that the dispute here involved a proposed future surgery, rather than a current treatment, does not vest jurisdiction in the Hearing's Division. Accordingly, inasmuch as the employer's "de facto" denial concerning the proposed surgery did not raise a matter concerning a claim within the jurisdiction of the Hearings Division, we vacate the Referee's order and dismiss claimant's hearing request as to that issue. See also James E. Niccum, 44 Van Natta 373 (1992).

Attorney fee/mileage expenses

Claimant contends that the employer failed to formally cross-request review of the issue of an attorney fee for services rendered in conjunction with the compensability of the mileage expense. However, we have previously held that, as part of our de novo review, we have the authority to consider issues that are raised other than by a formal cross-request for review. See Lyndia M. Bristol, 44 Van Natta 164 (1992). Accordingly, on review, we proceed to consider the employer's cross-request for review on the attorney fee issue.

On review, the employer contends that there is no evidence of a "de facto" denial. We disagree. In opening remarks at hearing, the parties stipulated that claimant was due a stated amount for late or nonpayment of mileage and expenses resulting from the compensable injury. The employer agreed to pay the amount plus a penalty of 25 percent with 50 percent of the penalty to claimant's

attorney. Claimant also raised the issue of an attorney fee pursuant to ORS 656.386 for a "de facto" denial. (Tr. 2). The employer's attorney did not object to claimant's characterization of the issue or the denial.

We agree with the Referee that claimant is entitled to a separate attorney fee pursuant to ORS 656.386 for overcoming the employer's "de facto" denial. Accordingly, we affirm the Referee on this issue.

We note that claimant did not prevail on the surgery issue on review. Moreover, claimant is not entitled to an attorney fee for services on review concerning the attorney fee issue. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated July 30, 1991 is vacated in part and affirmed in part. That portion of the Referee's order that purported to uphold the self-insured employer's "de facto" denial of claimant's carpal tunnel surgery is vacated. Claimant's hearing request on that denial is dismissed for lack of jurisdiction. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
PHYLLIS J. WHEELER, Claimant
WCB Case No. 91-03369
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

The SAIF Corporation requests review of Referee Leahy's order that: (1) refused to admit Exhibits 60 and 61; and (2) set aside its partial denial of claimant's medical services claim for headaches. On review, the issues are admissibility of evidence and compensability of medical services. We admit the proferred exhibits and affirm on the merits.

FINDINGS OF FACT

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

Exhibit 60 was received by SAIF on June 14, 1991; Exhibit 61 was received by SAIF on June 17, 1991. Claimant received copies of the exhibits on June 17, 1991.

The hearing was held on June 18, 1991, and the Opinion and Order issued July 18, 1991. On July 26, 1991, claimant withdrew her objection to the exhibits.

CONCLUSIONS OF LAW AND OPINION

Admission of Evidence

At hearing, claimant objected to the admission of SAIF's Exhibits 60 and 61, contending that she had received copies only the day prior to the hearing. The Referee did not admit these exhibits. On review, SAIF contends that the

Referee erred in refusing to admit Exhibits 60 and 61 as they were submitted to claimant within seven days of their receipt by SAIF.

OAR 438-07-015(4) provides that documents acquired after the initial exchanges of discovery materials shall be provided to the other parties within seven days after the disclosing party receives the documents. Documents submitted within the seven-day limit may not be excluded. Oliver F. Coon, 42 Van Natta 1845 (1990). Here, Exhibit 60 was received by SAIF on June 14, 1991, and Exhibit 61 was received by SAIF on June 17, 1991. Claimant received copies of the exhibits on June 17, 1991. Because the evidence was disclosed within seven days of receipt, pursuant to the requirement of the rule, we conclude that the Referee did not have discretion to exclude the evidence.

Moreover, after the hearing, claimant withdrew her objection to the admission of these exhibits. On review, claimant does not challenge the admissibility of these documents. Under such circumstances, Exhibits 60 and 61 are admitted into evidence and we proceed with our de novo review.

Compensability of Medical Services

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

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. 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 attorney's services on review concerning the compensability issue is $800, to be paid by the SAIF Corporation. 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 July 18, 1991 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $800, to be paid by the SAIF Corporation.

In the Matter of the Compensation
DENNIS L. BEAMER, Claimant
WCB Case Nos. 90-02809, 90-02808 & 90-01832
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Kevin L. Mannix, P.C., Defense Attorneys
Phillip Nyburg, Defense Attorney

Reviewed by Board Members Gunn and Tenenbaum.

Liberty Northwest Insurance Corporation requests review of Arbitrator/Referee Livesley's order that: (1) set aside its denial, issued on behalf of Conifer Douglas, of claimant's aggravation claim for a low back condition; (2) upheld Liberty Northwest's denial, issued on behalf of A & G Logging, of claimant's "new injury" claim for the same condition; and (3) concluded that a Determination Order had prematurely closed claimant's claim. On review, the issues are responsibility, premature closure and, alternatively, extent of permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Arbitrator/Referee's findings of fact. For purposes of our review, we add the following summation of the procedural posture of this case.

Claimant initially sustained a head and back injury in 1985, while working for Conifer Douglas. Liberty Northwest accepted the claim. In 1989, claimant experienced a sudden onset of back pain while working for A & G Logging. After claimant filed another claim, Liberty Northwest issued responsibility denials on behalf of both employers. The Department issued a ".307" order designating a paying agent, and claimant's claim was processed to closure by an August 6, 1990 Determination Order, which awarded 2 percent unscheduled permanent disability.

Upon issuance of the ".307" order, the responsibility issue was referred to an arbitrator to conduct an arbitration proceeding under ORS 656.307(2). That proceeding, however, was later consolidated with claimant's request for hearing regarding the August 6, 1990 Determination Order, in which claimant alleged premature closure. Following a hearing, the Arbitrator/Referee issued a single order disposing of all issues before him.

CONCLUSIONS OF LAW AND OPINION

Responsibility

Because the responsibility portion of the Arbitrator/Referee's order was issued pursuant to a ".307" order, it is properly considered a determination of an arbitrator for purposes of our review. Michael A. Brewer, 43 Van Natta 1074 (1990). Generally, we review such determinations solely for errors of law. ORS 656.307(2). Conifer Douglas, however, argues that our scope of review of the responsibility issue in this case is de novo, because it resolves a matter regarding a claim. We disagree.

ORS 656.307(2) provides, in pertinent part:

> "Review of the determination of the arbitrator by the board and the Court of Appeals is limited to questions of law and is not thereafter subject to review by any other court or administrative body. However, if the claimant can establish, on the arbitration record, that the determination resolves a matter concerning a claim as defined in ORS 656.704(3), review of the determination of the

> arbitrator by the board and the Court of Appeals shall be as provided for matters concerning a claim." (Emphasis supplied.)

That provision allows for de novo review where the claimant contends that the arbitrator erred and a different assignment of responsibility will resolve a matter concerning a claim. John L. Riggs III, 42 Van Natta 2816 (1990). Here, claimant has neither requested nor cross-requested review of the Arbitrator's decision. In fact, he seeks its affirmance. Accordingly, we review the Arbitrator's determination for questions of law only. See also Richard H. Long, 43 Van Natta 1309 (1991), aff'd mem Long v. Continental Can Co., 112 Or App 329 (1992).

We have reviewed the Arbitrator's order for questions of law. After conducting our review, we find that it was not an error of law for the Arbitrator to conclude that Conifer Douglas remains responsible for claimant's back condition. Accordingly, that portion of his order regarding responsibility is affirmed.

Premature Closure

The Referee found that, although claimant's back condition had become medically stationary, there was no evidence that his neurological residuals from the 1985 injury had reached the point where no further medical improvement would reasonably be expected from additional treatment. Therefore, the Referee concluded that the August 9, 1990 Determination Order had prematurely closed claimant's low back claim. We disagree.

In reaching his decision, the Referee relied upon Rogers v. Tri-Met, 75 Or App 470 (1985). In that case, the claimant sustained an elbow injury that ultimately produced mental difficulties, including memory lapses and blackouts. The claim was subsequently closed, even though the claimant was undergoing psychological treatment and there was no report from his psychiatrist concerning his mental status. The court held that, although closure was correct so far as the claimant's physical condition was concerned, the Department's failure to consider claimant's injury-produced psychological problems was in error. Without such inquiry, the court reasoned that there was no medical evidence that would support a finding that the claimant's mental condition was medically stationary at the time of closure. 75 Or App at 473.

Like the claimant in Rogers, claimant here also suffers from injury-produced psychological problems. Those problems, however, are related to the cerebral concussion he sustained with the initial low back injury in 1985, while working for Conifer Douglas. That claim was closed by a March 27, 1987 Determination Order, which has now become final by operation of law. The August 6, 1990 Determination Order at issue here was based solely on the employers' concession that claimant had sustained a compensable low back strain in December 1989, while working for A & G Logging. Claimant does not assert, nor does the medical evidence establish, that the 1989 low back injury worsened his mental condition. Therefore, unlike Rogers, the status of claimant's psychological condition is irrelevant to the determination of whether his low back aggravation/new injury claim had been prematurely closed. Because the medical record establishes that claimant's low back condition was medically stationary, we conclude the claim was properly closed by the August 6, 1990 Determination Order.

Extent of Permanent Disability

The Referee did not reach the issue of extent of permanent disability as he set aside the Determination Order on the basis that it was premature.

Because we have reinstated the Determination Order and find the record to be sufficiently developed, we now address the extent issue on review.

To prove entitlement to additional permanent disability based on an aggravation under ORS 656.273(1), a claimant must show a permanent worsening of the condition resulting from the original compensable condition resulting from the original compensable injury. Because this case involves an unscheduled body part, such a worsening must result in a further reduction in the claimant's earning capacity. Stepp v. SAIF, 304 Or 375 (1987).

After our review of the record, we conclude that claimant has failed to carry his burden of proof. The Orthopaedic Consultants, who examined claimant in February 1990, reported that claimant had a "[l]umbar contusion strain by history with temporary worsening on 12/29/89 which has recovered back to its previous state and remains neurologically intact." (Ex. 60-4). On July 6, 1990, the Western Medical Consultants reported that claimant "is medically stationary, is recovered fully from the injury of December 1989, and has no permanent partial disability as a result of that injury." (Ex. 66-3). Likewise, claimant's treating physician, Dr. McCullough, reported that any impairment claimant now has "preexisted the December 29, 1990 work exposure," which he described as a "relatively minor force." (Ex. 68-2).

Based on that evidence, we conclude that, while claimant sustained an aggravation of his condition in December 1989, the worsening was temporary and claimant has since returned to his pre-aggravation status with no additional impairment. Accordingly, claimant is not entitled to an award of additional permanent disability. Nonetheless, we will not reduce the August 6, 1990 Determination Order award of 2 percent permanent disability, because the insurer has not requested a reduction. See Daniel M. Alire, 41 Van Natta 752 (1989).

ORDER

The Arbitrator/Referee's order dated April 3, 1990 is affirmed in part and reversed in part. The August 6, 1990 Determination Order is reinstated and affirmed. The remainder of the order is affirmed.

In the Matter of the Compensation of
SHARON L. DOMINY, Claimant
WCB Case No. 90-18458
ORDER ON RECONSIDERATION
Rasmussen & Henry, Claimant Attorneys
Charles Cheek (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our April 30, 1992 order that enforced a June 8, 1990 stipulated order which states that SAIF will provide claimant with "physical therapy benefits under ORS 656.245." Specifically, SAIF contends that we improperly concluded that the agreement's reference to ORS 656.245 was not intended to restrict or eliminate claimant's entitlement to physical therapy under the agreement. Alternatively, SAIF requests that this matter be remanded to determine what physical therapy benefits were contemplated by the stipulated order if such benefits were not those allowed under ORS 656.245 when they were requested.

We conclude that the factual question raised by SAIF's first argument on reconsideration was adequately addressed in our prior order. Accordingly, we adhere to our prior reasoning and conclusion. We proceed to consider SAIF's motion to remand.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

At hearing, the parties stipulated that claimant gave up her contention that she was entitled to a work-hardening program in exchange for SAIF's promise, pursuant to the June 8, 1990 stipulated order, to provide "physical therapy benefits under ORS 656.245." The parties also stipulated that SAIF's claims adjuster intended that SAIF would pay for "such physical therapy as agreed," upon entering into the agreement. Considering these facts, in light of our reading of the parties' agreement, we conclude that the record is not improperly, incompletely or otherwise insufficiently developed. Moreover, SAIF has made no showing of good cause, or other compelling basis, for remand. Therefore, the motion to remand is denied.

Our April 30, 1992 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our April 30, 1992 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

May 18, 1992 Cite as 44 Van Natta 975 (1992)

In the Matter of the Compensation of
MARTY L. HORNBACK, Claimant
WCB Case No. 89-25371
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Kevin L. Mannix, P.C. Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Spangler's order that: (1) upheld the self-insured employer's denial of claimant's back injury claim; and (2) found that claimant had no permanent disability resulting from her compensable injury. Claimant contends that: (1) the Hearings Division lacked jurisdiction to address claimant's entitlement to permanent disability; (2) the Referee improperly admitted a deposition transcript offered by the employer; (3) the employer improperly issued a denial of compensability before the claim was closed; and (4) the claim is compensable. On review, the issues are jurisdiction, evidence, validity of the denial, and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

In December 1989, a Determination Order closed the claim, awarding claimant 13 percent unscheduled permanent partial disability. Claimant requested a hearing regarding the extent of unscheduled permanent disability. That request initially was deferred after claimant enrolled in an Authorized Training Program (ATP).

The employer then timely filed a cross-request for hearing and moved to set aside the order of deferral. On May 25, 1990, the Presiding Referee granted

the motion and reset the case for hearing. After claimant requested reconsideration of the order, on August 14, 1990, the Presiding Referee issued a second order finding that a "hearing should be conducted to determine if claimant is permanently disabled or not" and that, "if the referee found that claimant is not permanently disabled, claimant would not be entitled to continue in the authorized training program." The Referee then ordered that the case be set for hearing. After the employer denied the compensability of claimant's current condition in September 1990, the claimant added that issue for consideration at hearing.

A hearing followed on January 18, 1991. Referee Spangler found that claimant's condition was not compensable, therefore upholding the denial, and further concluded that "the employer has met its burden of proving that claimant has no permanent disability 'due to' the March, 1988, compensable injury."

Claimant argues on review that, although "the employer could file a cross-request for hearing on the extent of disability, and [] this issue could be brought before the hearings division," the Presiding Referee should not have set aside the order of deferral until the ATP was completed by claimant or terminated by the employer. Claimant's argument relies on ORS 656.268(1), which provides that "[c]laims shall not be closed if the worker's condition has not become medically stationary or if the worker is enrolled and actively engaged in training[.]" By citing this statute, we understand claimant to argue that the open status of a claim due to participation by claimant in a training program prevents the Hearings Division from having jurisdiction to consider the extent of permanent disability. We disagree for several reasons.

First, ORS 656.283(1) provides that "any party or the director may <u>at any time</u> request a hearing <u>on any question concerning a claim</u>." (Emphasis added.) Moreover, the Court of Appeals has held that the Board is precluded from denying a hearing regarding the adequacy of a Determination Order's award of permanent disability pending completion of a rehabilitation program. <u>See</u> <u>Minor v. Delta Truck Lines</u>, 43 Or App 29, 31 (1979), <u>rev</u> <u>den</u> 288 Or 253 (1980); <u>Leedy v. Knox</u>, 34 Or App 911, 920 (1978); <u>Kenneth R. Baning</u>, 40 Van Natta 1739, 1740 (1988). The court came to this conclusion despite its recognition that delaying a decision on the extent issue was administratively economical and convenient because such a determination again would be made by the Evaluation Section upon the completion or abandonment of the training program. <u>See</u> <u>Minor v. Delta Truck Lines</u>, <u>supra</u>; <u>Leedy v. Knox</u>, <u>supra</u>.

Furthermore, in those cases where we decline to address the extent of permanent disability, it is based on the fact that the claimant is not medically stationary rather than because of the open status of the claim. <u>See</u> <u>e.g.</u> <u>Kociemba v. SAIF</u>, 63 Or App 557, 560 (1983); <u>Raymond E. Pardee</u>, 41 Van Natta 548 (1989). Moreover, as we explained in <u>Glean A. Finley</u>, 43 Van Natta 1442, 1444 (1991), the reason for declining to rate disability in such cases "is not based on principles of jurisdiction, but rather based on notions of practicability. * * * Because permanent disability is evaluated at the time of hearing, it would be extremely confusing, if not impossible to rate claimant's disability, disregarding the permanent contribution, if any, which resulted from a subsequent aggravation."

Here, there is no contention that claimant's condition was not medically stationary at the time of hearing. Under such circumstances, we conclude that the Referee had jurisdiction to consider the employer's cross-request for hearing regarding the December 1989 Determination Order and its award of permanent disability.

In reaching this conclusion, we hold that the Presiding Referee did not abuse his discretion in rescinding the deferral order. The applicable version of OAR 438-06-105(1) provides that a "hearing may be deferred until a time specified in the order of deferral if * * * the primary issue is unscheduled permanent disability and the claimant is entitled to temporary disability compensation under an Authorized Training Program, except where there is an interruption of compensation or upon a showing of good cause[.]" (WCB Temp. Order 7-1990) (Emphasis supplied). In declining to defer the hearing, the Presiding Referee effectively found good cause to proceed with the hearing pursuant to the employer's cross-request. Because the rule gives a Referee discretion to defer the hearing, and we find no abuse of this discretion, we conclude that the Referee properly considered the extent of permanent disability prior to the termination of the training program.

Evidentiary Issue

Along with setting aside the order of deferral, the Presiding Referee also found that the employer could depose Dr. Chester, who treated claimant during her participation in the Pain Rehabilitation Program and had provided a report, dated June 10, 1990, to claimant's attorney. Claimant requests that the Board strike the deposition transcript, which was admitted at hearing. Claimant argues that the employer submitted the June 10, 1990 report; as such, claimant maintains that the employer was allowed to cross-examine its own witness.

Claimant has misunderstood the facts. At hearing, the employer offered the deposition transcript and claimant offered the June 10, 1990 report. Moreover, both documents were admitted without objection. (Tr. 1-2). Having failed to preserve her objection to submission of the deposition transcript, claimant is precluded from raising the objection on review. See Joseph B. Beaulieu, 40 Van Natta 1199, 1200 (1988).

Validity of Denial

Claimant next contends that the employer's denial should be set aside as improper because it issued while claimant was participating in the training program and, thus, the claim was in open status.

As a general rule, a carrier may not issue a partial denial of a previously accepted claim before the claim is processed and a Determination Order establishes the extent of disability. See Roller v. Weyerhaeuser Co., 67 Or App 583, on reconsideration 68 Or App 743, rev den 297 Or 601 (1984); Safstrom v. Riedel International, Inc., 65 Or App 728, rev den 297 Or 124 (1983).

Here, a Determination Order did issue, providing an award of permanent disability. Because the claim had been closed and the parties were proceeding to hearing on the extent issue, it is clear that the employer's conduct would not circumvent statutory claim closure procedures. Therefore, we conclude that the employer properly could deny compensability of claimant's current conditions.

Compensability

Finally, claimant argues that she proved her claim compensable. We find that the medical evidence supports the Referee's conclusion that claimant did not meet her burden of proving compensability, and we adopt that portion of the order.

ORDER

The Referee's order dated January 29, 1991 is affirmed.

In the Matter of the Compensation of
CARL M. PRICE, Claimant
Own Motion No. 66-0218M
OWN MOTION ORDER ON RECONSIDERATION
Jon Correll (Malagon, et al.), Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our April 15, 1992 Own Motion Order, in which we awarded claimant medical benefits for the compensable injury which has rendered him permanently and totally disabled. Claimant contends that, under the provisions of ORS 656.245(1)(b), as amended by Oregon Laws 1990, Chapter 2, Section 54, he is entitled as a matter of right, not Board discretion, to palliative medical services when he has been determined to have permanent total disability. The issue is jurisdiction.

A claim for palliative care for one who has been determined to be permanently and totally disabled is a claim for medical benefits. We earlier concluded that, notwithstanding the language of Oregon Laws 1990, Chapter 2, Section 54, the legislature did not intend to grant lifetime medical rights under ORS 656.245 for pre-1966 injuries, and that we continue to have own motion jurisdiction to review those claims for medical benefits. See Roy Hansen, 43 Van Natta 990 (1991). The only legislative exception that specifically extended lifetime rights to medical services was for injuries that occurred from August 5, 1959 through December 31, 1965 and resulted in permanent total disability. Oregon Laws 1959, Chapter 589, Section 2. This exception does not apply to claimant, who was injured in 1953.

Accordingly, our April 15, 1992 order is withdrawn. As supplemented herein, we adhere to and republish our April 15, 1992 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DORIS F. CLOTHIER, Claimant
WCB Case Nos. 90-20516 & 90-16107
ORDER ON REVIEW
Coughlin, et al., Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Tenenbaum's order that: (1) declined to award temporary disability benefits for the period of September 27, 1990 through January 1, 1991; and (2) declined to assess a penalty and attorney fee for an allegedly unreasonable termination of temporary disability benefits. In its brief, the insurer contends that it should be entitled to terminate temporary disability benefits as of September 15, 1990. On review, the issues are temporary total disability and penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of the last sentence in that section. The Referee's finding that claimant last saw Dr. Stringham on September 26, 1990, is corrected. Claimant last saw Dr. Stringham on September 15, 1990.

CONCLUSIONS OF LAW AND OPINION

Temporary total disability

The Referee concluded that, following claimant's failure to follow a recommended rehabilitation program prescribed by her treating physician, it could not be found that claimant's inability to work was due to the compensable condition. Accordingly, the Referee concluded that the insurer was authorized to terminate temporary disability benefits as of that date. We reverse.

On review, the insurer contends that it properly terminated temporary total disability because, pursuant to ORS 656.262(4)(b), temporary disability compensation was not owed for the period of time in question. We disagree.

ORS 656.262(4)(b) provides:

> "Temporary disability compensation is not due and payable for any period of time for which the insurer or self-insured employer has requested from the worker's attending physician verification of the worker's inability to work resulting from the claimed injury or disease and the physician cannot verify the worker's inability to work, unless the worker has been unable to receive treatment for reasons beyond the worker's control." Or Laws 1990 (Special Session), ch. 2, 15."

See also Joel O. Sandoval, 44 Van Natta 543 (1992).

Accordingly, we first determine whether the insurer requested from the worker's attending physician verification of the worker's inability to work. Here, claimant last saw her treating physician, Dr. Stringham, on September 15, 1990, when he referred her to a back rehabilitation program. There is no evidence in the record that the insurer contacted Dr. Stringham and requested verification of claimant's inability to work resulting from the injury.

The insurer contends that, following claimant's move on October 5, 1990, claimant was contacted and advised that a Form 829 and a treatment plan from her new treating physician was required, and temporary disability benefits could be suspended if claimant did not schedule an appointment. Claimant then saw Dr. McKim, who subsequently reported that claimant was not capable of employment until the exact etiology of her disability was more fully evaluated.

The record does not establish that Dr. McKim was claimant's attending physician as defined by OAR 436-60-005(2). Although the insurer sent claimant a Form 829, there is no evidence that the form was completed. Moreover, the record does not establish that claimant changed her attending physician from Dr. Stringham to Dr. McKim. Rather, Dr. McKim reported to the insurer that he saw claimant upon only one occasion. Under the circumstances, we conclude that the insurer has not established that it requested Dr. Stringham, who was claimant's attending physician, to verify claimant's inability to work. Therefore, the insurer could not properly rely upon ORS 656.262(4)(b) as authority for its termination of claimant's temporary total disability compensation.

An insurer may procedurally terminate temporary disability without the claimant being medically stationary if any one of the conditions set forth in amended ORS 656.268 is met. Soledad Flores, 43 Van Natta 2504 (1991). Amended ORS 656.268 provides, in part:

> "(3) Temporary total disability benefits shall continue until whichever of the following events first occurs:

"(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."

We agree with the Referee that neither ORS 656.268(3)(b) nor (3)(c) provide the insurer with the authority to terminate claimant's temporary disability benefits. Accordingly, we adopt the Referee's conclusion and opinion on that issue.

ORS 656.268(3)(a) provides that benefits can be terminated if the worker returns to regular or modified employment. Here, the insurer argues that it was entitled to terminate claimant's temporary total disability benefits when she began working as a waitress for Portland '76. We agree that the insurer could terminate such benefits during the time period that claimant had returned to regular work as a waitress. Moreover, the Referee found that the insurer paid either temporary total or temporary partial disability benefits for the period of June 25 through September 24, 1990.

However, on August 11, claimant was taken off work by Dr. Stringham, who authorized temporary disability benefits until "further notice." Accordingly, we conclude that the insurer was obligated to recommence payment of temporary total disability benefits pursuant to OAR 436-60-030(4)(a). The insurer was, therefore, required to commence paying temporary total disability benefits on August 11, 1990, until such time that it was appropriate to terminate the benefits according to law. Under the circumstances, we find that claimant was entitled to temporary disability benefits and we reverse the Referee on that issue.

Penalties and attorney fees

The Referee concluded that, although claimant argued that the insurer unilaterally terminated temporary disability on or about August 23, the record established that such benefits were paid through September 24, 1990. We agree that a penalty for that period of time is not warranted. However, we have above concluded that the insurer had no authority to unilaterally terminate claimant's temporary disability benefits after August 11, 1990. Under the circumstances, we find that the insurer's termination of benefits beginning September 24, 1990, was unreasonable and we assess a 25 percent penalty. ORS 656.262(1)(a). One-half of the penalty amount shall be awarded to claimant's counsel in lieu of an attorney fee.

ORDER

The Referee's order dated May 15, 1991 is reversed. Claimant is awarded temporary disability benefits from August 11, 1990 until such benefits can be terminated according to law. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. The insurer is assessed a penalty of 25 percent of the compensation made payable by this order. One-half of that amount shall be paid to claimant's counsel in lieu of an attorney fee.

In the Matter of the Compensation of
MICHAEL A. DIPOLITO, Claimant
WCB Case No. 91-02448
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

The SAIF Corporation requests review of that portion of Referee Thye's order that awarded claimant an attorney fee under ORS 656.386(1) for obtaining compensation for claimant without a hearing. Contending that claimant's hearing request concerning a surgery request was premature, SAIF argues that claimant was not entitled to an attorney fee award. We agree and reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee awarded claimant an assessed attorney fee for obtaining SAIF's March 1991 surgery authorization without a hearing, pursuant to amended ORS 656.386(1). Because we conclude that claimant's request for hearing was premature, we reverse.

Dr. Franks, claimant's treating neurosurgeon, first requested surgery in August 1990. (Ex. 9A). SAIF obtained an independent medical examination, and the examiners recommended against surgery. (Exs. 10, 11). Thereafter, Dr. Franks stated he would not be following up treatment with claimant. (Ex. 12B). Considering the circumstances (particularly in light of SAIF's denials as discussed below), we interpret such a statement as a withdrawal of the prior surgery request.

Meanwhile, SAIF had denied compensability of claimant's low back condition, as either an aggravation of a 1986 injury or as a new injury sustained on June 21, 1990, and claimant requested a hearing on both denials. (Ex. 12; see also Ex. 14-2). This dispute was resolved when the parties entered into a stipulation whereby SAIF accepted claimant's low back condition as a new injury and agreed to process the claim according to law. (Exs. 14, 15). This stipulation received Referee approval on January 29, 1991. Claimant's attorney received a $1,200 carrier-paid fee for these efforts.

We find that at the time of SAIF's claim acceptance, there was no outstanding surgery request, inasmuch as we have found that Dr. Franks withdrew his surgery request in November 1990. Therefore, SAIF had no immediate duty to process a surgery request.

After SAIF accepted claimant's new injury claim on January 29, 1991, claimant renewed his request for surgery authorization. Specifically, on February 12, 1991, claimant's attorney wrote to SAIF requesting surgery authorization. (Ex. 15A). Dr. Franks saw claimant on February 20 and February 27, 1991, and renewed the surgery authorization request. (Ex. 16). On February 28, 1991, the Board received claimant's request for hearing on an alleged "de facto" denial of medical services (surgery). On March 7, 1991, claimant's attorney called to inform SAIF that Dr. Franks was requesting surgery authorization. (See Ex. 16A). On March 25, 1991 (some 41 days after claimant's renewed surgery request), SAIF authorized the surgery. (Ex. 16B).

We find that the earliest date on which SAIF could have had notice or knowledge of a claim regarding claimant's renewed request for surgery was February 15, 1991. (Ex. 15B). From that date, SAIF had 90 days within which to accept or deny the claim. ORS 656.262(6).

Here, claimant filed his request for hearing on February 28, 1991, well before 90 days from the February 15, 1991 surgery request had expired. A prematurely filed request for hearing is ineffective and void. Syphers v. K-W Logging, Inc., 51 Or App 769 (1981); Barr v. EBI Companies, supra. Inasmuch as no denial had issued (written or "de facto"), it follows that claimant's hearing request was premature.

The Referee awarded a fee pursuant to amended ORS 656.386(1), which provides 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." However, this statute has no application when the hearing request did not pertain to a denial (written or "de facto") and, thus, there was no denial to withdraw after the hearing request and before the hearing. See Jones v. OSCI, 108 Or App 230 (1991) (amended ORS 656.386(1) allows attorney fee where denial withdrawn after claimant files hearing request but before Referee decides issue).

ORDER

The Referee's order dated July 8, 1991 is reversed in part and affirmed in part. The Referee's $1,000 attorney fee award is reversed. The remainder of the Referee's order is affirmed.

May 19, 1992 Cite as 44 Van Natta 982 (1992)

In the Matter of the Compensation of
DORIS S. KLAGER, Claimant
WCB Case No. 90-08318
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Schultz's order that: (1) found that claimant's back injury claim was not prematurely closed; and (2) declined to award an attorney fee for prevailing at hearing against the self-insured employer's cross-appeal of a Determination Order. The employer cross-requests review of those portions of the order that: (1) declined to find claimant medically stationary as of November 10, 1989; (2) found claimant entitled to temporary disability benefits between November 27, 1989 and May 9, 1990; and (3) assessed a penalty for its failure to pay temporary disability benefits from November 27, 1989 through May 9, 1990. On review, the issues are premature closure, temporary disability, penalties, and attorney fees. We reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exception. We do not adopt the last sentence in paragraph nine.

CONCLUSIONS OF LAW AND OPINION

Because claimant requested a hearing after May 1, 1990 and 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).

Premature Closure

The Referee found that claimant had failed to prove, by a preponderance of the evidence, that her claim was prematurely closed. We disagree.

Claims shall not be closed if the worker's compensable condition has not become medically stationary. ORS 656.268(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Evidence that was not available at the time of closure may be considered to the extent the evidence addresses the condition at the time of closure. Schuening v. J.R. Simplot & Co., 84 Or App 622, 625 (1987). Claimant bears the burden of proving that she was not medically stationary on the date of closure. Berliner v. Weyerhaeuser, 54 Or App 624 (1981). The resolution of the medically stationary date is primarily a medical question based on competent medical evidence. Harmon v. SAIF, 54 Or App 121 (1981).

The employer requested claim closure and a Determination Order issued on June 25, 1990 and found claimant medically stationary on May 9, 1990. (Ex. 12). The Determination Order noted that claimant had not attended a May 9, 1990 independent medical examination (IME) and did not appear to be under active medical treatment. Thus, the medically stationary date was evidently based on former OAR 436-30-035(7). Although applying the wrong version of the rule, claimant argues that former OAR 436-30-035(7) does not preclude a finding that claimant was not medically stationary on May 9, 1990. We agree.

The version of OAR 436-30-035(7) in effect at claim closure provides, in pertinent part, that "a worker shall be determined to be medically stationary on the earliest of the following dates:

> "* * * *
>
> "(b) If the worker fails without good cause to attend a mandatory independent medical examination or consultation scheduled to determine the worker's medically stationary status and/or extent of permanent impairment, on the date the independent medical examination or consultation was scheduled (emphasis supplied);
>
> "(c) If the worker has not sought medical care for a period in excess of 28 days, unless so instructed by the attending physician, on the date the worker last sought medical care." (WCD Admin. Order 7-1990).

We find that claimant falls within the exceptions provided in both subsections. First, she had good cause for failing to attend both the April 5, 1990 and the May 9, 1990 IME's. During the time in question, claimant was experiencing a problem pregnancy marked by four hospitalizations for premature labor. (Tr. 27). Claimant credibly testified that she was unable to attend the April IME due to illness. (Tr. 29, 30). Claimant notified the medical examiner and the claims processor that she was unable to attend. (Tr. 30). This IME was rescheduled for May 9, 1990. Dr. Simpson, one of claimant's treating obstetricians, confined claimant to bed rest from April 27, 1990 to June 1, 1990 for

medical reasons related to premature labor. (Ex. 9A). Claimant notified the medical examiner that she would not be able to attend the examination due to health problems. (Tr. 30, 31). On this record, we find that claimant's health problems constituted good cause for her failure to attend the IME's.

Second, claimant's testimony and the medical evidence establish that claimant did not seek medical care for her compensable back condition based on instructions from her physicians. At claim closure, claimant's attending physician was Dr. Homer, chiropractor. Prior to claim closure, claimant last treated with Dr. Homer on April 13, 1990 and last attended physical therapy prescribed by Dr. Homer on April 23, 1990. (Exs. 5AAA, 6A). Claimant credibly testified that Dr. Homer did not want to treat her until after her delivery. (Tr. 43). This testimony is supported by Dr. Simpson's order of bed rest as of April 27, 1990. (Ex. 9A). We find that, at claim closure, claimant was instructed by her physicians, including Dr. Homer, to temporarily discontinue treatment of her back condition due to her other health problems. Thus, former OAR 436-30-035(7) does not apply in this case.

We turn now to the medical evidence relating to the issue of claimant's medical stationary status at claim closure. On October 5, 1989, the Western Medical Consultants examined claimant and opined that she was not medically stationary but that "she will probably be stationary in two months." (Ex. 3A-3, -4). The Consultants did not reexamine claimant and their statement regarding future predictions does not establish a medically stationary status. See Volk v. SAIF, 73 Or App 643, 646 (1985); Edward B. Castro, 44 Van Natta 362 (1992); Lloyd Fisher, 41 Van Natta 1694 (1989).

The employer argues that the various times that claimant was released to modified or regular work establish that she was medically stationary. We disagree. Although a release to work may affect temporary disability benefits, it does not affect a worker's medically stationary status.

In the same regard, we find that Dr. Homer's report dated January 12, 1990 addresses claimant's ability to return to work, rather than her medically stationary status. (Ex. 5C). He requested that claimant "not return to work until her condition is more stable" and concluded that this "may [not] be until February 1990." (Ex. 5C). In addition to relating to claimant's ability to return to work, this statement involves a future prediction, which would not establish a medically stationary status. See Volk v. SAIF, supra; Edward B. Castro, supra; Lloyd Fisher, supra.

Dr. Pomerleau, chiropractor, treated claimant prior to and after the work injury. She remained claimant's attending physician until her retirement sometime around November 1989. She referred claimant to Dr. Guyer, orthopedist, who opined that claimant was medically stationary as of October 31, 1989. (Ex. 4-2).

Dr. Pomerleau discussed claimant's examination with Dr. Guyer and stated that "[m]edically he [Guyer] felt she is stable meaning she has to learn to deal with the pain of healing." (Ex. 5-2). Dr. Pomerleau also opined that through continued exercise and strengthening, claimant's condition should return to her pre-injury status. (Ex. 5-2). Thus, Dr. Pomerleau was of the opinion that claimant's condition would improve with treatment.

As of claim closure, the record contains no other reports regarding claimant's medically stationary status. The Board generally gives greater weight to the conclusions of a treating physician; however, it will not so defer when there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds, 37

Van Natta 1596 (1985), republished 38 Van Natta 423 (1986). Here, there are no persuasive reasons not to defer to the opinion of Dr. Pomerleau.

Furthermore, Dr. Pomerleau's opinion is supported by a later opinion from Dr. Guyer. Claimant was unable to continue her exercise and strengthening program due to her problem pregnancy. (Exs. 6B, 9A, 12A, 15). Her child was born in July 1990 and she sought treatment for her compensable back condition again in September 1990. (Ex. 12A). Due to the 1990 amendments restricting chiropractors from acting as attending physicians, Dr. Guyer eventually became her attending physician. Claimant participated in an exercising and strengthening program in November 1990. When Dr. Guyer next saw claimant on December 3, 1990, he found her to be medically stationary. (Ex. 17). Significantly, in response to an inquiry from the employer's attorney, Dr. Guyer crossed out his prior statement that claimant was medically stationary on October 31, 1989 and restated that her medically stationary date was December 3, 1990. (Ex. 18).

On this record, we find that claimant has established that she was not medically stationary when her claim was closed.

Temporary Disability

Because the Referee affirmed the Determination Order, he did not address claimant's procedural entitlement to temporary disability benefits. Claimant argues that application of the 1990 amendments in determining her procedural entitlement to temporary disability benefits would produce absurd results. Therefore, she argues that, under the law in effect prior to the 1990 amendments, she is procedurally entitled to the continued payment of temporary disability until she is both released to return to regular work and is medically stationary. Fazzolari v. United Beer Distributors, 91 Or App 592, 595 on recon, 93 Or App 103 (1988), rev den 307 Or 236 (1988).

We disagree that the law in effect prior to the 1990 amendments applies in this case. In Rocky L. Coble, 43 Van Natta 1907 (1991), we found 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.

ORS 656.268(3) provides that temporary total disability shall continue until whichever of three events first occurs. Those events are: (1) the worker returns to regular or modified employment; (2) the attending physician gives the worker a written release to return to regular employment; or (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. See ORS 656.268(3)(a), (b), and (c).

Here, on November 10, 1989, Dr. Pomerleau released claimant for light duty work for two weeks, then regular duties. (Ex. 5-2). On this basis, we find that claimant was released to regular work as of November 25, 1989. Thus, the employer's procedural obligation to pay temporary disability ended as of November 25, 1989. However, on December 22, 1989, Dr. Homer released claimant from work until February 12, 1990. (Ex. 5B). This release reinstated the employer's obligation to pay temporary total disability. ORS 656.210. Dr. Homer applied no restrictions upon claimant's release to work after February 12, 1990. On this basis, we find that claimant was released to regular work as of February 12, 1990. The record contains no other release from work.

These releases to regular work are evidence that claimant was no longer disabled due to her compensable injury. This evidence can be rebutted at claim closure when substantive entitlement to temporary disability is determined.

Nevertheless, while the claim remains in open status, claimant is no longer procedurally entitled to temporary disability once she is released to regular work. ORS 656.268(3)(b); Thomas W. Lundy, 43 Van Natta 2307 (1991). Accordingly, the employer was not procedurally obligated to pay temporary disability from November 25, 1989 to December 21, 1989. The employer was obligated to pay temporary disability from December 22, 1989 until February 12, 1990 based on Dr. Homer's release from work. The employer's procedural obligation to pay temporary total disability compensation ended again on February 12, 1990.

Because we have concluded that claimant's claim was prematurely closed, we do not address the question of claimant's substantive entitlement to temporary disability benefits.

Penalties

The Referee assessed penalties pursuant to ORS 656.262(10)(a) based in part on the employer's unreasonable conduct in unilaterally terminating temporary disability benefits as of November 27, 1989. Given our findings regarding the employer's procedural obligation to pay temporary disability compensation, we find that the employer was not unreasonable in terminating temporary disability benefits as of November 27, 1989.

However, the employer was unreasonable in failing to reinstate these benefits during claimant's release from work as authorized by Dr. Homer. Therefore, we adjust the period of the penalty to include only the amounts due from December 22, 1989 to February 12, 1990, less amounts received through actual earnings.

Attorney Fees

Claimant argues that she is entitled to an attorney fee for prevailing at hearing on the employer's cross-appeal regarding its contention that claimant was medically stationary as of November 10, 1989. We agree.

The employer requested an earlier medically stationary date than the one specified in the Determination Order. Such a finding would have resulted in reduced temporary disability benefits. Claimant prevailed over this request in that the Referee affirmed the Determination Order. Furthermore, the employer made the same cross-request on Board review. We have found that claimant's claim was prematurely closed. Claimant is entitled to a reasonable attorney fee pursuant to ORS 656.382(2) for prevailing over the employer's cross-appeals at hearing and on review. 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 fee for claimant's attorney's services at hearing and on review concerning the employer's cross-appeals is $1,500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record and claimant's reply brief), the complexity of the issue, and the value of the interest involved.

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); OAR 438-15-055; Earl F. Childers, 40 Van Natta 481, 485 (1988). Consequently, we award claimant's counsel 25 percent of the increased temporary disability benefits created by this order, not to exceed $3,800. This award is in addition to the assessed fee awarded above. Dianne M. Bacon, 43 Van Natta 1930 (1991).

ORDER

The Referee's order dated April 12, 1991, as reconsidered May 28, 1991, is reversed in part, modified in part, and affirmed in part. The June 25, 1990 Determination Order is set aside as premature. The claim is remanded to the self-insured employer for further processing. In lieu of the temporary disability awarded by the Referee, claimant is awarded temporary total disability from December 22, 1989 to February 12, 1990. In lieu of the penalty awarded by the Referee, claimant is awarded a penalty of 25 percent of the temporary disability due from December 22, 1989 to February 12, 1990. This penalty is to be divided equally between claimant and her attorney. That portion of the Referee's order that found claimant medically stationary as of May 9, 1990 is reversed. The remainder of the Referee's order is affirmed. In lieu of the Referee's attorney fee award, claimant's counsel is awarded a reasonable attorney fee of: (1) 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's counsel; and (2) $1,500 for services at hearing and on review regarding the employer's cross-appeal, payable by the employer.

In the Matter of the Compensation of
LEROY C. AMES, Claimant
WCB Case No. 90-21344
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Cummins, Brown, et al., Defense Attorneys

Reviewed by Board Members Hooton and Brazeau.

The self-insured employer requests review of those portions of Referee Baker's order that: (1) increased claimant's scheduled permanent disability award for loss of use or function of the right leg from 15 percent (22.5 degrees), as awarded by a January 14, 1988 Amended Order on Stipulation, to 45 percent (67.5 degrees); and (2) found that the increased scheduled permanent disability award was to be paid at the rate of $305 per degree. Claimant cross-requests review of those portions of the order that: (1) did not increase claimant's scheduled permanent disability award for loss of use or function of the left leg, whereas the January 14, 1988 Amended Order on Stipulation had awarded a total of 30 percent (45 degrees) for the left leg; and (2) did not award an out-of-compensation attorney fee. On review, the issues are extent of scheduled permanent disability, rate of scheduled permanent disability and attorney fees.

We affirm and adopt the Referee's order regarding the extent and rate of permanent disability issues, with the following supplementation. We modify the order regarding the attorney fee issue.

The primary issue on review is extent of scheduled permanent disability. With regard to claimant's right knee/leg, neither party disputes that claimant is entitled to the 27 percent scheduled permanent disability awarded by the Referee under the standards. We therefore accept those values and discuss only claimant's entitlement to an award "outside" the standards.

A scheduled disability rating outside the standards must be supported by clear and convincing evidence. ORS 656.283(7). "Clear and convincing evidence" means that the truth of the facts is highly probable. The evidence must be free from confusion, fully intelligible and distinct. Riley Hill General Contractor,

Inc. v. Tandy Corp., 303 Or 390, 407 (1987). In examining for clear and convincing evidence, the record is viewed as a whole. Thomas L. Swanger, 42 Van Natta 887 (1990).

We find the evidence clear and convincing in support of an 18 percent award outside the standards. In reaching this conclusion, we note that it is undisputed that claimant has bilateral chondromalacia (softening of articular cartilage) and that chondromalacia is not ratable under the standards. The fact that the standards omit an impairment value for chondromalacia is not sufficient in and of itself to establish clear and convincing evidence when a claimant is suffering from chondromalacia Wilma L. Emerich, 44 Van Natta 203, 204 (1992). Nevertheless, here, the record contains more than a diagnosis of chondromalacia. Specifically, we note the opinion of Dr. Freudenberg, treating physician, to the effect that claimant suffers 45 percent impairment of the right leg. Freudenberg's conclusion in this regard is based on his expert opinion concerning claimant's loss of right knee function and his worsened chondromalacia. (See Exs. 51, 55-20-22). Pursuant to a right knee examination, Freudenberg specifically opined that claimant's "physical capacities are quite limited: He can only walk for about 15 minutes and stand for about 30 minutes." (Ex. 51-2). In addition, we are persuaded by claimant's credible testimony regarding his ability to use his right knee. He has constant right knee pain and cannot kneel, climb ladders, or lift any weight. (See Tr. 9-16). Considering this evidence, and the record as a whole, we conclude that claimant has established entitlement to an 18 percent award outside the standards, for injury-related loss of use or function of his right knee.

Because the Referee awarded additional permanent partial disability compensation, claimant's counsel is entitled to an out-of-compensation attorney fee. OAR 438-15-040(1). In addition, claimant is entitled to an assessed attorney fee for prevailing on the self-insured employer's request for review. 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 attorney's services on review concerning the extent of right knee/leg disability and rate of scheduled disability issues is $800, to be paid by the self-insured 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 June 7, 1991 is modified in part and affirmed in part. The order is modified so that claimant's counsel is awarded 25 percent of the increased compensation created by the Referee's order, not to exceed $2,800. The remainder of the order is affirmed. Claimant's counsel is awarded an assessed fee of $800 for prevailing on the self-insured employer's request for review regarding the extent and rate of permanent disability issues.

In the Matter of the Compensation of
PAUL D. O'NEAL, Claimant
WCB Case No. 91-03408
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Susan D. Ebner (Saif), Defense Attorney

Reviewed by Board Members Kinsley, Brazeau and Hooton.

The SAIF Corporation requests review of those portions of Referee Bethlahmy's order that: (1) directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree; and (2) assessed a penalty for SAIF's allegedly unreasonable resistance to the payment of compensation. Claimant cross-requests review of that portion of the order that declined to award a separate attorney fee pursuant to ORS 656.382(1). On review, the issues are the rate of scheduled permanent disability, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND REASONING

Rate of Scheduled Disability

We adopt the conclusions and reasoning concerning the rate of scheduled disability as set forth in the Referee's order. Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991).

Penalties

The Referee assessed a penalty for SAIF's allegedly unreasonable refusal to pay scheduled permanent disability at $305 per degree. We reverse.

In paying claimant's award of scheduled disability at the rate of $100 per degree, SAIF relied on former OAR 436-35-010(5)(Temp.), which provided that the increased award of $305 per scheduled degree applies only to injuries sustained on or after May 1, 1990. Although our decision in Herron expressly gave no effect to that rule, we did not declare the rule invalid. Inasmuch as SAIF has complied with a valid administrative rule, we do not find its actions to have been unreasonable. Accordingly, no penalty is warranted. Mary E. Weaver, 43 Van Natta 2618 (1991); John Keller, 38 Van Natta 1351 (1986).

Attorney Fee

We adopt the conclusion and reasoning concerning claimant's entitlement to a separate attorney fee under ORS 656.382(1); as set forth in the Referee's order. See Nicolasa Martinez, 43 Van Natta 1638 (1991).

Attorney Fees on Review

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. 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 attorney's services on review concerning the rate of scheduled permanent disability issue is $600, to be paid by the SAIF Corporation. 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 July 17, 1992 is affirmed in part and reversed in part. That portion of the Referee's order that assessed a penalty against the SAIF Corporation is reversed. The remainder of the order is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $600, to be paid by the SAIF Corporation.

Board Member Hooton specially concurring.

In Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), we made a specific finding which seems contrary to the position we have subsequently taken on the claimant's entitlement to penalties. In the Order on Reconsideration in Herron we characterized the statute and the administrative rule as follows:

> "That portion of 1990 Oregon Laws, Ch. 2 which is here under consideration is a provision written in precise terms and which is clearly meant to be a complete expression of legislative intent with regard to when the amendments became operative and to which claims the 1990 Act applies. With respect to such legislation, an administrative agency has no authority to interpret or complete the stated legislative policy." 43 Van Natta @ 1103.

In his request that we assess a penalty for SAIF's failure to pay at the correct rate, claimant asks whether we really meant what we said.

If the legislative expression really is "precise" and "clear" such that the Department lacks authority to "complete" the expression of legislative policy, the insurer must be bound by that precise and clear expression regardless of any contrary administrative rule. The ultimate authority on all questions regarding the Workers' Compensation Act is, necessarily, the Act itself.

The Act provides a procedure under which the insurer can protect its interest while the Board's interpretation of Section 54 remains in litigation before the appellate courts of this state. ORS 656.313(1) provides a stay of compensation if the insurer requests review. If the insurer believes that its obligation to pay at the rate of $305 per degree is in doubt, it ought to be required to initiate a review from the Determination Order or Notice of Closure, and the subsequent Order on Reconsideration protecting that interest. By ignoring the procedure provided in ORS 656.313(1) we are requiring claimants to surrender to their attorney 25 percent of an entitlement provided by the statute in every scheduled disability case only to protect the insurer's interest to a review of its statutory obligation, but without requiring the insurer to initiate that review or request that protection. The insurer ought to be required to assume the responsibility for requesting review.

I would find that failure to pay an award at the statutorily prescribed rate, in reliance upon an administrative rule we have already determined to be ultra vires, without taking the steps prescribed by statute to perfect review and stay compensation is an unreasonable resistance to the payment of compensation entitling claimant to penalties as a matter of law.

I acknowledge that the Board has taken a contrary position in prior decisions. See Mary E. Weaver, 43 Van Natta 2618 (1991). So long as the majority of the Board continues to support that decision, despite the apparent

contradiction with the principles espoused in Herron, stare decisis requires that I apply it, and I will. If, however, the Board should decide to revisit the question, I would overrule Weaver and its progeny and assess, at the very least, a penalty of 25 percent of the unpaid compensation due pursuant to ORS 656.262(10).

May 20, 1992 Cite as 44 Van Natta 991 (1992)

In the Matter of the Compensation of
JAMES M. PUMPELLY, Claimant
WCB Case No. 90-18229
ORDER ON REVIEW
Black et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Brazeau.

The self-insured employer requests review of Referee Mongrain's order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) assessed an attorney fee for the employer's allegedly unreasonable resistance to the payment of compensation. On review, the issues are aggravation and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Aggravation

The Referee concluded that claimant had established a compensable aggravation claim and set aside the employer's denial. We agree and adopt his conclusion with the following supplementation.

As amended, ORS 656.273(1) provides, in part:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence supported by objective findings. However, if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable."

On review, the employer does not dispute that claimant's condition has worsened. It argues, however, that the worsening is not compensable, because the medical evidence establishes that the major contributing cause of the worsening of his condition were two off-the-job incidents. It relies on the language of ORS 656.273(1), which provides that a worsening is not compensable "if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment."

The employer misreads the statute. ORS 656.273(1) specifically provides that a worsening is not compensable if an off-the-job injury is "the major contributing cause the worsened condition." (Emphasis supplied.) As noted by claimant, the noun "condition" defines the underlying injury or process that is compensable. The adjective "worsened" is a modifier. Accordingly, the question

is not whether an off-the-job injury is the major contributing cause of the worsening (i.e., the exacerbation itself), but whether that injury is the major contributing cause of the worsened condition (i.e., claimant's condition after the exacerbation). See Kassahn v. Publisher's Paper Company, 76 Or App 105 (1985).

In this case, the medical record establishes, and the employer does not dispute, that claimant's off-the-job injuries were a relatively minor contributing factor to his need for additional medical services and disability, when compared to his original compensable injury. Given those facts, we agree with the Referee's conclusion that those off-the-job injuries do not preclude the finding that claimant has established a compensable aggravation.

Attorney Fees

When elective neurological surgery is requested for a compensable condition, an insurer or self-insured employer may obtain a second opinion as to the need for surgery under OAR 436-10-070(2). Upon receipt of the second opinion, the insurer shall notify the treating surgeon within 72 hours whether payment will be provided for the treatment. OAR 436-10-070(3). Because the employer failed to notify Dr. Dunn whether payment was authorized for the proposed surgery within 72 hours after obtaining a second opinion from Dr. Rosenbaum, the Referee concluded that the employer's actions amounted to the unreasonable resistance to the payment of compensation and awarded claimant's attorney an assessed fee under ORS 656.382(1). We disagree.

ORS 656.382(1) provides for an assessed attorney fee when an insurer or self-insured employer unreasonably resists the payment of compensation. In this case, the employer argues that its delay in notifying Dr. Dunn was caused by Dr. Rosenbaum's failure to provide information necessary to determine whether the proposed surgery was compensable. Accordingly, it sought a follow-up report from Dr. Rosenbaum, and notified Dr. Dunn as to its decision once it received the follow-up report. Obtaining a complete report from Dr. Rosenbaum before notifying Dr. Dunn is reasonable. Accordingly, an attorney fee is not warranted.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. 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 attorney's services on review concerning the aggravation issue is $850, to be paid by the self-insured 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 June 27, 1991 is affirmed in part and reversed in part. The Referee's $500 assessed attorney fee for the employer's allegedly unreasonable resistance to the payment of compensation is reversed. The remainder of the order is affirmed. For services on Board review, claimant's attorney is entitled to an assessed fee of $850, to be paid by the self-insured employer.

In the Matter of the Compensation of
LYNNETTE D. BARNES, Claimant
WCB Case Nos. 90-18152, 90-14715, 90-17215 & 90-18151
ORDER ON REVIEW (REMANDING)
Olson, et al., Claimant Attorneys
Steve Cotton (Saif), Defense Attorney
Daryl Nelson, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Arbitrator Harri's decision which: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim for a left knee condition; and (2) set aside Liberty's "new injury" denial of the same condition. On review, the issue is responsibility. We review for questions of law, ORS 656.307(2), and remand.

Finding that there was no clear evidence that the 1990 injury independently contributed to a pathological worsening of claimant's knee condition, the Arbitrator applied the rebuttable presumption set forth in Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984) and concluded that Liberty was responsible. We disagree.

We note at the outset that, following claimant's April 11, 1990 work incident with Liberty's insured, Liberty denied claimant's left knee claim. (Ex. 35). Therefore, SAIF is the only insurer with an accepted claim. Accordingly, the Kearns presumption is inapplicable here. See Linda L. Wise, 42 Van Natta 115, 116 (1990).

Turning to the applicable standard under the 1990 amendments to the Workers' Compensation Act, we have interpreted Section 49(1) of the amended law to mean 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 a subsequent work exposure. Ricardo Vasquez, 43 Van Natta 1678 (1991); Ronald L. Rushton, 44 Van Natta 124 (1992). Thus, in this case, SAIF, as the last insurer against which claimant had an accepted knee injury, remains presumptively responsible. In order to avoid responsibility, SAIF has the burden of establishing that claimant sustained a new compensable injury involving the same condition when Liberty was at risk.

In order to prove a new compensable injury, SAIF must show that the April 11, 1990 incident when Liberty was at risk was a material contributing cause of claimant's disability or need for treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991). The injury must be established by medical evidence supported by objective findings. See ORS 656.005(7)(a), 656.005(19); Suzanne Robertson, 43 Van Natta 1505 (1991).

In applying the the Kearns presumption, the Arbitrator made Liberty presumptively responsible for claimant's current condition and allocated the burden to Liberty to establish that the April 11, 1990 incident with its insured did not independently contribute to the worsening of claimant's underlying knee condition. Consequently, the Arbitrator's order is inconsistent with the applicable law. Accordingly, because our review is limited to questions of law, we remand this matter to the Arbitrator for proper application of law. ORS 656.307(2).

ORDER

The Arbitrator's order dated July 5, 1991 is vacated. This matter is remanded to the Presiding Referee to reassign the case to another Arbitrator for a

determination of the responsible carrier. The assigned Arbitrator may make that determination with or without further proceedings and in any manner that will achieve substantial justice.

May 21, 1992 Cite as 44 Van Natta 994 (1992)

In the Matter of the Compensation of
CHARLES R. BUTLER, Claimant
WCB Case No. 91-10689
ORDER ON REVIEW (REMANDING)
Whitehead & Klosterman, Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of those portions of Referee Myers' order that: (1) dismissed claimant's request for hearing; (2) set aside an Order on Reconsideration because it was invalidly issued; and (3) found that jurisdiction over this matter remained with the Appellate Unit of the Workers' Compensation Division (WCD). On review, the issue is the validity of the WCD's Order on Reconsideration. We remand.

FINDINGS OF FACT

On June 1, 1989, claimant sustained a compensable injury to his left wrist. Claimant's claim was closed by an April 25, 1991 Notice of Closure that awarded 12 degrees for 8 percent scheduled permanent disability. The award was paid by the SAIF Corporation at $145 per degree.

By letter of June 24, 1991, claimant's counsel requested reconsideration of the Notice of Closure. The letter stated that claimant disagreed with the amount of scheduled permanent disability. Claimant also disagreed with the rate of scheduled permanent disability used by SAIF.

The Director did not appoint a medical arbiter. Thereafter, on August 5, 1991, the Order on Reconsideration was issued which reduced claimant's award of scheduled permanent disability to 7 percent.

At hearing, claimant objected to the Reconsideration Order on the ground that the Director did not appoint a medical arbiter. Following admission of the documentary evidence and opening statements, the Referee indicated that he would prepare an order finding the Order on Reconsideration invalid. In light of this conclusion, the Referee did not permit the parties to present testimony.

CONCLUSIONS OF LAW AND OPINION

Validity of Department's Order

The Referee found that the Order on Reconsideration was not valid. Therefore, he dismissed claimant's request for hearing, set aside the Order on Reconsideration and found that jurisdiction remained with the WCD Appellate Unit. We disagree.

Claimant became medically stationary after July 1, 1990. Therefore, the 1990 amendments to the Workers' Compensation Act apply to this case. See Oregon Laws 1990 (Special Session), 54(3). The Director's rules in effect at the time of the August 5, 1991 Order on Reconsideration are applicable. Former OAR 436-30-003(4) (WCD Admin. Order 7-1990, effective July 1, 1990).

As amended, ORS 656.268(4)(e) provides that: "If a worker objects to the notice of closure, the worker must first request reconsideration by the department under this section." In conjunction with this section, amended ORS 656.268(5) provides that: "If a worker, the insurer or self-insured employer objects to a determination order issued by the department, the objecting party must first request reconsideration of the order." Amended ORS 656.268(6)(b) then provides that:

> "If any party objects to the reconsideration order, the party may request a hearing under ORS 656.283 within 180 days after the copies of the notice of closure or the determination order are mailed, whichever is applicable. The time from the request for reconsideration until the reconsideration is made shall not be counted in any limitation on the time allowed for the request for hearing."

Read together, it is clear from ORS 656.268(4)(e), 656.268(5) and 656.268(6)(b) that claimant or the objecting party must not only request reconsideration from a Notice of Closure or Determination Order before requesting a hearing pursuant to ORS 656.283, but the reconsideration process established by ORS 656.268(5)-(7) must be completed before a hearing may be requested. See Lorna D. Hilderbrand, 43 Van Natta 2721 (1991).

ORS 656.268(7) provides, in part:

> "If the basis for objection to a notice of closure or determination order issued under this section is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter appointed by the director. . . . The findings of the medical arbiter shall be submitted to the department for reconsideration of the determination order or notice of closure. . . ." (Emphasis supplied).

We have recently interpreted this provision to mean that where a party requests reconsideration of a Notice of Closure or Determination Order and the basis for that request is a disagreement with the medical findings for impairment, then the Director is required to submit the matter to a medical arbiter or panel of arbiters prior to issuing an Order on Reconsideration. See Olga I. Soto, 44 Van Natta 697 (1992). However, where a party does not contest the medical findings of impairment, referral to an arbiter or panel of arbiters is not required. Doris C. Carter, 44 Van Natta 769 (1992).

In accordance with ORS 656.268(7), the Director has adopted rules implementing the reconsideration process. See former OAR 436-30-050 et seq. Pursuant to the Director's rules, a request for reconsideration must contain certain information. Former OAR 436-30-050(4). Specifically, the request for reconsideration must include "whether there is disagreement with the specific impairment findings of the attending physician at the time of claim closure and if so, an explanation of the specific areas of disagreement." Former OAR 436-30-050(4)(d).

Here, claimant requested reconsideration of the Notice of Closure on the basis that he did not agree with the amount of disability awarded by SAIF for his scheduled injury. His request was in the form of a letter from his counsel and did not specify that he disagreed with the impairment findings of his attending physician.

Although the letter requesting reconsideration may have been sufficient to initiate the reconsideration process, it did not specify that claimant disagreed with the impairment findings of his attending physician as required by former

OAR 436-30-050(4)(d). Therefore, the Director was not required to submit the matter to a medical arbiter prior to issuing the Order on Reconsideration. Doris C. Carter, supra. Accordingly, the Order on Reconsideration is valid.

Inasmuch as we have found the Order on Reconsideration valid, the issue of extent of scheduled permanent disability is properly before us. However, in light of his conclusion that the Order on Reconsideration was invalid and that claimant's Hearing request was dismissed, the Referee concluded the hearing without permitting the parties an opportunity to present testimony. Under these circumstances, we find that the record is incompletely developed with regard to the issue of extent of scheduled permanent disability. We therefore find it appropriate to remand this matter to the Referee for further proceedings consistent with this order. ORS 656.295(5). These further proceedings may be conducted in any manner that the Referee determines will achieve substantial justice. ORS 656.283(7).

ORDER

The Referee's order dated November 1, 1991 is vacated. The matter is remanded to Referee Myers for further proceedings consistent with this order.

In the Matter of the Compensation of
VALERIE A. CARLSON, Claimant
WCB Case Nos. 91-07596 & 91-04836
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Charles A. Ringo, Defense Attorney
John Motley (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Referee Nichols' order which: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition. Claimant cross-requests review, arguing that SAIF is the responsible carrier. On review, the issues are compensability and responsibility.

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

The Referee found that claimant's 1991 claim against SAIF's insured was an occupational disease claim. She determined that claimant's employment at SAIF's insured did not independently contribute to a pathological worsening of claimant's underlying condition nor were the work activities the major cause of claimant's current low back condition. Therefore, she concluded that Liberty remained responsible for claimant's low back condition. We agree with the Referee that claimant's 1991 claim against SAIF's insured is an occupational disease claim and that responsibility for claimant's low back condition remains with Liberty. However, we analyze this matter under the Workers' Compensation Act as amended by Senate Bill 1197, effective July 1, 1990. Ida M. Walker, 43 Van Natta 1402 (1991).

Subsequent to the Referee's order, we interpreted the term "new compensable injury," as used in Section 49(1) of the amended Act, to include and apply equally to both new injuries and new occupational diseases. Donald C. Moon, 43 Van Natta 2595, 2664 n. 1 (1991). Consequently, in cases in which an accepted

injury is followed by an increase in disability during employment with a later carrier, responsibility presumptively rests with the original carrier unless the claimant sustains an actual, independent compensable injury or occupational disease during the subsequent work exposure. ORS 656.308(1); Ricardo Vasquez, 43 Van Natta 1678, 1680 (1991); Donald C. Moon, supra. Thus, as the last carrier against which claimant had an accepted low back condition, Liberty remains responsible unless it establishes that claimant's work activities with SAIF's insured were the major contributing cause of claimant's current low back condition. See Rodney H. Gabel, 43 Van Natta 2662, 2664 (1991).

In concluding that claimant's 1986 injury with Liberty Northwest was the major contributing cause of her current low back condition, the Referee relied on the opinion of Dr. Strukel. We concur with the Referee that Dr. Strukel's opinion is the most persuasive because it is well-reasoned and based on complete information. See Somers v. SAIF, 77 Or App 259 (1986).

Liberty first argues on review that Strukel's opinion should be discounted because he was not aware of claimant's work activities with SAIF's insured. We do not agree. Dr. Strukel notes claimant's work activities with SAIF's insured in his report. (Ex. 33-2). Moreover, in formulating his opinion, Strukel reviewed claimant's entire exhibit file, which included the reports of both Dr. Koski and Dr. Lafrance. Those reports also described claimant's work activities. (See Exs. 22 and 26). Liberty next argues that Strukel's opinion should be discounted because he did not perform a physical examination. We do not find Liberty's argument persuasive. Because of claimant's pregnancy, any additional diagnostic procedures were not available. In any event, this case required expert analysis of the medical information rather than expert observation. See Allie v. SAIF, 79 Or App 284 (1986). Dr. Strukel persuasively provided that analysis.

Consequently, based on Dr. Strukel's persuasive opinion, we agree with the Referee that claimant's work exposure while employed with SAIF's insured was not the major contributing cause of claimant's low back condition. Accordingly, Liberty has not established that claimant suffered a "new" compensable occupational disease. See Rodney H. Gabel, supra. Therefore, Liberty remains responsible for medical services and disability related to claimant's compensable low back condition.

Because Liberty initiated the request for 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), we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $500. 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 July 29, 1991 is affirmed. For services rendered on review, claimant's counsel is awarded an assessed fee of $500, to be paid by Liberty Northwest Insurance Corporation.

In the Matter of the Compensation of
ANTHONY M. MIDDLETON, Claimant
WCB Case Nos. 91-01991 & 90-19279
ORDER ON REVIEW
Parker & Bush, Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of those portions of Referee Otto's order that: (1) upheld Fire and Casualty Insurance Company's (Fire and Casualty) denials of claimant's "new injury" claim for a back condition; and (2) set aside SAIF's denial of claimant's aggravation claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Relying on case law prior to the 1990 amendments, the Referee found that SAIF failed to established that claimant's April 9, 1990 work incident while Fire and Casualty was at risk caused or worsened claimant's compensable underlying back condition. Therefore, he concluded that SAIF remained responsible for claimant's current condition. We affirm.

Because claimant requested a hearing after May 1, 1990 and a hearing was convened after July 1, 1990, his claim is properly analyzed under the 1990 revisions to the Workers' Compensation Act. See Ida M. Walker, 43 Van Natta 1402 (1991).

We have interpreted Section 49(1) of the amended law to mean 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 a subsequent work exposure. Richardo Vasquez, 43 Van Natta 1678 (1991); Ronald L. Rushton, 44 Van Natta 124 (1992). Thus, in this case, SAIF, as the last insurer against which claimant had an accepted back injury, remains presumptively responsible. In order to avoid responsibility, SAIF has the burden of establishing that claimant sustained a new compensable injury involving the same condition when Fire and Casualty was at risk.

In order to prove a new compensable injury, SAIF must show that the April 9, 1990 incident when Fire and Casualty was at risk was a material contributing cause of claimant's disability or need for treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991). The injury must be established by medical evidence supported by objective findings. See ORS 656.005(7)(a), 656.005(19); Suzanne Robertson, 43 Van Natta 1505 (1991).

Claimant testified that following the 1989 injury, he was able to return to work. (Tr. 8). Although he did not seek medical treatment between July 1989 and the April 1990 work incident, it is clear from his testimony that the 1989 injury had not resolved and that he did not seek medical treatment for his chronic pain solely because he believed his employer would not give him paid leave for that purpose and he could not afford to take time off from work without pay. He testified:

"Q. Then were you having any physical problems with your low back between July of '89 and April of '90?

"A. Well, I -- between after that first incident, I was always having somewhat problems with my back.

"Q. Can you tell us specifically what kind of problems you were having?

"A. Well, I just -- it hurt mostly, you know. I'd get numbing in my leg. I couldn't -- you know, I had restless sleeping. I -- its just a number of things that was uncomfortable for me.

"Q. Did you have any problems with your job activities because of those physical problems?

"A. Well, I couldn't run a route no more because of the -- and that's why I went to drop box, because it was easier, a little bit easier. It was more driving than physical work, and I couldn't afford to take time off work to wait for my back to heal. That's why I continued to work, and they just -- the doctor advised that I go on lighter duty.

"Q. And to you the lighter duty was driving drop box?

"A. Right.

"Q. What were you doing on April 9, 1990?

"A. I was running a route filling in for a driver.

"Q. And what happened?

"A. I picked up an extra can of * * * garbage. It was grass, dirt and garbage mixed, and I picked it up, and twisted, and my back popped, and it was like it knocked the wind out of me." (Tr. 9-10).

Although claimant's testimony is probative here, whether claimant suffered a "new injury" in 1990 will also require analysis of the medical evidence. See Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

The medical record contains the opinions of Dr. Browning, a Kaiser Permanente (Kaiser) physician, Dr. Berselli, claimant's treating orthopedist, and Dr. Amodt, a chiropractor. Dr. Browning examined claimant on October 18, 1990 and stated that claimant's 1989 injury had resolved and, if claimant did not require medical services or was not disabled until the 1990 work incident, the 1990 incident was the major contributing cause of claimant's need for treatment. (Ex. 37).

On the other hand, Dr. Berselli, who became claimant's treating orthopedist four months after the 1990 incident, diagnosed chronic lumbar strain. (Ex. 25). Berselli opined that, while the 1990 work incident caused claimant to seek treatment, it did not cause or worsen the condition created by the 1989 injury. (Exs. 34 and 36). Finally, Dr. Amodt (whose associate Dr. Mann, evaluated and treated claimant one day after the 1990 work incident), opined that the 1990 incident represented an exacerbation of the 1989 injury and that the major cause of claimant's current condition and need for treatment is the 1989 injury. (Ex. 35).

After reviewing the medical record, we are most persuaded by the opinions of Dr. Berselli and Dr. Amodt who attribute claimant's pain and need for treatment in 1990 to the 1989 work injury. Their opinions recognize and are consistent with the fact that after the 1989 injury, claimant continued to have chronic pain. Dr. Amodt specifically noted that claimant's "history of discontinuing treatments prematurely has been to his detriment. That is, it is extremely unlikely that he could have corrected his conditions." (Ex. 32-1). On the other hand, we are not persuaded by Dr. Browning's opinion, particularly since she opined, contrary to the actual facts, that claimant's 1989 injury had resolved. Thus, we find that claimant was actually in need of medical treatment for the 1989 injury before the 1990 work incident, and claimant did not suffer a new compensable injury when he lifted objects at work and his preexisting 1989 back injury became more painful. Taylor v. Mult. Co. School District No. 1, 109 Or App 499 (1991).

Consequently, SAIF has not sustained its burden of proving a new injury for which Fire and Casualty is responsible under Section 49(1) of the 1990 Act. Accordingly, we affirm.

ORDER

The Referee's order dated June 5, 1991 is affirmed.

In the Matter of the Compensation of
SANTIAGO REYES, Claimant
WCB Case Nos. 91-01013 & 91-01012
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Baker's order that upheld the SAIF Corporation's denial of claimant's back injury claim and the "de facto" denial of claimant's hand injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Although the Referee found that claimant proved that he was hit on the back by a hay bale on October 18, 1990 and hurt his hand with a hay hook on December 16, 1990, the Referee concluded that the work incidents were not compensable, finding that claimant failed to prove they resulted in the need for medical services or disability. See ORS 656.005(7)(a). We disagree.

Claimant first sought treatment on January 11, 1991, shortly after he was fired for absenteeism. At that time, claimant was found to have "generalized tenderness" in the shoulder, hand, low back and leg. (Ex. 3A). He was diagnosed as suffering from "multiple muscular contusions and sprains" and prescribed physical therapy. (Id). After a recheck, a thoracic and lumbosacral strain was diagnosed. (Id). Claimant was told to continue physical therapy. (Id).

We find that claimant carried his burden in proving that his need for medical treatment was caused by the October and December work incidents. The

Referee found that claimant credibly testified that he experienced pain after the incidents and that his symptoms did not resolve until he was treated by the physician. The medical reports also recite the hay bale incident and provide no suggestion that claimant's symptoms were caused by any other event. In light of the physician's observations, evaluation, and diagnosis, claimant's claim is established by medical evidence supported by objective findings. ORS 656.005(19); Suzanne Robertson, 43 Van Natta 1505 (1991). Finally, claimant provided a reasonable explanation as to why he did not seek treatment until after he was terminated in January 1991, credibly testifying that he feared he would have been fired if he left work for a medical appointment. (Tr. 21).

Therefore, having found that claimant proved that he was injured at work (established by medical evidence supported by objective findings) and that the incidents required medical treatment, we conclude that his claims are compensable.

Claimant's counsel is entitled to a reasonable attorney fee for services rendered at hearing and on Board review for prevailing on the issue of compensability of claimant's injury claims. See ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review is $2,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (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 June 12, 1991 is reversed. The SAIF Corporation's denial of claimant's back injury claim and "de facto" denial of claimant's hand injury claim are set aside and the claims are remanded for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded $2,500, to be paid by the SAIF Corporation.

May 21, 1992 Cite as 44 Van Natta 1001 (1992)

In the Matter of the Compensation of
CHARLES W. ROLLER, Claimant
Own Motion No. 92-0024M
OWN MOTION ORDER
Rasmussen, et al., Claimant Attorneys

The self-insured employer submitted this claim for an alleged worsening of claimant's January 11, 1980 low back and left leg injuries. Claimant's aggravation rights expired on February 20, 1986. The employer has accepted the compensability of an emergency cardiac catheterization and recommends that we authorize the payment of temporary disability compensation. The employer also requests authorization for reimbursement from the Reopened Claims Reserve.

Claimant requested that he be awarded permanent total disability effective December 12, 1990, the date he was hospitalized for surgery. We consider claimant's request first.

Effective January 1, 1988, the legislature limited our own motion jurisdiction to the authorization of temporary disability compensation and certain medical benefits. ORS 656.278(1)(a) and (b). Thus, when a claimant's claim is reopened under our own motion jurisdiction, no additional permanent disability

compensation, including permanent total disability, can be awarded. Id.[1]

We may authorize, on our own motion, the payment of temporary disability compensation 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). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. Id.

Claimant has established that his diabetes mellitus is compensably related to his original low back and left leg injury. See Roller v. Weyerhaeuser Company, 67 Or App 583, 679 (1984); Weyerhaeuser v. Roller, 85 Or App 500 (1987); Charles W. Roller, 39 Van Natta 504 (1987). Dr. MacDowell, cardiologist, who saw claimant in consultation on December 12, 1990, when he was hospitalized with chest pain and an abnormal EKG, opined that the diabetes mellitus is the major contributing cause of claimant's diagnosed coronary atherosclerosis and cardiomyopathy. Therefore, we find that claimant's compensable injury has worsened requiring hospitalization.

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning December 12, 1990, the date he was hospitalized. When claimant is medically stationary, the employer shall close the claim pursuant to OAR 438-12-055.

Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45.

IT IS SO ORDERED.

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[1] We do not decide whether amendments to ORS 656.245, which provide for the compensability of palliative care if claimant is permanently and totally disabled, require that determination as a question of fact or law under ORS 656.245 without regard to whether claimant has been awarded PTD benefits. Claimant has not raised the issue, and it can not be determined until claimant is medically stationary.

In the Matter of the Compensation of
JAMES O. SEIBERT, Claimant
Own Motion No. 91-0722M
THIRD OWN MOTION ORDER ON RECONSIDERATION
Emmons, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our April 21, 1992 Own Motion Order on Reconsideration that denied the reopening of his claim on the ground that he had not provided evidence that he was willing to work, but unable to work or look for work, after May 22, 1990 until his surgery in January 1992. We found in our March 11, 1992 Own Motion Order that claimant's compensable condition had worsened and required surgery.

In order to prevail on this issue, claimant must prove that he was willing to work and that either: (1) he was making reasonable efforts to obtain work after May 22, 1990; or (2) reasonable efforts to obtain work would have been futile due to the compensable injury. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). Dr. Golden, claimant's treating neurologist, certifies

that claimant was continuously disabled from May 22, 1990 through January 13, 1992, the date he had surgery. Dr. Golden also states that claimant was willing to work but that it would have been unreasonable for claimant to attempt to work because of his compensable back injury and that any attempt would have been futile. (Letter of May 6, 1992). We accordingly find that claimant was willing to work but any attempt to work would have been futile after May 22, 1990.

We are persuaded that claimant's compensable injury has worsened requiring surgery. Consequently, we withdraw our April 7 and April 21, 1992 orders and authorize the reopening of claimant's claim to provide temporary total disability compensation beginning January 13, 1992, the date he was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-12-055.

Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45.

Finally, claimant's counsel is entitled to a reasonable attorney fee, payable out of the increased compensation awarded by this order. However, we cannot approve a fee unless claimant's attorney files a retainer agreement. See OAR 438-15-010(1). Because no retainer agreement has been received to date, an attorney fee shall not be approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
DEAN L. WATKINS, Claimant
WCB Case No. 90-17604
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Bottini, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of that portion of Referee Peterson's order that found that a Determination Order had prematurely closed claimant's jaw injury claim. Claimant cross-requests review of those portions of the Referee's order that: (1) found that claimant's low back condition was not compensable; and (2) declined to assess a penalty under ORS 656.262(10). Claimant also contends that, if the Board finds that claimant is medically stationary, he is entitled to permanent total disability benefits. On review, the issues are the effect of prior actions concerning this claim and penalties. We reverse in part and affirm in part.

PRELIMINARY MATTER

The Board issued orders on March 13, 1991 and April 19, 1991 relating to the same claim. Dean L. Watkins, 43 Van Natta 527 (1991). On April 1, 1992, both orders were affirmed without opinion by the Court of Appeals. Equipment Leasing Associates v. Watkins, 112 Or App 327 (1992). The employer moves to supplement the record with those subsequent Board orders or, alternatively, take administrative notice of the prior actions.

We may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned," including agency orders. See e.g. Grace B. Simpson, 43 Van Natta 1276,

1277 (1991). Inasmuch as the prior Board and court decisions meet the aforementioned standard, we shall take administrative notice of them.

FINDINGS OF FACT

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

On March 13, 1991, the Board issued its order reviewing Referee Lipton's September 20, 1989 order in WCB 89-02361. Dean L. Watkins, supra. The Board reversed the Referee's order which had set aside a Determination Order as premature. The Board found that claimant's jaw injury claim had not been prematurely closed by a February 22, 1989 Determination Order. Id. at 531. The Board also considered the compensability of claimant's current symptoms, including a low back condition, psychological condition, and bilateral temporomandibular joint (TMJ) condition. The Board concluded that only the psychological and TMJ conditions were compensable. Id. at 535. Finally, the Board found that claimant was not permanently and totally disabled, but that he was entitled to 8 percent unscheduled permanent partial disability. Id. at 535-38.

On April 19, 1991, the Board affirmed Referee Peterson's August 27, 1990 order in WCB 89-24358 which set aside the employer's "de facto" denial of TMJ surgery.

On April 1, 1992, the Court of Appeals affirmed the Board's March 13, 1991 and April 19, 1991 orders. Equipment Leasing Associates v. Watkins, supra.

CONCLUSIONS OF LAW AND OPINION

This case arose as a result of Referee Lipton's decision that claimant's jaw injury claim had been prematurely closed. In response to Referee Lipton's order, the claim was eventually reclosed pursuant to a June 4, 1990 Determination Order. Following a hearing, on February 20, 1991, the present Referee (Peterson) found that the June 4, 1990 Determination Order had prematurely closed the claim.

Subsequent to Referee Peterson's February 20, 1991 order, the Board reversed Referee Lipton's September 20, 1989 order which had found the February 22, 1989 Determination Order to have been premature. Dean L. Watkins, supra. Upon issuance of the Board's order, the February 22, 1989 Determination Order was reinstated. Thus, the June 4, 1990 Determination Order which had issued in response to Referee Lipton's order became moot.

Inasmuch as the Board's order has now been affirmed by the Court of Appeals, it has become the law of the case that the February 22, 1989 Determination Order properly closed the claim. Under such circumstances, the June 4, 1990 Determination Order is null and void. Consequently, the issues of medically stationary date, premature closure, and extent of permanent disability (including permanent total disability), which arise from the June 4, 1990 Determination Order, are moot.

Pursuant to its April 19, 1991 order, in determining the extent of claimant's permanent disability under the February 22, 1989 Determination Order, the Board found that claimant's back condition was not related to his 1983 compensable injury. Since that determination was essential to the Board's decision, claimant's claim that his low back condition is related to his compensable injury is barred by "issue preclusion" unless claimant's current condition is different from the condition found not compensable in the earlier decision. North Clackamas School Dist. v. White, 305 Or 48, 53, modified 305 Or 468 (1988). The

record fails to establish that claimant's current low back condition is different from the condition which we previously found unrelated to his compensable injury.

Therefore, we hold that claimant is precluded from establishing the compensability of his current low back condition. Alternatively, we agree with the Referee's conclusion that, in light of claimant's unreliability and the lack of medical evidence, claimant has not proven that his current low back condition is causally related to his 1983 compensable injury.

Claimant's remaining argument is that he is entitled to a penalty under ORS 656.262(10) for unreasonable refusal to pay compensation and delay in denying the claim. In this regard, claimant cites numerous allegedly unreasonable acts by the employer, including the employer's January 30, 1989 denial of treatment; request for claim closure on September 22, 1989, two days after the Referee found that claimant's jaw injury claim was prematurely closed; October 22, 1989 and November 13, 1989 denials of treatment; continuing failure to authorize TMJ surgery; failure to forward evidence to the Division regarding claimant's medically stationary status following its request for claim closure; and failure to respond to claimant's September 20, 1984 827 form.

At hearing, claimant sought penalties and attorney fees for the employer's allegedly unreasonable conduct in obtaining claim closure. (Tr. 8). Claimant did not raise any other claim processing issues at hearing. However, during written closing arguments, claimant asserted that the employer had failed to respond to claimant's 1984 claim for a low back condition. Without addressing whether claimant had properly raised the issue, the Referee declined to assess penalties and attorney fees, finding that it was unclear whether claimant's physician had related claimant's low back condition to the compensable injury and that, in any event, the condition was not compensable.

Inasmuch as the sole claim processing issue properly raised at hearing concerned the employer's conduct in submitting the claim for closure, we are not inclined to address the other claim processing charges raised by claimant on review. Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). Nevertheless, had we considered claimant's contentions, we would conclude that claimant has not established that the employer's conduct was unreasonable. Therefore, penalties and attorney fees would not be warranted.

ORDER

The Referee's order dated February 20, 1991 is reversed in part and affirmed in part. That portion of the order finding that claimant's jaw injury claim was prematurely closed is reversed. The June 4, 1990 Determination Order is null and void. The remainder of the order is affirmed.

In the Matter of the Compensation
DEAN L. WATKINS, Claimant
WCB Case No. 91-04219
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Bottini, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee Fink's order that: (1) directed it to recommence payment of temporary total disability benefits in accordance with Referee Peterson's February 20, 1991 order; and (2) assessed penalties for an unreasonable refusal to pay these temporary total disability benefits. On review, the issues are the effect of prior actions concerning this claim. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exception and supplementation. We do not adopt the last paragraph.

This date, we reversed Referee Peterson's February 20, 1991 order in WCB 90-17604. Dean L. Watkins, 44 Van Natta 1003 (1992). Specifically, we held that the June 4, 1990 Determination Order, which Referee Peterson had set aside as premature, was null and void. In doing so, we reasoned that a prior action had determined that the claim was properly closed by a February 22, 1989 Determination Order. See Dean L. Watkins, 43 Van Natta 527 (1991); aff'd mem, Equipment Leasing Associates v. Watkins, 112 Or App 327 (1992).

CONCLUSIONS OF LAW AND OPINION

To begin, we may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned," including agency orders. See e.g. Grace B. Simpson, 43 Van Natta 1276, 1277 (1991). Inasmuch as the prior Board and court decisions meet the aforementioned standard, we take administrative notice of them.

The employer commenced payment of compensation for temporary total disability effective the date of Referee Peterson's order, February 20, 1991. Referee Peterson had set aside a June 4, 1990 Determination Order as premature. The June 4, 1990 Determination Order had issued as a result of Referee Lipton's September 20, 1989 order which found that a February 22, 1989 Determination Order had been premature. On March 13, 1991, the Board reversed Referee Lipton's order and found that the February 22, 1989 Determination Order had properly closed the claim. Thereafter, the employer discontinued payment of this compensation effective March 13, 1991, the date the Board's Order on Review issued in Dean L. Watkins, supra, holding that the claim was properly closed in February 1989. Id., Ex. 4.

Referee Fink ordered the employer to recommence payment of temporary total disability compensation pursuant to Referee Peterson's February 20, 1991 order. We disagree.

Inasmuch as the February 22, 1989 Determination Order properly closed the claim, the June 4, 1990 Determination Order became null and void. Likewise, upon issuance of the Board's order reinstating the February 22, 1989 Determination Order, Referee Peterson's order setting aside the June 4, 1990 Determination Order became null and void. Consequently, once the February 22, 1989 Determination Order was reinstated, claimant was not entitled to additional

temporary disability arising from Referee Peterson's order concerning the June 4, 1990 Determination Order. See Robert W. Bright, Jr., 44 Van Natta 917 (1992).

Claimant argues that the employer could not unilaterally terminate temporary disability compensation because none of the requirements of ORS 656.268(3) were met. However, it is the law of the case that claimant's claim was properly closed in February 1989. Since the claim was no longer in open status as a result of the Board's March 13, 1991 order, claimant was no longer entitled to temporary disability compensation.

Because we conclude that claimant was not entitled to any temporary disability compensation, we find that the employer's action in terminating payment of that compensation was not unreasonable. Therefore, we reverse the Referee's award of penalties and attorney fees.

ORDER

The Referee's order dated May 20, 1991 is reversed. The assessed attorney fee of $2,000 is reversed.

May 22, 1992 Cite as 44 Van Natta 1007 (1992)

In the Matter of the Compensation of
JEFFERSON S. CASE, Claimant
WCB Case No. 91-03735
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Garrett, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Davis' order that upheld the self-insured employer's denial of reimbursement for a lumbar surgery. On review, the issue is medical services. We vacate.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the lumbar surgery was neither related to the compensable low back injury nor reasonable and necessary. We vacate.

In Michael A. Jaquay, 44 Van Natta 173 (1992), we held that there is no other procedure provided by ORS Chapter 656 for resolving disputes concerning the causal relationship between an injury and a need for medical services. Accordingly, where a denial is based on the ground that the need for medical services is not causally related to the compensable injury, the Board has jurisdiction. Michael A. Jaquay, supra; Ralph D. Stinson, Jr., 44 Van Natta 485 (1992). Thus, the Hearings Division has jurisdiction over the issue of causation regarding medical services.

Here, however, the employer's denial denied the lumbar surgery solely on the basis that it was not reasonable and necessary. (Ex. 9). Furthermore, at hearing, claimant's counsel represented and the employer's counsel agreed that the sole issue was the reasonableness and necessity of the lumbar surgery. (Tr.

2, 3). It was not until the closing arguments that the employer raised the issue of causation regarding the lumbar surgery.[1]

OAR 436-60-140(4) requires that when an insurer denies a claim, it must do so in a writing which states the factual and legal basis for the denial. We have held that an employer's denial frames the issues for hearing, and that an employer may not deny on one basis and then seek to raise another at hearing. Patricia N. Hall, 40 Van Natta 1873 (1988). See also, Runft v. SAIF, 303 Or 493, 496, n.1 (1987). And even more surely, an insurer may not deny on one basis, proceed at hearing on that basis and then, during closing arguments, raise a new basis of denial. See Ricardo Aguas, 42 Van Natta 2783 (1990), aff'd, 109 Or App 220 (1991); Edward A. Rankin, 41 Van Natta 1926, on recon, 41 Van Natta 2133 (1989). Accordingly, the Referee erred in addressing the causation issue, and we vacate that portion of the Referee's order.

Furthermore, we conclude that the Referee lacked jurisdiction to address the issue of the reasonableness and necessity of the lumbar surgery. Subsequent to the Referee's order, we held that under amended ORS 656.704(3) "matters concerning a claim" over which the Board, and thus the Hearings Division, has jurisdiction, do not include any dispute regarding medical treatment or fees for which a resolution procedure is otherwise provided in ORS Chapter 656. Stanley Meyers, 43 Van Natta 2643 (1991). ORS 656.327 provides a procedure for the resolution of disputes between a carrier and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of the rules regarding the performance of medical services."

Here, the denial contended that the lumbar surgery was not reasonable and necessary. We conclude that this denial presents a dispute concerning medical treatment that was allegedly inappropriate or ineffectual. Because such disputes are no longer matters concerning a claim, original jurisdiction lies exclusively with the Director. ORS 656.327; ORS 656.704(3); Stanley Meyers, supra. Accordingly, by operation of ORS 656.704(3) and 656.327(1)(c), the employer's denial of the treatment under ORS 656.262 is null and void as a matter of law, and the Referee was without jurisdiction to consider the matter. Kevin S. Keller, 44 Van Natta 225 (1992).

ORDER

The Referee's order dated August 19, 1991 is vacated.

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[1] Although the request for hearing and the employer's written response framed the issues as aggravation and medical services, at hearing, the attorneys for the respective parties represented that the "sole issue" was the reasonableness and necessity of surgery, and the case was tried on that basis.

In the Matter of the Compensation of
DOUGLAS K. DVORAK, Claimant
WCB Case No. 90-13121
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Hoguet's order which dismissed his hearing request concerning claimant's contention that his scheduled permanent disability should be paid at $305 per degree. The Referee took this action in light of the Board's decision that claimant was not entitled to additional scheduled permanent disability. Douglas K. Dvorak, 43 Van Natta 1035, 1281 (1991).

On January 15, 1992, the Court of Appeals affirmed the Board's decision in Dvorak without opinion. Dvorak v. Liberty Communications, 110 Or App 634 (1992). Inasmuch as it is the law of the case that claimant is not entitled to additional scheduled permanent disability, it follows that claimant's hearing request concerning whether a nonexistent award should be paid at a rate of $305 is moot. Consequently, we affirm the Referee's dismissal order.

ORDER

The Referee's order dated May 17, 1991 is affirmed.

In the Matter of the Compensation of
MELVA J. GREGORY, Claimant
WCB Case No. 91-01197
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of that portion of Referee McWilliam's order that found that claimant's counsel was entitled to a $2,200 attorney fee under ORS 656.386(1). On review, the issue is amount of attorney fees. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On January 23, 1991, SAIF issued a partial denial stating that "[a] review of a recent medical report indicates that treatment you are seeking and prescriptions for which you are seeking reimbursement are unrelated to the [] original 1974 injury. Therefore, we must respectfully deny ongoing benefits." (Ex. 1). On behalf of claimant, her attorney filed a request for hearing regarding the denial on January 29, 1991. On February 27, 1991, SAIF rescinded the denial, explaining that it "was issued in error and what we intended to do was to deny payment of prescriptions for Premarin and Provera. These are hormones and I think the pharmacy billed us in error, but we should have checked that out prior to taking any action." (Ex. 2).

The Referee concluded that claimant's attorney was entitled to a $2,200 fee, finding that he was instrumental in obtaining compensation for claimant by causing SAIF to rescind its denial. See ORS 656.386(1); Jones v. OSCI, 108 Or App 230, 232 (1991). SAIF does not contest this conclusion, but asserts that the amount of the fee is unreasonable and requests a reduction.

In determining the amount of the fee, the Referee correctly considered those factors set forth in OAR 438-15-010(4). In applying those factors on review, we first note that the record establishes that claimant's counsel's efforts in affecting SAIF's rescission of its denial were modest, consisting principally of submitting a hearing request. Furthermore, the denial primarily concerned claimant's entitlement to medication, which, although of some benefit to claimant, does not present the complexity or value that would be presented by a denial of compensability or aggravation. With regard to the nature of the proceeding, the record demonstrates that SAIF rescinded the denial approximately one month after the request for hearing was filed and two months before the scheduled hearing, thereby promptly limiting the issues at hearing to penalties and attorney fees well in advance of hearing.

Finally, as the Referee found, because of the contingency nature of the fee arrangement between claimant and her attorney, there is a risk that the work may go uncompensated. The Referee also noted that both claimant's and SAIF's attorneys had a high level of competence.

Having considered the factors set forth in OAR 438-15-010(4), we find that a reasonable attorney fee is $750. See Kimberly Wayne, 44 Van Natta 328 (1992).

Finally, we note that claimant's counsel has submitted a statement for services on review. However, when the issue on review solely concerns attorney fees, there is no entitlement to an award for services on review. See e.g. Dotson v. Bohemia, Inc., 80 Or App 233, 236 (1986).

ORDER

The Referee's orders dated May 24, 1991, as amended June 10, 1991 and August 1, 1991, are modified. The Referee's award to claimant's counsel of $2,200 is reduced to $750, payable by SAIF. The remainder of the order is affirmed.

In the Matter of the Compensation of
KATHERN A. KNIGHTEN, Claimant
WCB Case No. 90-15985
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of those portions of Referee Brown's order which: (1) set aside its "de facto" denial of proposed carpal tunnel surgery; (2) awarded a $100 attorney fee for allegedly unreasonable claim processing; and (3) set aside a Determination Order as premature. In her respondent's brief, claimant moves to strike the insurer's appellant's brief as untimely filed. On review, the issues are motion to strike appellant's brief, medical services, premature closure and extent of scheduled permanent disability. We deny the

motion, vacate the Referee's surgery decision, reverse the Referee's premature closure finding, and affirm the Evaluation Section's Order on Reconsideration.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant objects to the Board's administrative decision which granted the insurer's request for an extension of time in which to file its appellant's brief. We adhere to our prior decision that the insurer's request was based on extraordinary circumstances beyond the control of the party requesting the extension. See OAR 438-11-020(3). Accordingly, the motion to strike appellant's brief is denied.

Medical Services

This dispute concerned whether claimant's proposed carpal tunnel surgery was reasonable and necessary treatment. The Referee reasoned that since the insurer had failed to accept, deny or refer this medical services dispute to the Director within 90 days, jurisdiction over this matter rested with the Hearings Division. We disagree.

Subsequent to the Referee's order, we concluded that original jurisdiction over such disputes is no longer shared by the Director and the Hearings Division. Stanley Meyers, 43 Van Natta 2643 (1991). Rather, because such disputes do not constitute matters concerning a claim, original jurisdiction lies exclusively with the Director. See ORS 656.704(3); 656.327(1)(a); Stanley Meyers, supra. We have further reasoned that disputes regarding proposed medical treatment, as well as those regarding current medical treatment, are within the Director's original jurisdiction in accordance with ORS 656.327. Kevin S. Keller, 44 Van Natta 225 (1992). Inasmuch as this dispute regarding the appropriateness of a proposed surgery did not raise a matter concerning a claim within the jurisdiction of the Hearings Division, we vacate the Referee's order which set aside the insurer's "de facto" denial.

The insurer contends that claimant's hearing request was premature. However, even if the hearing request was timely, the Board would still not have jurisdiction to address the reasonableness and necessity of the proposed carpal tunnel surgery. Accordingly, we find it unnecessary to address the insurer's contention.

In light of our jurisdictional decision, we conclude that the insurer properly sought Director review of this dispute pursuant to ORS 656.327. Therefore, we do not find the insurer's conduct to have been unreasonable.

Premature Closure

Inasmuch as the Referee found that the proposed surgery was reasonable and necessary, the Referee also held that the claim had been prematurely closed. Accordingly, the Referee set aside the Determination Order. In light of our decision that the Director had original jurisdiction over this dispute, and since the premature closure issue was solely contingent on claimant's need for the proposed surgery, it follows that the resolution of the premature closure issue should have awaited the Director's decision as to whether the proposed

surgery is appropriate. Consequently, the premature closure issue should have been deferred by the Referee pending Director resolution of the medical services dispute. See Gary L. Waldrupe, 44 Van Natta 702 (1992).[1]

Nevertheless, the Director subsequently issued an order finding that the proposed surgery is not appropriate medical treatment. This date, we have affirmed a later Referee's decision that the Director's order was supported by substantial evidence. Kathern A. Knighten, 44 Van Natta 1013 (1992). In light of that decision, and since we find the record sufficiently developed, we address the premature closure issue at this time.

The sole basis for the Referee's decision that claimant's claim was prematurely closed was his decision that the carpal tunnel surgery was reasonable and necessary medical treatment for claimant's compensable condition. In our companion decision issued on this date, we have found that the Medical Director's order, which held that the proposed surgery was inappropriate, was supported by substantial evidence. It follows, then, that since the surgery is not reasonable and necessary treatment, the claim was not prematurely closed. Accordingly, we reinstate the Determination Order and address the extent of scheduled permanent disability.

Extent of Scheduled Permanent Disability

The Referee did not reach the issue of extent as he set aside the Determination Order on the basis that it was premature. We have reinstated the Determination Order. Inasmuch as we find the record sufficiently developed to decide the issue, we proceed to rate claimant's permanent disability.

A September 5, 1990 Determination Order awarded claimant 20 percent (30 degrees) scheduled permanent disability for loss of use or function of the right forearm. A subsequent Order on Reconsideration decreased this award to 5 percent (7.5 degrees) for the right forearm and also awarded 5 percent (7.5 degrees) for the left forearm.

Claimant has normal range of motion in her wrists. The record contains no expert medical evidence that claimant has decreased grip strength due to nerve damage, atrophy or other anatomical changes. Therefore, no award is appropriate under OAR 436-35-110(3).

OAR 436-35-010(8) provides that a worker may be entitled to scheduled chronic condition impairment when a preponderance of medical opinion establishes that the worker is unable to repetitively use a body part due to a chronic and permanent medical condition. The phrase "body part" includes the wrist. Id. Dr. Nelson, orthopedic surgeon, of the Orthopaedic Consultants recommended that claimant should "avoid repetitive fine hand movement." Such a restriction establishes that claimant had sustained permanent impairment as a result of her compensable bilateral wrist condition. Moreover, Dr. Bitter, claimant's treating hand surgeon, concurred with Dr. Nelson's report. Under such circumstances, we conclude that claimant is entitled to an award of 5 percent scheduled permanent disability for each forearm. OAR 436-35-010(1); OAR 436-35-010(8)(a). Accordingly, the Order on Reconsideration is affirmed.

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[1] In Waldrupe, we recommended a procedure to deal with deferred issues in which referees would direct the Central Files Section of the Hearings Division to create a new WCB case number to be assigned to the deferred issue(s). This procedure allows a referee to issue a final, appealable order resolving those issues which are presently viable, while assigning another WCB number to those issues which must be deferred pending Director review.

ORDER

The Referee's order dated September 9, 1991 is reversed in part and vacated in part. That portion of the Referee's order which set aside the Determination Order is reversed. The Order on Reconsideration is reinstated and affirmed. That portion of the Referee's order which set aside the insurer's "de facto" denial of carpal tunnel surgery is vacated. The Referee's penalty-related attorney fee of $100, and his assessed attorney fee award of $2,000 for claimant's counsel's services on the "de facto" surgery denial are also vacated.

May 22, 1992 Cite as 44 Van Natta 1013 (1992)

In the Matter of the Compensation
KATHERN A. KNIGHTEN, Claimant
WCB Case No. 91-14319
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Michael Johnson's order which affirmed a Medical Director's order finding that claimant's proposed surgery was not appropriate. On review, claimant contends that the Medical Director lacked jurisdiction to consider the surgery dispute, or alternatively, that the Referee erred in finding that the Medical Director's order was supported by substantial evidence.

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

This date, we have vacated that portion of a prior Referee's order which concluded that the Hearings Division had original jurisdiction to address this surgery dispute. Kathern A. Knighten, 44 Van Natta 1010 (1992). Based on the reasoning expressed in that decision, we hold that the Medical Director had jurisdiction to resolve this dispute pursuant to ORS 656.327.

The Referee found that substantial evidence in the record supports the Director's finding that claimant's proposed surgery was not appropriate medical treatment. We agree.

ORS 656.327(2) sets out the standard for review of the Director's order. It provides in pertinent part: " * * * Review of a Director's order shall be as provided in ORS 656.283 in accordance with expedited hearing procedures established by the Board, except that the order of the Director may be modified only if the order is not supported by substantial evidence in the record." Substantial evidence exists to support a finding when the record, viewed as a whole, would permit a reasonable person to make that finding. Armstrong v. Asten-Hill Co., 90 Or App 200 (1988). If a finding is reasonable in light of countervailing as well as supporting evidence, the finding is supported by substantial evidence. Garcia v. Boise Cascade, 309 Or 292 (1990); Armstrong v. Asten-Hill Co., supra at 206.

Here, the Director relied on the opinion of the medical reviewer, Dr. Englander, neurologist, which was supported by the opinions of Drs. Jewell and Nelson. The Director also considered the opinion of Dr. Streitz and Dr. Bitter. We conclude that the record, viewed as a whole, would permit a reasonable person

to rely on Dr. Englander's medical opinion, as supported by the majority of the other medical experts. Moreover, such a finding is reasonable in light of the countervailing, as well as supporting, evidence. Finally, such a finding and reasoning substantiates the Medical Director's conclusion that the proposed surgery is not appropriate treatment. Accordingly, we conclude that the Director's order is supported by substantial evidence.

ORDER

The Referee's order dated February 10, 1992 is affirmed.

In the Matter of the Compensation of
SUSAN LYNCH, Claimant
WCB Case No. 90-17248
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Pam Schultz, Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of those portions of Referee McWilliam's order that: (1) affirmed a Notice of Closure determining that claimant was medically stationary on January 1, 1990; and (2) found no basis for awarding unscheduled permanent partial disability. On review, the issues are premature closure and extent of unscheduled permanent partial disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

The Notice of Closure, which issued on August 27, 1990, found claimant medically stationary on January 1, 1990. The Referee agreed that the medical evidence proved that claimant was medically stationary on that date and accordingly concluded that the claim was not prematurely closed. Claimant objects to this conclusion, contending that the medical evidence does not support a conclusion that claimant was medically stationary on the date of the Notice of Closure.

Under ORS 656.268(1), claims shall not be closed if the worker's condition has not become medically stationary. "Medically stationary" means that "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). It is claimant's burden to show that she was not medically stationary on the date of closure. Berliner v. Weyerhaeuser, 54 Or App 624, 628 (1981). In determining whether claimant has carried this burden, we examine medical evidence available at the time of closure, as well as evidence submitted after closure; however, medical evidence submitted after closure that pertains to changes in claimant's condition subsequent to closure is not properly considered. Scheuning v. J. R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (1987).

Claimant contends that she was not medically stationary at any time prior to the January 10, 1991 hearing. In attempting to prove that she was not

medically stationary, claimant relies on chart notes from Dr. Reeves, D.O., and Dr. Matteri, her current treating physician, as well as a November 9, 1990 report from the Western Medical Consultants, stating that claimant was "not yet medically stationary." (Ex. 39-5).

Claimant injured her low back on September 1, 1989. She sought treatment for back pain from the Fernridge Medical Clinic until October 26, 1989; the clinic is made up of Drs. Bailey and Saavedra and Charles Roberts, P.A. Claimant also saw Dr. Matteri on December 8, 1989. Because she was pregnant, claimant did not see Matteri again until August 1990. On that visit, Matteri found only "a little bit of local pain over the lumbosacral junction." (Ex. 44-1). Dr. Reeves, D.O., who treated claimant in September and October 1990, also found some low back pain, but reported that claimant was "in no acute distress." (Ex. 36-1).

On October 24, 1990, however, claimant suffered a sudden increase in back pain. Matteri found that claimant "was having a symptomatic exacerbation of a pre-existing underlying condition." (Ex. 44-1). He further stated that he did not

> "believe that [claimant's] back symptoms have been continuous and ongoing, and I do concur that back in January 1990, [claimant] was medically stationary. She has an anatomic congenital underlying condition which predisposes her, with her rather slight body build, to have intermittent back pain. * * * It is impossible to differentiate between limitations due to her September 1, low back strain and limitations which may be attributable to her congenital anomaly as they are one in the same." (Id. at 2).

Based on Dr. Matteri's opinion, we find that claimant's condition changed after October 24, 1990 in that her back symptoms increased. Having determined that claimant's condition changed after that date, we do not consider any medical evidence pertaining to claimant's medical status after October 24, 1990, including the November 9, 1990 report of the Western Medical Consultants. Moreover, the Consultants' opinion was apparently premised on a need for further diagnostic services (CT scan). However, suggested diagnostic services do not establish that a claimant is not medically stationary. Bobby G. Todd, 42 Van Natta 1648 (1990).

The remaining evidence consists of a June 25, 1990 report by Dr. Bailey, M.D., who stated that he "assumed" that claimant was medically stationary as of January 1, 1990. (Ex. 30) Bailey based his conclusion on the fact that claimant had not sought treatment since October 26, 1989, and the physician's assistant's report on that date that claimant's back strain was resolving. (Id). As stated above, claimant's treating physician, Dr. Matteri, concurred with Dr. Bailey's opinion that claimant was medically stationary in January 1990. (Ex. 44-2).

The only evidence that could be construed as disputing the opinions of Drs. Bailey and Matteri is that of Dr. Reeves. Reeves reported that claimant's "low back injury was probably medically stationary" as of October 8, 1990. (Ex. 37). However, we do not find Reeves' opinion to be as reliable as that of Matteri since, unlike Matteri, Reeves did not first see claimant until September 1990, a year after her injury, and he treated her on only four occasions. Thus, we find that claimant did not carry her burden of proof in demonstrating that she was not medically stationary as of August 27, 1990 and we conclude that the claim was not prematurely closed.

Permanent Disability

Finally, claimant contends that she is entitled to permanent disability. We affirm and adopt that portion of the Referee's amended order regarding the extent of permanent disability.

ORDER

The Referee's order dated February 27, 1991, as amended June 18, 1991, is affirmed.

May 22, 1992 Cite as 44 Van Natta 1016 (1992)

In the Matter of the Compensation of
ANNIE M. NEUBERGER, Claimant
WCB Case No. 90-12870
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of that portion of Referee Knapp's order that set aside its July 18, 1990 denial insofar as it denied claimant's cervical disc injury claim. In its brief, the employer also asks the Board to uphold its May 21, 1991 denial of medical services and denial of responsibility for any treatment or disability resulting from an unrelated April 1991 motor vehicle accident, contending the Referee did not address these issues in the order. In her respondent's brief, claimant contends that he Referee erred in denying claimant's request for penalties for the employer's allegedly unreasonable denial.[1] On review, the issues are compensability, medical services, and penalties. We affirm on the issues of compensability and penalties, set aside the medical services denial, and decline to consider the denial of responsibility for any treatment or disability resulting from the April 1991 motor vehicle accident.

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1. Claimant's respondent's brief was due no later than September 30, 1991. Claimant mailed the brief (of 19 pages) to the Board on October 2, 1991 under a cover letter requesting an extension of time to October 2 to file the brief. The letter explained the significant reasons for the untimeliness, and also represented that the employer's attorney had no objection to the request for an extension. The Board denied the request for an extension due to claimant's failure to show extraordinary circumstances justifying the untimely filing. OAR 438-11-020(3). Ordinarily, the Board will not consider a brief that is untimely filed unless a request for an extension is granted. Here, however, the employer timely submitted a reply brief, evidently due to a misunderstanding about the nature and affect of the Board's ruling. Under these unusual circumstances, and given the complexities of this case (both procedurally and on the merits), we have granted an exception to the rule, and accordingly, have considered the respondent's and reply briefs filed by claimant and the employer respectively. However, the fact of the untimely filing will be considered by the Board on the question of attorney fees for claimant's counsel's services on Board review.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and "Ultimate Finding of Fact," as supplemented.

Claimant's treating chiropractic physician, Dr. Wheeler, filed an 827 Form regarding claimant's cervical condition on April 30, 1990. Claimant filed an 801 Form on approximately May 1, 1990.

Claimant filed a Request for Hearing on June 18, 1990, concerning the employer's alleged failure to timely accept or deny her claim.

The employer denied, inter alia, the compensability of claimant's cervical condition on July 18, 1990. On July 25, 1990, claimant supplemented her hearing request to include the July 18, 1990 denial.

The employer issued a second denial on May 21, 1991 contending that: (1) claimant's cervical discectomies and fusions were not causally related to her work for the employer; and (2) it is not responsible for any treatment or disability resulting from an unrelated April 1991 motor vehicle accident.

On May 22, 1991, claimant supplemented her hearing request to include the May 21, 1991 medical services denial.

The hearing was held on May 22, 1991. The parties identified the issues as the propriety of the employer's July 18, 1990 compensability denial and May 21, 1991 medical services denial. Claimant's attorney indicated that he had prepared for the hearing with the issue of cervical surgery in mind; similarly, the employer's attorney noted that the employer had issued the May 1991 denial to assure the parties had an opportunity to litigate the issue of surgery at the hearing. The parties agreed to defer and preserve the issue of the employer's May 1991 denial of responsibility for any treatment or disability resulting from the April 1991 motor vehicle accident.

Claimant's C5-6 and C6-7 discectomies and fusions were causally related to her work for the employer.

CONCLUSIONS OF LAW AND OPINION

Compensability

We affirm and adopt the Referee's reasoning and conclusions that claimant's cervical herniated discs are compensable, with the following comments.

On review, the employer argues that no injurious event occurred on April 10, 1990. We understand the employer to assert that claimant has a tendency to somatasize, and thus, her testimony about the event should not be credited as true. However, we are satisfied by claimant's testimony and the great weight of the medical evidence that on April 10, 1990, an injurious event occurred as claimant described. Here, the real issue is a complex medical question: whether the disc lesions found by objective examinations were caused, in major part, by the April 10, 1990 work incident. The Referee resolved the question in claimant's favor. We agree.

The employer argues that claimant has failed to prove that she sustained a compensable injury because her symptoms after the April 1990 injury were the same as those she complained of after a 1987 injury. We disagree. A compensable injury is established by medical evidence supported by objective findings. ORS 656.005(7)(a). The last examination of claimant prior to the April 1990

injury was the Orthopedic Consultants' December 1988 independent examination. At that time, claimant reported that her earlier hand numbness had completely resolved. Moreover, the Consultants found no evidence of cervical radiculopathy, and noted that claimant's physical examination was entirely normal.

After her April 1990 injury, claimant developed left upper extremity numbness, tingling and cervical radiculopathy. Earlier x-rays revealed slight foraminal narrowing and osteophytes at the C5-6 level with no disc space narrowing. An MRI performed in June 1990 and an MRI and myelogram performed in February 1991 reveal a progression of claimant's underlying degenerative condition, and, most significantly, new findings of herniated C5-6 and C6-7 discs (or lesions) with amputation of the nerve roots, compatible with the type of injury claimant sustained.

Finally, the employer questions the diagnoses of herniated C5-6 and C6-7 discs, because "there is no mention" in the surgical report of "removal of disc material." However, the operative report clearly states that claimant underwent two discectomies and two fusions.

May 21, 1991 Denial

The employer also requests that this Board address its May 21, 1991 denial of claimant's cervical surgeries and denial of responsibility for any treatment or disability resulting from an unrelated April 1991 motor vehicle accident. At hearing, the parties agreed that the only issues were the July 18, 1990 compensability denial and May 21, 1991 medical services denial. They agreed to defer and preserve that portion of the May 1991 denial concerning the issue of responsibility for any treatment or disability resulting from the April 1991 motor vehicle accident. Therefore, we conclude that only that portion of the May 1991 denial pertaining to claimant's cervical surgery claim was properly at issue at hearing. Accordingly, we consider the compensability of that surgery, but we do not consider the remainder of the employer's May 1991 denial in accordance with the parties agreement at hearing.

As a preliminary matter, we note that in Michael A. Jaquay, 44 Van Natta 173 (1992), we held that there is no procedure provided by ORS Chapter 656 for resolving disputes concerning the causal relationship between an injury and a need for medical treatment. Therefore, such disputes are "matters concerning a claim" over which we have jurisdiction. See ORS 656.704(3). Accordingly, where an employer has denied that the need for medical services is causally related to the compensable injury, the Board has jurisdiction over this aspect of a medical services dispute. Michael A. Jaquay, supra.

The employer denies that claimant's need for surgery was causally related to a compensable injury. The employer did not deny that the surgery was reasonable and necessary treatment for claimant's cervical disc condition. Thus, we retain jurisdiction over this medical services dispute. Michael A. Jaquay, supra.

The employer concedes that if a work-related injury on April 10, 1990 caused the cervical herniations, claimant's surgery is compensable. We have herein affirmed the Referee's conclusion that claimant's herniated cervical discs are compensable. We find, therefore, that the C5-6 and C6-7 discectomies and fusions to treat claimant's cervical disc conditions are likewise compensable. Accordingly, that portion of the employer's May 21, 1991 denial that denied claimant's claim for cervical surgery is set aside.

Inasmuch as we have set aside that portion of the employer's May 21, 1991 denial concerning the causal relationship of claimant's surgery claim, claimant

is entitled to an assessed attorney fee for services at hearing and on review. ORS 656.386(1).

Penalties

We affirm and adopt the conclusion and reasoning of the Referee on the question of penalties.

Attorney Fees

Claimant is entitled to an assessed attorney fee for prevailing on that portion of the employer's May 21, 1991 denial that denied the causal relationship of her cervical surgery. ORS 656.386(1). Moreover, because the employer initiated the request for review concerning the compensability of claimant's cervical disc condition (denied by the July 1990 denial), and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is also entitled to an assessed fee for services on review 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 assessed attorney fee for claimant's counsel's services at hearing and on review concerning the denied causal relationship in the May 1991 denial is $2,300, to be paid by the employer. We further find that a reasonable assessed attorney fee for claimant's counsel's services on review concerning the compensability of the cervical disc condition denied by the July 1990 denial is $450, also payable by the employer. In reaching these conclusions, we have particularly considered the time devoted to the case (as represented the hearing record and claimant's untimely, but considered, appellate brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated June 24, 1991 is affirmed in part, reversed in part, and modified in part. The self-insured employer's May 21, 1991 denial is partially set aside. That portion of the employer's denial which denied claimant's cervical surgery claim is set aside, and the claim is remanded to the employer for acceptance and processing in accordance with the law. For services at hearing and on review concerning this issue, claimant's counsel is awarded an assessed attorney fee of $2,300, payable by the self-insured employer. That part of the May 21, 1991 denial which denied responsibility for any treatment or disability resulting from an unrelated April 1991 motor vehicle accident is deferred and will not be considered pursuant to the parties' agreement at hearing. The remainder of the Referee's order is affirmed. For services on review concerning the July 1990 denial issue, claimant's counsel is awarded $450, to be paid by the self-insured employer.

In the Matter of the Compensation of
JOHN E. PERKINS, Claimant
WCB Case No. 91-03986
ORDER ON REVIEW
Flaxel, et al., Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Seifert's order which upheld the SAIF Corporation's denial of claimant's injury claim for a congestive epididymitis condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, as modified and supplemented below.

On September 5, 1990, claimant was injured when he lifted an approximately 150-pound truck tire out from underneath a trailer. (Tr. 9, Ex. 7).

Dr. Uno, claimant's treating urologist, had treated him in 1988 for right testicular swelling, which he diagnosed as "probable congestive epididymitis with hydrocele active anteriorly." (Ex. 2-9 to 2-10). Dr. Uno never confirmed the diagnosis of congestive epididymitis, but he did perform a right hydrocelectomy on July 1, 1988. (See Exs. 2, 3, 4).

By August 9, 1988, claimant had recovered from his surgery, and Dr. Uno reported his testes were normal. (Ex. 1-4). Claimant had no further testicular problems until the September 5, 1990 lifting incident at work, for which he sought treatment from Dr. Uno on November 16, 1990. (Ex. 1-4 to 1-6).

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's compensable injury combined with a preexisting condition to cause or prolong his disability or need for treatment. Because he found that the compensable injury was not the major contributing cause of claimant's resultant condition, he upheld SAIF's denial of the claim. We disagree.

We find that claimant did not have any preexisting condition or disease that combined with his work injury to cause or prolong disability or need for treatment. The medical record does not reveal that claimant had congestive epididymitis previously. Moreover, even if it had, the medical record reveals that claimant had fully recovered by at least November 1988 from the conditions Dr. Uno treated in 1988. Therefore, we conclude that claimant did not have a preexisting congestive epididymitis condition that combined with his September 5, 1990 work injury to cause or prolong his disability or need for treatment.

SAIF contends that claimant's vasectomy, performed in approximately 1973, also is a preexisting condition for purposes of ORS 656.005(7)(a)(B). We disagree. Dr. Uno explained that the vasectomy is a prerequisite for developing congestive epididymitis because the vasectomy causes elevated tubule pressure in the epididymis and predisposes to leakage of the contents. When these factors combine with trauma or straining, congestive epididymitis may develop. Dr. Uno explained that both elevated tubule pressure, caused in major part by claimant's vasectomy, and straining and trauma are major components for the etiology of congestive epididymitis. He identified the straining and trauma as causing the congestive epididymitis. (Ex. 9).

Dr. Bailey, a urologist who performed a records review and an independent medical examination, explained that the epididymis tends to become more prominent after a vasectomy. However, he noted that this does not usually produce any untoward symptoms. (Ex. 15-2). In this regard, we note that claimant apparently had no prior problems related to epididymal fullness, and that Dr. Bailey was impressed with claimant's forthright cognizance of his body. (See Ex. 18-2, Tr. 7). Dr. Bailey does not identify the vasectomy, nor any related condition, as a preexisting disease or condition which combined with the compensable injury to cause or prolong claimant's disability or need for treatment. (See Exs. 15, 18).

Based on the medical explanations in the record, we conclude that the vasectomy was a predisposition, a special susceptibility to contracting congestive epididymitis, but not a disease or pathological condition itself. See Rodney T. Buckallew, 44 Van Natta 358, 360 (1992); Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566, 569 (1991).[1] Accordingly, we conclude that the vasectomy is not a preexisting disease or condition within the meaning of ORS 656.005(7)(a)(B).

SAIF also contends that claimant's congestive epididymitis condition should be classified as a consequential condition, pursuant to ORS 656.005(7)(a)(A), secondary to claimant's accepted back strain, which was caused by the September 5, 1990 lifting incident at work. Claimant contends that the congestive epididymitis was a direct result of the lifting incident, not a secondary consequence of the compensable back strain condition. We agree with claimant's analysis.

We have previously distinguished between direct or primary consequences of an industrial accident and secondary consequences. The former we defined as those "conditions intrinsically related to the underlying industrial accident," while the latter we interpreted in the context of ORS 656.005(7)(a)(A) as meaning "complications or related problems that arise from conditions previously deemed compensable." Julie K. Gasperino, 43 Van Natta 1151, 1152-53 (1991) (emphasis added). Where to draw the line between primarily and secondarily consequential conditions we said is a question of "medical cause and effect which must be determined on a case by case basis." Id. at 1153.

In this case, we find that claimant's congestive epididymitis condition was caused not by complications arising out of his compensable back strain, but

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1. Dr. Uno is clearly not a lawyer or a grammarian. Certain statements in his report (Ex. 9) can be misleading and misunderstood if taken out of context. One source of the problem is that the issue was not framed for the doctors in terms of susceptibility versus cause. However, we are persuaded that he addresses that issue consistent with our understanding, perhaps not cogently, on page 2 of his report, as follows:

> "Congestive epididymitis [inflammation of the epididymis] results from the elevated tubule pressure in the epididymis secondary to obstruction secondary to vasectomy which predisposes to leakage of contents with trauma, strain, etc."

In other words, the elevated tubule pressure following the vasectomy predisposed claimant to congestive epididymitis upon the occurrence of some traumatic or straining event. Thus, the vasectomy was at most a susceptibility or predisposition, whereas the work injury caused the epididymitis.

rather it was caused directly by the lifting incident. When he examined claimant after the industrial injury, Dr. Uno diagnosed sacroiliac (SI) joint strain and congestive epididymitis bilaterally "since his straining episode 2-1/2 months ago." (Ex. 1-7). Later, Dr. Uno explained that the severe straining episode of September 5, 1990, set claimant up for the epididymitis, as well as for the SI joint strain. (Ex. 9-1). He stated that the "straining and trauma which caused the epididymitis is [sic] . . . a necessary component for the etiology of congestive epididymitis." (Ex. 9-1). Based on Dr. Uno's opinion, we conclude that the lifting incident at work directly caused both the SI joint strain and the congestive epididymitis.

Dr. Bailey, a urologist who conducted an independent medical examination on May 31, 1991, suggested that "in some way the genital discomfort [claimant] experiences relates to a radiation effect from pain that emanates from his back." However, he deferred a more definitive causal analysis to a neurologist or orthopedist. (Ex. 18-3). Consequently, Dr. Bailey's suggested causal analysis does not cause us to reject Dr. Uno's opinion.

Because we have concluded that the September 5, 1990 lifting incident at work directly caused claimant's congestive epididymitis, the condition will be compensable if claimant establishes that the work incident was a material contributing cause of his disability or need for treatment. ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). Based on Dr. Uno's initial examination, progress notes, and opinion letter, as discussed above, we conclude that claimant has carried his burden. We find no persuasive reason not to rely on the treating doctor's opinion in this case. Weiland v. SAIF, 64 Or App 810, 814 (1983).

Dr. Bailey agreed that epididymitis can develop as a result of a lifting or straining incident, and that it usually presents itself within 2 or 3 days of the straining event. However, he questioned the role of the straining episode in this case because of the apparently nonacute, insidious presentation over a 2-1/2 month period. (Ex. 15-1). At that time, Dr. Bailey had not examined claimant, and he acknowledged that it was "difficult to reach any solid conclusions" without an examination. (Ex. 15-2). Moreover, claimant testified that after about three days he discovered "knots" in his testicles and that he has a high tolerance to pain. (Tr. 12). Therefore, we are not persuaded by Dr. Bailey's initial opinion letter based only on a review of medical records. (Ex. 15).

After examining claimant on May 31, 1991, Dr. Bailey opined that he has "little doubt" that claimant's pain relates to his work injury, although he questioned whether it relates specifically to the epididymis, or whether it emanates from his back. (Ex. 18-2 to 18-3). However, we have previously stated that we give little weight to Dr. Bailey's causation analysis because he defers to more qualified medical experts. Consequently, we rely on Dr. Uno's opinion, both because he is the treating doctor and because there is no persuasive contrary opinion.

Accordingly, we conclude that claimant has established that the September 5, 1990 lifting incident at work was a material contributing cause of his disability or need for treatment resulting from his congestive epididymitis condition. Therefore, SAIF's denial shall be set aside.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). Inasmuch as he was represented only at the Board level, his counsel will receive a fee only for those legal 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 attorney fee for claimant's

counsel's services on review concerning the compensability issue is $1,425, 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 appellate briefs and counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney might go uncompensated.

ORDER

The Referee's order dated July 17, 1991 is reversed. The SAIF Corporation's denial is set aside, and the claim is remanded to SAIF for processing according to law. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,425, payable by SAIF.

May 22, 1992 Cite as 44 Van Natta 1023 (1992)

In the Matter of the Compensation of
GLORIA J. SCRIVEN, Claimant
WCB Case Nos. 91-08719 & 91-07641
ORDER OF DISMISSAL (REMANDING)
Goldberg & Mechanic, Claimant Attorneys
Norman Cole (Saif), Defense Attorney
Daryl Nelson, Defense Attorney

The SAIF Corporation has requested review of Referee Neal's December 27, 1991 order, which found it responsible for claimant's current low back condition. SAIF acknowledges that its request for review is submitted more than 30 days after the date of the Referee's order. However, SAIF notes that it was not mailed a copy of the order and only recently received notice of the decision. We hold that the Referee's order was not final. Consequently, this case is returned to the Referee for publication of a final order which is mailed to all parties to this proceeding.

FINDINGS OF FACT

Claimant requested a hearing concerning Liberty Northwest Insurance Corporation's denial of her "new injury" claim for her current low back condition and SAIF's denial of her aggravation claim for the same condition. (During different time periods, claimant's employer was insured by SAIF and, subsequently, Liberty Northwest). Claimant also sought assessment of penalties and attorney fees against SAIF for an allegedly unreasonable denial.

On December 27, 1991, the Referee issued an Opinion and Order, finding SAIF responsible for claimant's current low back condition. The order did not indicate that a copy had been mailed to SAIF.

On May 5, 1992, SAIF obtained a copy of the Referee's order. Thereafter, SAIF requested Board review of the order.

ULTIMATE FINDING OF FACT

SAIF was not mailed a copy of the Referee's order.

CONCLUSIONS OF LAW

A Referee's order shall be mailed to all parties in interest. ORS 656.289(2). "Party" means a claimant for compensation, the employer of the

injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(20).

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

Inasmuch as the Referee's order is not final, SAIF's request for Board review is premature. Accordingly, the request for review is dismissed and the matter returned to Referee Neal with instructions to issue a republished and final order bearing a new date of actual mailing to all parties to this proceeding, including their respective representatives.

IT IS SO ORDERED.

In the Matter of the Compensation of
CURTIS W. STINSON, Claimant
WCB Case No. 89-16397
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Neidig and Brazeau.

The insurer requests review of that portion of Referee Emerson's order that directed it to recalculate the rate of temporary total disability and permanent total disability. On review, the issues are the res judicata effect of the litigation on the rate of temporary and permanent total disability and the correct rate of permanent total disability. We reverse in part and affirm in part.

FINDINGS OF FACT

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

On November 4, 1984, a Determination Order issued awarding claimant 30 percent unscheduled permanent partial disability and temporary total disability. Claimant did not request a hearing regarding the order.

On July 29, 1988, a second Determination Order issued awarding claimant 20 percent unscheduled permanent partial disability and additional temporary total disability. Claimant requested a hearing regarding the order, as well as a July 15, 1988 partial denial. On April 12, 1989, the Referee awarded permanent total disability. The order was affirmed by the Board on August 10, 1990. No appeal was filed.

Before the Board affirmed the Referee's order, claimant requested a hearing on August 15, 1989 regarding the insurer's failure to pay the permanent total disability award. Supplemental requests for hearing subsequently were filed on September 18, 1989 and November 27, 1989 regarding the correct rate of payment for temporary and permanent total disability.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was not precluded by res judicata from litigating whether the insurer calculated temporary and permanent total disability using the correct rate of payment and ordered the insurer to recalculate both awards based upon a weekly wage of $352.03. The insurer challenges the Referee's conclusion regarding res judicata.

Res judicata is composed of two doctrines, claim preclusion and issue preclusion. Issue preclusion bars future litigation between the same parties concerning an issue that was "actually litigated and determined" in a setting where "its determination was essential to" the final decision reached. North Clackamas School Dist. v. White, 305 Or 48, 53, modified 305 Or 468 (1988). Here, we agree with the Referee that, because the proper rate of total and permanent total disability was never actually litigated by the parties, issue preclusion does not apply.

Claim preclusion, however, does not require actual litigation of an issue or that the determination of the issue be essential to the final decision reached. Rather, a claim is barred if it is based on the same factual transaction that was at issue in a prior action between the same parties. Drews v. EBI Companies, 310 Or 134, 140 (1990). Moreover, there must be a prior opportunity to litigate the claim, whether or not used, and there must be a final judgment. Id.

The facts of Drews are instructive in deciding this case. In Drews, the claimant successfully challenged the denial of his aggravation claim. A Determination Order followed awarding the claimant temporary total disability. The claimant filed a request for hearing seeking increased permanent partial disability and temporary total disability. The claimant then discovered that the temporary total disability benefits were paid at an erroneously low rate and requested payment at the correct wage rate. The insurer refused, and the claimant added to the hearing request the issue regarding the proper rate of payment of temporary total disability.

The Supreme Court concluded that the question of the proper rate of temporary total disability "is but one of the many issues involved in that ongoing claim for aggravation" and that "no finality has yet been accorded the aggravation claim opened in 1984, and no splitting of that claim occurred." Id. at 150. The Court therefore concluded that "neither issue nor claim preclusion applies to the TTD rate issue." Id. In a footnote, however, the Court stated that the original claim filed in 1981 was final in all respects and therefore correction of TTD amount paid before that closure was barred by claim preclusion. Id. at n. 13.

Here, claimant was awarded temporary total disability by a November 4, 1984 Determination Order and a July 29, 1988 Determination Order. Both Determination Orders expressly provided for the amount of claimant's entitlement to such benefits. Claimant did not request a hearing from the 1984 Determination Order. A request for hearing regarding the second Determination Order was filed; the resulting order from the Referee was affirmed by the Board and no appeal was filed. Therefore, any claim determination regarding temporary and permanent total disability made in the 1984 Determination Order and 1988 action is final. See id. at 149. Because both Determination Orders required the payment of temporary total disability benefits, and the insurer paid those benefits, we conclude that claimant is barred by claim preclusion from litigating the proper rate of temporary total disability. See id. at 150 n 13.

However, we further find that there has been no prior claim determination regarding the rate of permanent total disability. Claimant was awarded permanent total disability by the Referee on April 12, 1989; that order was affirmed by the Board on August 10, 1990. Any finality attaching to this action, however, does not extend to the rate of payment of permanent total disability. Until the insurer elected to pay the award at a particular rate, no justiciable controversy existed between the parties. See id. at 142-43. Once payment was made, claimant timely requested a hearing regarding the rate of payment. We therefore conclude that claimant is not barred by claim preclusion from litigating the proper rate of payment of his permanent total disability benefits.

Rate of permanent total disability

We affirm and adopt that portion of the Referee's order determining that claimant is entitled to permanent total disability at the rate of $352.06 per week.

ORDER

The Referee's order dated September 4, 1991 is reversed in part and affirmed in part. That portion of the order finding that claimant is not barred by claim preclusion from litigating the proper rate of his temporary total disability benefits is reversed. We conclude that claimant is barred by claim preclusion from relitigating this issue. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
OTHO D. COON, Claimant
WCB Case No. 91-01936
ORDER ON REVIEW
Jim L. Scavera, Claimant Attorney
Foss, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

The insurer requests review of Referee Livesley's order that increased claimant's unscheduled permanent disability award for a low back injury from 25 percent (80 degrees), as awarded by Determination Order, to 44 percent (140.8 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's "FINDINGS OF FACT."

CONCLUSIONS OF LAW AND OPINION

Because the Determination Order issued after October 1, 1990, we apply the standards adopted in WCD Admin. Order 15-1990.

The insurer argues the Referee erred by: (1) granting a value of +4 for the skills factor based on a finding that claimant had only attained a Specific Vocational Preparation (SVP) level of 1; and (2) rating the adaptability factor under former OAR 436-35-310(4) based on a finding that claimant is not working at modified work.

Regarding the skills factor, the Referee does not adequately justify the finding of an SVP level of 1. Accordingly, we do not adopt that finding. Instead, because claimant has demonstrated competence for many years as a movie projectionist, we rely on that job to find claimant's highest SVP level. The projectionist job is most accurately described in DOT 960.362-010 (motion-picture projectionist). Therefore, we find that claimant has attained an SVP level of 6, giving him a value of +2 for the skills factor. See former OAR 436-35-300(4)(e).

Regarding the adaptability factor, the Referee applied former OAR 436-35-310(4) based on an apparent finding that claimant had not returned to work. Notwithstanding the fact that claimant had returned to his part-time job as a movie projectionist, the Referee reasoned that he could not consider that job because claimant was not injured on that job. We disagree.

There is no requirement that the modified job be the job at which claimant was injured. "Modified work" is defined to include "some job other than the job held at the time of injury." Former OAR 436-35-270(3)(b). Here, at the time of his injury, claimant was working at two jobs: as a full-time newspaper-delivery driver and as a part-time projectionist. Claimant has returned only to the projectionist job. Because claimant has not returned to both jobs, we find that he has effectively returned to "modified work." Thus, the adaptability factor must be rated under former OAR 436-35-310(3)(a).

Claimant's newspaper job required frequent lifting of up to 40 pounds, thus classifying it as medium to heavy work. See former OAR 436-35-270(3)(e), (f). Claimant's projectionist job is classified as light work. Using the matrix in former 436-35-310(3), we rate the adaptability value as +2.

We adopt the Referee's conclusions and opinion regarding the remaining values: +1 for age; 0 for formal education; +1 for training; and +18 for impairment.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value +1 is added to his education value +3, the sum is +4. When that value is multiplied by claimant's adaptability value +2, the product is +8. When that value is added to claimant's impairment value +18, the result is +26 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 26 percent. The Referee's order is modified accordingly.

ORDER

The Referee's order dated June 10, 1991 is modified. In lieu of the Referee's unscheduled permanent disability award of 19 percent (60.8 degrees) unscheduled permanent disability, and in addition to the Determination Order award of 25 percent (80 degrees) unscheduled permanent disability, claimant is awarded 1 percent (3.2 degrees) unscheduled permanent disability, giving him a total award of 26 percent (83.2 degrees) unscheduled permanent disability. Claimant's attorney fee award is adjusted accordingly.

In the Matter of the Compensation of
FRANCES J. GILLIAM, Claimant
WCB Case No. 91-03938
ORDER ON REVIEW
W. Daniel Bates Jr., Claimant Attorney
Garrett, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Gruber's order that upheld the self-insured employer's denial of her temporomandibular joint (TMJ) complaints. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction. Dr. Huling did not complete comprehensive tomographs, pantographic tracing, and equilibration. Rather, he submitted cost estimates for these tests. (Ex. 9).

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's reasoning and conclusions regarding the compensability of claimant's alleged TMJ condition with the following supplementation.

Claimant was examined by two dentists and neither one opined that claimant had TMJ symptomology or a TMJ condition. (Exs. 3, 11). Dr. Huling, consulting dentist, provided no diagnosis and no narrative report. (Ex. 3). On May 14, 1990, Dr. Huling examined claimant, and his chart note regarding that examination stated as follows:

> "Exam/consult TMJ - 2 1/2mm slide to left. CR [not equal to] CO. Comfortable opening 30mm. Maximum opening 38 1/2mm. No

palpable muscle tenderness. Good transiation mobility. No joint sounds. No deviation on opening."

We are without expertise to interpret this chart note as demonstrating that claimant had TMJ symptomology or a TMJ condition. Claimant argues that Dr. Huling's notation of "TMJ therapy" at the bottom of his cost estimate for further tests indicates that he must have concluded that claimant had a TMJ condition. (Ex. 9). We disagree that such a conclusion can be reached without some explanation from Dr. Huling.

Furthermore, Dr. Staley, examining dentist, noted that claimant "did not exhibit any notable temporomandibular joint symptomology" and functionally she was within normal limits, although she had slight tenderness on palpitation. (Ex. 11).

In addition, while Dr. Carter, treating psychiatrist, is qualified to render an opinion on whether claimant has a TMJ condition, we accord greater weight to Drs. Huling and Staley, who specialize in the field of dentistry. See Marcella L. Woltersdorf, 42 Van Natta 1235 (1990); Gloria Serna, 42 Van Natta 54, 57 (1990). Accordingly, on this record, since neither dentist opined that claimant has TMJ symptomology or a TMJ condition, claimant has not established that she has a TMJ condition.

ORDER

The Referee's order dated July 25, 1991 is affirmed.

May 27, 1992 Cite as 44 Van Natta 1029 (1992)

In the Matter of the Compensation of
MARIA L. HERNANDEZ, Claimant
WCB Case No. 90-18037
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by the Board en banc.

Claimant requests review of that portion of Referee Harri's order that upheld the insurer's denial of claimant's right ankle injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant's employer, Polehn Orchards, owns and operates a series of agricultural properties near The Dalles, Oregon. Claimant and her husband are migrant workers, and were hired as pickers during the 1990 cherry season and offered temporary housing free of charge. Claimant and her husband were not contractually required to live on the employer's premises. During 1990, however, all but one of the approximately 150 workers lived on the employer's premises due to the location of the work site and lack of affordable housing in The Dalles. As part of its normal operations, the employer cleaned the labor camp grounds daily. It washed the outdoor toilet areas by hosing them down with water, causing puddles to form around the outhouses.

On July 9, 1990, claimant's husband compensably injured his ankle and was unable to work. Claimant requested and received permission to take a few days off work to care for her husband. The employer allowed claimant and her husband

to remain in the labor camp despite their not working, and did not terminate their employment or request them to leave the premises.

On July 12, 1990, claimant walked from the housing to the outdoor toilet to empty her husband's bedpan. As claimant left the outhouse, she slipped in a mud puddle outside the door and fell, injuring her right ankle and back. Claimant sought treatment and underwent a surgical reduction of a right ankle bimalleolar fracture. After approximately four days in the hospital, claimant returned to the work site for a few days until the end of cherry season. She filed a claim for injuries resulting from this fall.

On August 21, 1990, the insurer denied the compensability of the claim, asserting that the injury did not occur within the course and scope of claimant's employment. Claimant timely requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The issue presented in this case is whether claimant's injury arose out of and in the course of her employment. The Referee concluded that it did not and upheld the insurer's denial. We find the injury compensable under the "bunkhouse" rule and reverse.

A compensable injury is one "arising out of and in the course of employment[.]" ORS 656.005(7)(a). In Rogers v. SAIF, 289 Or 633 (1980), the court rejected the mechanistic two-step method of analysis by which "arising out of" and "in the course of" were treated as two separate tests, both of which had to be met for an injury to be compensable. Instead, the court adopted a unitary "work connection" approach and defined the ultimate inquiry as whether the relationship between the injury and the employment is sufficient to allow compensability. It explained:

> "[I]t is not our intention to substantially change fundamental Workers' Compensation law. If the injury has sufficient work relationship, then it arises out of and in the course of employment and the statute is satisfied. Existing law regarding proximity, causation, risk, economic benefit and all other concepts which are useful in determining work relationship remain applicable[.]" 298 Or at 643.

Under that unitary test, the course of employment inquiry has not been confined to the actual manipulation of tools of work or to exact hours of work. Rather, the court has held that injuries arising out of certain personal comfort activities of employees having a fixed time and place for work may be compensable. Clark v. U.S. Plywood, 288 Or 255 (1980) (employee killed while retrieving his lunch from atop a hot glue press). Similarly, a resident employee's personal comfort activities may be within the course of employment when the employee is on call at all hours. Wallace v. Green Thumb, 296 Or 79 (1983) (Resident caretaker of a rural fire station compensably injured while preparing dinner).

Some jurisdictions have extended the rationale underlying these types of "personal comfort" cases to allow compensation for similar on-premise injuries sustained by employees who, while not continuously on call, are required to live on the employer's premises. As to these so-called "bunkhouse" cases, Professor Larson provides the following rule:

> "When an employee is required to live on the premises, either by his contract of employment or by the nature of the employment, and is continuously on call (whether or not actually on duty), the

entire period of his presence pursuant to this requirement is deemed included in the course of employment. However, if the employee has fixed hours of work outside of which he is not on call, compensation is awarded usually only if the source of injury was a risk associated with the conditions under which claimant lived because of the requirement of remaining on the premises.

"* * * * *

"When residence on the premises is merely permitted, injuries resulting from such residence are not compensable under the broad doctrines built up around employees required to reside on the premises. * * * The theory is that when residence is mandatory, it is the constraints and obligations of the employment that subject the employee to the risk that injured him, while if the residence is optional, the employee is free to do as he pleases and there is no continuity of employment obligation of any kind during the time the employee is voluntarily sleeping in a place provided for his convenience by the employer." 1A Larson, Workmen's Compensation Law 24.00, 24.40 (footnotes omitted).

Our courts have neither adopted nor rejected the "bunkhouse" rule.[1] Nonetheless, we find the rule consistent with the well-established requirement in Oregon that compensation is available for all activities related to the employment if it carries out the employer's purposes or advances the employer's interests directly or indirectly. See Phil A. Livesly Co. v. Russ, 296 Or 25 (1983). Accordingly, we adopt the rule, and hold that injuries to employees required to live on the employer's premises are generally compensable if the claimant was continuously on call, or the source of the injury was a risk distinctly associated with the conditions under which the claimant was required to live. See 1A Larsons, supra at 24.10.

In this case, it is not seriously disputed that claimant sustained a broken ankle when she slipped and fell in a mud puddle outside the steps of an outhouse located in the employer's labor camp. Although claimant was not contractually required to live in the camp, Professor Larson notes:

"[E]ven in the absence of a requirement in the employment contract, residence should be deemed 'required' whenever there is no reasonable alternative in view of the distance of the work from residential facilities or the lack of availability of accommodations elsewhere." 1A Larson, supra, at 24.40.

Here, the record shows that other affordable housing was not readily available in The Dalles and there was no bus service from the town to the employer's premises. The employer obviously recognized those problems and provided the workers temporary housing, which was used by all but one of the approximately 150 employees. The evidence further suggests that the employer provided the temporary housing for its benefit in securing a reliable work force within a short distance from the work area to harvest its perishable product. Under the circumstances, we conclude that, for all practical purposes, claimant's occupancy in the labor camp was required and contemplated by the employer.

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[1] We note that the court addressed the "bunkhouse" rule in SAIF v. Reel, 303 Or 210 (1987). However, it decided the case on different grounds, thereby rendering its discussion dicta.

We also conclude that the source of claimant's injury was a risk distinctly associated with the labor camp. As noted above, claimant slipped and fell in a puddle that had formed outside an outhouse. The employer maintained the outhouse, and had actually caused or contributed to the water puddle by cleaning the facility by hosing it out daily with water. Thus, the particular living conditions of the premises created the source of injury.

In short, the circumstances compelled claimant to reside on the employer's premises. Her occupancy was incidental to her employment, and her activities on those premises were an incident to the performance of her duties of employment. Because the source of her injuries was a risk particularly associated with the employer's premises, we find that the relationship between her injury and her employment is sufficient to allow compensability. Rogers v. SAIF, supra. Accordingly, the insurer's denial is set aside.

Because claimant has prevailed against a denial of compensability, claimant's counsel is entitled to an assessed fee under ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $7,020, 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 statement of services with supporting affidavit), the complexity of the issue, the value of the interest involved, and the risk in this case that claimant's attorney's efforts might go uncompensated.

ORDER

The Referee's order dated March 21, 1991 is reversed. The insurer's denial is set aside and the claim is remanded for further processing according to law. For services rendered in overturning the denial, claimant's counsel is awarded a reasonable fee of $7,020, to be paid by the insurer.

Board Members Kinsley and Neidig dissenting.

The majority applies the "bunkhouse" rule to find a sufficient connection between claimant's injury and her work activities. We disagree and, therefore, dissent.

The question is whether the relationship between the injury and the employment is sufficient to find that the injury is compensable. Rogers v. SAIF, 289 Or 633, 642 (1980). Considering the facts, we find the work connection too attenuated to award compensation. To determine whether an injury is work-related, we are guided by the following factors identified in Jordan v. Western Electric, 1 Or App 441, 443 (1970):

> "a. Whether the activity was for the benefit of the employer * * *;
>
> "b. Whether the activity was contemplated by the employer and employee either at the time of hiring or later * * *;
>
> "c. Whether the activity was an ordinary risk of, and incidental to, the employment * * *;
>
> "d. Whether the employee was paid for the activity * * *;
>
> "e. Whether the activity was on the employer's premises * * *;

"f. Whether the activity was directed by or acquiesced in by the employer * * *;

"g. Whether the employee was on a personal mission of his own * * *."

The circumstances of this case persuade us that claimant's injury did not arise out of and in the course of her employment. At the time of her injury, claimant was neither engaged in any work activity nor on call for any work activity. She was caring for her injured husband while she was on unpaid leave from work at her request. Because she was off work, claimant was free to do anything and go anywhere she pleased. The care of her husband did not directly benefit the employer, it was not contemplated by the parties as a part of the employment contract, it was not an ordinary risk of, or incidental to, her employment, nor did the employer direct or acquiese in any employment related activity leading to the injury. Although the injury occurred on housing premises provided by the employer, the employer did not require employees to live there. It was claimant who elected to accept free housing from the employer.

Of the eight factors cited in Jordan v. Western Electric above, only one possible employment related factor is applicable to this case; i.e., that the injury occurred on the premises of the employer. That factor alone is insufficient to find this injury compensable. The last factor, that claimant was on a personal mission of her own, is descriptive of this case. Claimant was not injured within the course and scope of her employment. For these reasons, we would not adopt the "bunkhouse" rule on the facts of this case.

In the Matter of the Compensation of
JANET L. LYTLE, Claimant
WCB Case No. 91-00166
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Brazeau.

Kemper Insurance Company requests review of that portion of Referee Harri's order that set aside its denial of claimant's occupational disease claim for a cervical disc condition. On review, Kemper contends that claimant's remedy, if any, rests with a prior carrier not joined as a party to this proceeding. We affirm.

FINDINGS OF FACT

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

Claimant filed a request for hearing on January 2, 1991; the hearing was held on March 28, 1991.

Claimant's repetitive work activity while Kemper was on the risk is the major contributing cause of claimant's current disability and need for medical treatment.

CONCLUSIONS OF LAW AND OPINION

We affirm and adopt the Referee's reasonings and conclusion, except for the last three paragraphs in the "Compensability" section.

Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990. Ida M. Walker, 43 Van Natta 1402 (1991).

The Referee found that claimant sustained a compensable occupational disease rather than a "new compensable injury." However, believing that Section 49 of Senate Bill 1197 (codified ORS 656.308) does not apply to occupational disease claims, the Referee applied the last injurious exposure rule. See Inkley v. Forest Fiber Products Co., 288 Or 337 (1980). He further concluded that claimant's continuing work activities for the same employer could have caused her current cervical condition. He, therefore, assigned responsibility to the insurer on the risk when claimant's disc ruptured.

Subsequent to the Referee's order, we held in Donald C. Moon, 43 Van Natta 2595 (1991), that an insurer responsible for a compensable injury remains responsible for continued or increased disability during employment covered by a later carrier, unless claimant sustains a new injury or occupational disease during the subsequent employment. See Oregon Laws 1990 (Special Session), chapter 2, section 49 (codified ORS 656.308). We find Section 49 (ORS 656.308) equally applicable to the circumstances presented by this claim. Thus, we hold that where one employer is successively insured by later carriers, an insurer that is responsible for a compensable injury remains responsible for continued or increased disability during later employment, unless the worker sustains a new injury or occupational disease while a subsequent carrier is on the risk.

We agree that claimant sustained a compensable occupational disease. Dr. Randle, claimant's treating neurologist, postulates that claimant may have herniated a disc at the time of her 1983 injury. However, he persuasively testified that it was claimant's repetitive work activities after that date, including her work as an off-bearer in 1990, that compressed a previously-undiagnosed and asymptomatic disc, causing it to extrude, thereby leading to cervical nerve root compression for which claimant now requires surgery.

We find, therefore, that claimant's work activity while Kemper was on the risk is the major contributing cause of her current disability and need for treatment. ORS 656.802(1)(c)(2). Kemper is responsible. ORS 656.308; Donald C. Moon, supra.

Claimant is entitled to an assessed attorney fee for prevailing against Kemper's request for review. 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 attorney's services on review is $800, to be paid by Kemper. In reaching this conclusion, we have particularly considered the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 29, 1991 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $800, to be paid by Kemper Insurance Company.

In the Matter of the Compensation of
WANDA J. McBRIDE, Claimant
WCB Case No. 90-15971
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board members Neidig and Brazeau.

Claimant requests review of Referee Knapp's order that: (1) granted the insurer's motion to dismiss claimant's Request for Hearing; (2) upheld the insurer's denial of claimant's medical services claim; and (3) declined to invalidate and set aside a December 8, 1990 Stipulation and Order wherein the insurer withdrew its May 8, 1989 denial, and accepted a temporary worsening of claimant's underlying lung condition, while partially denying any permanent worsening of her underlying lung condition. Should the Board find the Stipulation and Order invalid, claimant requests the claim be remanded for hearing on the merits. On review, the issues are propriety of hearing dismissal, compensability of medical services, validity of the Stipulation and Order, and remand.

We affirm and adopt the Referee's order, as supplemented.

The insurer did not issue a preclosure denial on an accepted condition. In the Stipulation and Order, the insurer both accepted a temporary worsening of claimant's underlying lung condition, and denied any permanent worsening of that condition. The denial of a separate, unaccepted condition, is procedurally proper. See Roller v. Weyerhaeuser Co., 67 Or App 583 (1984); Aquillon v. CNA Insurance, 60 Or App 231, 235 (1982).

We find no merit in claimant's argument that, by implication, the Referee misapplied the doctrine of issue preclusion. See Drews v. EBI Companies, 310 Or 134 (1990). Here, the parties did not litigate the compensability of claimant's lung condition. Rather, in lieu of a hearing, they entered into a stipulated order wherein the insurer again denied any permanent worsening of claimant's underlying lung condition. Claimant was given formal hearing rights as to the partial denial. She did not appeal; thus, the partial denial has become the law of the case.

Similarly, we find no merit in claimant's argument that the stipulation order is void insofar as it purports to release claimant's rights concerning her compensable condition. See ORS 656.236(1). Claimant has not released any rights as they pertain to her accepted condition.

Finally, claimant moves the Board to set aside a Stipulation and Order approved by a referee. We regard vacating prior settlements to be an extraordinary remedy to be granted sparingly only in the most extreme situations. Mary Lou Claypool, 34 Van Natta 943, 946 (1982); James Leppe, 31 Van Natta 130 (1981). Claimant has offered no explanation why this Board should grant her motion. Under such circumstances, we decline to do so.

As the stipulation order has become final, it precludes entitlement to compensation for the noncompensable condition. The Referee properly dismissed claimant's hearing request; accordingly, there is no basis upon which to remand this claim to the Hearings Division.

ORDER

The Referee's order dated May 15, 1991 is affirmed.

In the Matter of the Compensation of
TONY L. RIVORD, Claimant
WCB Case No. 91-00728
ORDER ON REVIEW
Dennis H. Henninger, Claimant Attorney
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Kinsley, Brazeau and Gunn.

The self-insured employer requests review of that portion of Referee Schultz's order that set aside its denial of claimant's right shoulder injury claim. On review, the issue is compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had sustained a compensable injury to his right shoulder as a result of a work-related incident on December 18, 1990, because the incident was a material contributing cause of his need for medical treatment. We agree and adopt that conclusion. See Mark N. Wiedle, 43 Van Natta 885 (1991). However, the Referee did not address the issue of whether the compensable injury is and remains the major contributing cause of claimant's right shoulder disability and need for treatment. Because we conclude that this issue was raised and litigated at hearing, we address the issue on review.

The persuasive medical record establishes that claimant has a preexisting right shoulder condition. Therefore, while claimant has proven a compensable injury, to obtain compensation for his resulting condition claimant must, under ORS 656.005(7)(a)(B), also prove by a preponderance of the evidence that the compensable injury is the major contributing cause of his disability or need for medical services. Bahman M. Nazari, 43 Van Natta 2368 (1991). We find that the causation of claimant's right shoulder condition is of sufficient medical complexity that we cannot decide it without expert opinion. Uris v. Compensation Department, 247 Or 420, 424-26 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Two expert opinions on medical causation were submitted in this matter. Dr. Fuller, an independent medical examiner, opined that the major contributing cause of claimant's condition was his preexisting shoulder laxity caused by his prior shoulder dislocation. (ex. 15) He also commmented:

> "The nature of shoulder subluxation/dislocation is that once they have occurred, then re-dislocation subsequently will become easier and easier. It is probable that, in the future, he will require surgical repair to prevent the right shoulder subluxation/dislocation. The root cause of this condition has been present since the injury of June 1989." (Ex. 14-5)

That opinion is shared by Dr. Battalia, an independent medical doctor who testified at hearing. Battalia explained that once a shoulder is dislocated it becomes "lax" and is prone to subsequent dislocations. He further testified that the work-related incident would not have caused a shoulder dislocation if claimant had not previously separated his shoulder. We find both opinions well-reasoned and based on complete information. Consequently, we find them persuasive. Somers v. SAIF, 77 Or App 259 (1986). There is no contrary evidence.

In Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566 (1991), the court discussed the need to distinguish susceptibilities or predispositions from actual causes of conditions. In this case, we have determined that claimant's preexisting shoulder ligament laxity is a cause, in fact the major contributing cause, of his present condition, not just a susceptibility.

After our review of the record, we conclude that although claimant has established that the work injury in December 1990 was a material cause of his immediate need for medical services and/or disability, he has failed to establish by a preponderance of the evidence that the December 18, 1990 injury is the major contributing cause of the resultant right shoulder condition for which he seeks medical treatment.

We continue to adhere to the premise that the employer takes the worker as it finds him; Senate Bill 1197 (Or Laws 1990 (Special Session), Ch. 2) did not change that. For that reason, we find compensable that portion of the claim relating to claimant's initial medical treatment and time loss. We rely on Dr. Fuller's March 6, 1991 report: "[T]he incident at work in December 1990 did cause his subsequent need for treatment in relationship to that particular incident." (Ex. 14-5). We also rely on Dr. Battalia's testimony that the work incident was the immediate cause of the second dislocation. (Tr. 52). However, although claimant has established the occurrence of a compensable injury on December 18, 1990, any claim for ongoing medical treatment and/or disability related to the underlying lax ligament condition is not compensable. See Cresent Hayward, 43 Van Natta 2477 (1991).

The Referee set aside the employer's denial and awarded an assessed attorney fee. Because we are reinstating and upholding a portion of that denial, the Referee's assessed fee shall be adjusted accordingly. In addition, claimant has, in part, successfully defended against the employer's request for review. Therefore, he is entitled to an assessed attorney fee under ORS 656.382(2). In lieu of the Referee's assessed fee, we award a reasonable assessed fee for services at hearing and on review concerning the compensability of the December 18, 1990 injury, in the amount of $1,800. We have arrived at this fee after considering the factors set forth in OAR 438-15-010(4), in particular the time devoted to this issue (as represented by the hearing record and claimant's respondent's brief), and the value of the interest involved.

ORDER

The Referee's order dated April 30, 1991, is affirmed in part and reversed in part. That portion of the Referee's order that set aside the employer's denial insofar as it denied medical services and/or disability for claimant's right shoulder condition is reversed and that portion of the employer's denial is reinstated and upheld. In lieu of the Referee's assessed attorney fee award, claimant is awarded a reasonable assessed fee for services at hearing and on review concerning the compensability of the December 18, 1990 injury, in the amount of $1,800, to be paid by the insurer. The remainder of the order is affirmed.

Board Member Gunn dissenting.

The majority finds that claimant has a preexisting right shoulder condition. Therefore, it concludes that, in order to prove a compensable claim, he must establish that the compensable injury is the major contributing cause of his current disability, rather than a material contributing cause. I do not believe that claimant suffers from a "preexisting condition" and respectfully dissent.

ORS 656.005(7)(a)(B), provides:

> "If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment."

In this case, the majority concludes that claimant has a "preexisting condition," because he had previously dislocated his right shoulder. It relies on testimony from Dr. Battalia, who explained that once a shoulder is dislocated it becomes lax and is predisposed to subsequent dislocation.

I believe that the majority erred by labeling claimant's "predisposition" as a "preexisting condition" for purposes of ORS 656.005(7)(a)(B). First, the laxity produced no prior symptoms, but merely caused claimant's shoulder to be more prone to injury. Second, as the court noted in Preston v. Wonder Bread, 96 Or App 613 (1989), "[a] predisposition is a 'condition of special susceptibility to a disease,' not a disease in and of itself." Citing Stedmans Medical Dictionary 1133 (23rd ed 1976). (Emphasis theirs.) Thus, contrary to the majority's conclusion, I do not believe that such a vulnerability can properly be used to limit claimant's entitlement to benefits for a compensable injury.

This conclusion is supported by the legislative history. The revised definition of a "compensable injury" was proposed in Senate Bill 1997 and added to the Workers' Compensation Law in May 1990. Or Laws 1990 (Special Session), Ch. 2. During the first day of public hearings, a sponsor of the bill explained that the amendments to ORS 656.005(7) were not intended to modify the doctrine that an employer takes a worker as he finds him. See Barrett v. D & H Drywall, 300 Or 325, clarified 300 Or 553 (1986). Specifically, he testified:

> "I had one further clarification, Mr. Chairman. Earlier in the hearing, Representative Edmunson asked a question that I believe we didn't answer as we should have, in the detail we should have. I believe you made a statement that you felt that some of what we had done might have modified the doctrine that you take the worker as they come. And that is not our intent and we don't believe that's what we're doing. We believe we're saying that if you have a preexisting condition and you claim an on the job injury, that you should be able to prove that the on the job injury is the major contributing cause to the worsening of your original condition. There are some conditions we have that cause pain no matter what we do. And so I'm in pain at home, I'm in pain at work because I have a condition. That shouldn't become compensable just because it happens at work, too. But if the work situation causes a worsening of my condition that I came to work and that's the major contributing cause then of my worsening, then it should be compensable. And that was our intent. And we don't believe we've changed any doctrine and we would not be comfortable with changing that initial doctrine that you take the worker as they come." Testimony of Cecil Tibbett, Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 4, Side A at 208.

In short, the majority limits claimant's right to receive compensation based on its conclusion that claimant suffers from a "preexisting condition." Given the applicable case law and legislative history, I find no support for the majority's conclusion and, therefore, believe that claimant is entitled to the full amount of benefits for his compensable injury.

In the Matter of the Compensation of
SHARON Y. RODAKOWSKI, Claimant
Own Motion No. 90-0554MM
OWN MOTION ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys

Claimant requests reconsideration of our April 27, 1992 Own Motion Order in the above-captioned case.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. SAIF is requested to file a response to the motion within ten days of the date of this order. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS L. ABEL, Claimant
Own Motion No. 91-0386MM
OWN MOTION ORDER
Pozzi, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's claim for an alleged worsening of his June 25, 1971 compensable injury in which claimant's face was fractured by a log, resulting in the loss of his left eye and a severe seizure condition. Claimant's aggravation rights expired on May 24, 1977. SAIF has accepted the compensability of claimant's seizure condition, but recommends against the reopening of his claim for temporary disability compensation for a November 9, 1990 hospitalization and an April 5, 1991 right temporal lobectomy on the ground that claimant has withdrawn from the work force. Claimant seeks temporary disability compensation from May 27, 1982, the date his conditioned worsened and he was first hospitalized for seizures, until he becomes medically stationary. Claimant also seeks penalties and attorney fees for SAIF's allegedly unreasonable delay in processing his own motion claim.

Temporary Disability Compensation

We may authorize, on our own motion, the payment of temporary disability compensation 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). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. Id.

Claimant experienced a severe head injury in 1971, for which he underwent extensive plastic reconstruction of his face. In 1982, while he was working, he experienced a grand mal epileptic seizure, for which he was hospitalized and treated. At this time, the cause of his condition was misdiagnosed and was not related to the original injury. Claimant continued to seek work, but was unable to find or keep work because of his seizure disorder and related depression. Claimant was again hospitalized with grand mal seizures in 1987, twice in 1988, and twice in 1989. On June 2, 1989, Dr. Grossman, M.D., claimant's treating physician, located scarring on claimant's brain, which he related to the original injury. Dr. Englander, neurologist, opined that claimant's seizure disorder was probably related to the 1972 head injury, despite the length of time

intervening. (Letter of July 17, 1989.) An electroencephalogram that revealed a scar in claimant's brain confirmed Dr. Englander's opinion. (Letter by Dr. Grossman, October 6, 1989).

On July 9, 1990, claimant was hospitalized for a full diagnostic work-up, including an EEG, which proved to be abnormal. He had a seizure while hospitalized. Claimant was again hospitalized on November 9, 1990 for seizure treatment. On January 15, 1991, claimant was hospitalized for further evaluation. During the hospitalization he had five seizures. Claimant was hospitalized for another seizure on March 1, 1991, and on April 5, 1991, was hospitalized for right temporal lobectomy surgery. Even after the surgery, claimant continued to be hospitalized periodically for treatment of his seizure disorder. In addition to the seizure disorder and resultant depression, claimant has also suffered significant impairment of concentration, visual and verbal memory, and mental tracking, which were revealed by neuropsychological testing performed by Dr. Robert Stanulis, and which have not improved after claimant's lobectomy. Dr. Smith, of the Oregon Comprehensive Epilepsy Program, reviewed claimant's medical records for SAIF. He opined that claimant's intractable localization-related epilepsy with recurrent complex partial seizures and secondarily generalized tonic clonic seizures is secondary to his 1971 injury to the right temporal lobe. (Letter of June 24, 1991).

We are persuaded that claimant's compensable injury worsened as of May 27, 1982, when claimant's condition initially required hospitalization. Furthermore, we find that claimant was in the workforce at the time he was hospitalized in 1982. Accordingly, we authorize the reopening of claimant's claim for the payment of temporary disability compensation beginning May 27, 1982, the date claimant was initially hospitalized for the accepted seizure condition. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-12-055. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45.

Penalty and Attorney Fees

Claimant seeks penalties and attorney fees for SAIF's alleged unreasonable delay in processing his own motion claim for temporary disability compensation.

Effective April 1, 1989, within 60 days after receipt of an own motion claim, the own motion insurer was required to notify the claimant and the Board in writing of its recommendation as to whether the claim should be reopened or denied by the Board. Former OAR 438-12-020(2) (WCB Admin. Order 2-1989). Claimant first requested the reopening of his claim in writing on July 24, 1989. On September 11, 1989, SAIF replied to claimant and sought additional information from him specifying whether claimant was "seeking medical benefits, temporary disability payments, or both," and requiring "proof of earnings for the last two years." Claimant again requested medical and disability payments from SAIF in writing on October 11, 1989. He explained that he had been a displaced worker since his last job was eliminated in 1982, and that he had not been able to obtain employment because of his condition and, therefore, had had no earnings for seven years. On October 30, 1989, SAIF agreed to pay all reasonable and necessary medical expenses related to claimant's seizure disorder, including those expenses claimant had paid prior to 1989, but instructed claimant that it was not necessary to reopen his claim for the payment of temporary disability compensation until such time as he was hospitalized or had surgery. SAIF did not submit a written recommendation to the Board within the required 60 days.

On April 2, 1990, claimant requested permanent total disability benefits from SAIF in a letter in which he referred to SAIF's September 11, 1989 instructional letter. On April 16, 1990, SAIF issued a letter recommending that

the request for permanent total disability be denied and the Board issued a May 18, 1990 Own Motion Order denying claimant's request for a permanent disability award.

Claimant was hospitalized for his seizure condition on November 9, 1990 and for a right temporal lobectomy on April 5, 1991. SAIF did not submit a recommendation regarding reopening for temporary disability compensation in relation to either surgery.

By a July 16, 1991 letter, SAIF explained to claimant's attorney that it did not submit the own motion matter to the Board "because [it] was unaware that the [claimant] wanted that done." On July 17, 1991, in response to claimant's attorney's question "[a]re you paying time loss or have you petitioned for own motion jurisdiction," SAIF submitted a recommendation to the Board, recommending that claimant's request for temporary disability compensation be denied because claimant was not in the workforce at the time of the current worsening, which it identified as a November 9, 1990 hospitalization and an April 5, 1991 surgery.

This record establishes that SAIF, which received claimant's initial request for temporary disability compensation on July 24, 1989, failed to submit a recommendation to the Board until July 17, 1991, almost two years after claimant's initial request. The purpose of the Workers' Compensation Law is to provide prompt compensation to injured workers. Edward Hines Lumber Co. v. Kephart, 81 Or App 43 (1986). Own motion jurisdiction provides a mechanism by which a claimant who no longer has aggravation rights may obtain additional temporary disability compensation. However, the Board is unable to exercise its own motion jurisdiction absent a request to do so. By failing to timely submit a recommendation to the Board, SAIF delayed the prompt payment of benefits which are now due. We conclude that this delay was an unreasonable resistance to the payment of compensation.

However, a penalty may not be assessed under ORS 656.262(10)(a) unless there is an unpaid amount of compensation "then due" upon which to base the penalty. Wacker Siltronic Corporation v. Satcher, 91 Or App 654, 658 (1988). At the time claimant requested temporary disability compensation, his claim was closed and could only be reopened under our own motion jurisdiction. When a claim is under own motion jurisdiction, no compensation is due claimant until we issue an order reopening the claim. Thus, because no compensation was due at the time of SAIF's unreasonable delay, a penalty cannot be assessed under ORS 656.262(10)(a). See Fredrick D. Oxford, 42 Van Natta 476 (1990). On the other hand, where, as here, we find that an insurer has unreasonably resisted the payment of compensation, we may assess an attorney fee even in the absence of amounts of compensation "then due." See ORS 656.382(1); Nicolasa Martinez, 43 Van Natta 1638 (1991). Here, it is clear that SAIF's dilatory conduct placed a greater burden on claimant to prove his request. Accordingly, for SAIF's unreasonable resistance to the payment of compensation, we assess an attorney fee of $3,000.

In addition, an amount of 25 percent of the increased temporary disability compensation is awarded as a reasonable attorney fee, not to exceed $1,050, payable by the insurer directly to claimant's attorney. See OAR 438-15-010(4); 438-15-080.

IT IS SO ORDERED.

In the Matter of the Compensation of
LYLE J. JOHNSON, Claimant
WCB Case No. 91-17457
ORDER OF ABATEMENT
Bonnie Laux (Saif), Defense Attorney

On May 15, 1992, we dismissed claimant's request for Board review. We took this action because claimant's March 15, 1992 letter, although dated within 30 days of the Referee's March 2, 1992 order, was received by the Board on April 17, 1992. Inasmuch as claimant's letter was not mailed by certified or registered mail, we presumed that the letter was filed untimely. See OAR 438-05-046(1)(b). In reaching our conclusion, we noted that "an uncontested statement from a party that a request was mailed to the Board on a particular date" would be sufficient to rebut a presumption of untimely filing.

In response to our order, claimant has submitted a May 18, 1992 letter stating that he mailed his March 15, 1992 letter on March 15, 1992 to the Board, as well as to SAIF. Contending that his letter was timely filed, claimant requests that we proceed with our review.

Before taking claimant's request under advisement, we grant SAIF an opportunity to respond. To be considered, SAIF's response should be submitted within 14 days from the date of this order. Thereafter, we will proceed with our deliberations.

IT IS SO ORDERED.

In the Matter of the Compensation of
OSWALD F. KUZNIK, Claimant
WCB Case No. 90-09502
ORDER ON REVIEW
Grover C. Dahn, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Brazeau.

The self-insured employer requests review of those portions of Referee Menashe's order that: (1) set aside its denials of claimant's aggravation claim for a right thumb condition; and (2) set aside its denials of claimant's occupational disease claim for right thumb arthritis. In addition, claimant has filed a Motion For Leave To Present Additional Evidence. On review, the issues are aggravation, compensability, and motion to remand. We deny the motion, affirm in part, and reverse in part.

FINDINGS OF FACT

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

Dr. Harris, orthopedic surgeon, first treated claimant for his November 12, 1984 hand injury in January 1985. X-rays revealed very mild degenerative osteoarthritis of the right carpometacarpal (CMC) thumb joint (basal joint of the thumb). Dr. Harris noted no evidence of a significant thumb injury, but rather diagnosed mild preexisting degenerative arthritis of the right thumb and tendinitis of the right forearm. On April 26, 1985, the employer wrote claimant that it was "accepting your claim for your tendonitis [sic] right forearm."

In his June 25, 1985 report finding claimant medically stationary, Dr. Harris noted that claimant's arthritis "probably represents an occupational condition at least in part[.]" In a July 1985 report, Dr. Harris clarified by explaining that claimant's work activities had contributed to increased symptoms, but that there was no objective evidence of any material worsening of claimant's preexisting arthritic condition.

Claimant did not thereafter work for the employer. In March 1988, claimant filed an aggravation claim which the employer denied. The parties entered into a stipulated agreement whereby claimant received an additional award of 15 percent scheduled permanent partial disability for the "right forearm (wrist)."

Dr. Woodham, chiropractic physician, was claimant's treating physician from January through June 1990. Dr. Woodham testified at hearing that he was unaware whether claimant sustained any significant injury to his right thumb prior to November 1984. He explained that he assumed that claimant sustained a significant "tearing" injury with inflammation in November 1984 which began the degenerative arthritic process, because everything has to have a "cause." Dr. Woodham also testified that it takes a substantial period of time from the date of an initial injury for arthritic changes to appear on x-rays. After reviewing claimant's medical records, Dr. Woodham concurred that there was evidence of mild degenerative changes on the first x-rays taken after the November 1984 injury.

Dr. Beck, sports medicine and rehabilitation medicine specialist, examined claimant in consultation on June 16, 1990, and thereafter became claimant's treating physician. X-rays from that examination reveal that claimant's right CMC thumb joint osteoarthritis had become severe. Dr. Beck reported that a significant initial injury to the CMC joint, such as a fracture or dislocation, is required to begin the degenerative arthritic process. Later, in an October 1990 telephone conference with claimant's counsel, Dr. Beck opined that overuse and "microtrauma" [repetitive trauma] during claimant's work activities for the employer were the major contributing cause of claimant's osteoarthritis and current need for treatment.

Dr. Buehler examined claimant on referral from Dr. Beck on June 16, 1990. He testified that there is no medical data that repetitive trauma leads to arthritis of the basal joint of the thumb. He explained that the CMC joint of the thumb is the joint most commonly involved with osteoarthritis. He further testified that it is "very clearly shown in the literature" that "people [who] use their thumb a lot in everyday activities do not seem to be more predisposed in the development of degenerative arthritis of the basal joint of the thumb."

Dr. Button, orthopedic hand surgeon, examined claimant four times between June 1985 and September 1990. Dr. Button explained that while arthritis of the CMC joint can occur after injury, the trauma must be quite severe, with fracture or dislocation of the joint. After reviewing all of claimant's medical records, including those from the date of injury, Dr. Button reported that there were no signs of severe trauma such as instability or ligamentous laxity. The doctor also testified during deposition that the medical literature does not substantiate that arthritis of the CMC joint is a result of repetitive trauma. The CMC joint is the one most frequently requiring surgery, whether overused or not. Dr. Button further noted that, "not surprising," claimant is now developing a similar degenerative process of his non-dominant left thumb.

Independent medical consultants, Dr. Cottrell, orthopedist, and Dr. Gatterman, chiropractic physician, examined claimant in June 1990. They opined that while work over a period of years of the "type" claimant performed may have

contributed to "some" degree of hastening of the degenerative process, claimant's work exposure between 1979 and 1985 did not cause claimant's arthritis.

Claimant worked as a deli supervisor for another employer from August 1989 through March 1990. Claimant filed aggravation and new injury/occupational disease claims with that employer in January 1990 which were denied.

This employer denied compensability of claimant's current right thumb condition under both occupational disease and injury theories. Claimant requested a hearing on May 1, 1990, specifying the issues as, inter alia, compensability as a new injury or occupational disease, and aggravation. In response to the employer's August 3, 1990 denial, claimant's attorney filed an "amended specification of issues," again identifying the issues as, inter alia, compensability as a new injury or occupational disease, and aggravation.

The hearing was held on November 1, 1990 and continued to March 12, 1991. At hearing, the issues were identified as compensability of claimant's right thumb condition as either an aggravation of the November 1984 injury, or as an occupational disease resulting from his work activities between 1979 and 1985. At the March 1991 hearing, claimant and the subsequent insurer entered into a Disputed Claim Settlement, and stipulation whereby the insurer accepted claimant's tendinitis of the right wrist. Its acceptance did not include claimant's separate degenerative osteoarthritis of the right thumb.

Claimant's right thumb osteoarthritis condition is not causally related to the accepted right wrist tendinitis. Claimant's current right thumb condition and need for surgery are due to natural progressive degenerative osteoarthritis.

Claimant's work as a meat cutter for this employer between 1979 and 1985 did not constitute a series of traumatic events or occurrences which are the major contributing cause of his current disability and need for treatment.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that claimant did not request a hearing before May 1, 1990, and a hearing was not convened before July 1, 1990. Neither matter at issue here is subject to a special exception to the Act's general applicability provision. See e.g. SB 1197, Section 54(3). Accordingly, we analyze this matter under the Workers' Compensation Act as amended, effective July 1, 1990. See Or Laws 1990 (Special Session), Chapter 2, Section 54(2); Ida M. Walker, 43 Van Natta 1402 (1991).

Remand

Claimant has filed a Motion For Leave To Present Additional Evidence. We have no authority to consider evidence not in the record. Consequently, we interpret claimant's motion as one for remand. Judy A. Britton, 37 Van Natta 1262 (1985).

Should the Board determine that the record has been improperly, incompletely or otherwise insufficiently developed, we may remand a case to the Referee for further evidence taking, correction, or other necessary action. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). In addition, 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 Van Natta 1054, 1055 (1985), aff'd mem, 80 Or App 152

(1986). In this regard, we consider the proferred evidence on review only for purposes of claimant's remand motion.

We are not persuaded that the evidence claimant seeks to admit is relevant to the issue of the employer's scope of acceptance, or that the record concerning this issue was otherwise insufficiently developed. The evidentiary record includes an 801 Form completed by claimant identifying the nature of his injury and injured body parts, an 827 Form completed by claimant's treating physician listing two diagnoses for two areas of the body and finally, a letter from the employer advising claimant that it was "accepting your claim for your tendonitis right forearm." The letter claimant seeks to admit, on the other hand, contains no statement of acceptance by the employer of any condition.

Moreover, we are not persuaded that the evidence claimant seeks to introduce was not obtainable with due diligence at the time of the hearing. The proferred evidence is a copy of a letter from the employer's claims processing agent to claimant's treating physician. In her affidavit, claimant's counsel advises that "[o]n September 23, 1991 claimant was clearing a desk drawer out and found this January 16, 1986 letter on his claim." We conclude from this affidavit that the proferred evidence was obtainable with due diligence at the time of the November 1990 and March 1991 hearings. Accordingly, we conclude that remand is not appropriate and we proceed to review the merits. ORS 656.295(5).

Aggravation Claim

In order to establish a compensable claim for aggravation, claimant must prove he has a worsened condition resulting from the compensable injury. ORS 656.273(1); See Perry v. SAIF, 307 Or 654, on rem 99 Or App 52 (1989). It is undisputed that claimant's right thumb osteoarthritic condition has worsened. It is disputed, however, whether claimant's current condition is causally related to his compensable injury. Claimant does not argue that his current right thumb condition "results" from his right forearm tendinitis. Rather, he contends that the employer accepted his right thumb arthritis condition and cannot now retroactively deny its compensability.

The Referee concluded that the employer "intended to and did accept [claimant's] arthritic thumb problem, notwithstanding the language of the acceptance," such that "[c]laimant's right thumb arthritic condition is a component of the accepted claim." The Referee, therefore, reasoned that under Georgia Pacific v. Piwowar, 305 Or 494 (1988) and SAIF v. Abbott, 103 Or App 49 (1990), the employer was precluded from retroactively denying the compensability of claimant's current right thumb condition.

On review, the employer contends that it specifically limited its acceptance to claimant's wrist condition and that is has never accepted claimant's thumb condition. Thus, the employer argues that its liability is limited to those conditions specifically accepted. See Johnson v. Spectra Physics, 303 Or 49 (1987); Barnett v. EBI Companies, 105 Or App 145 (1991). We agree.

In January 1985, Dr. Harris, claimant's then treating orthopedic physician, diagnosed mild preexisting degenerative arthritis of the right thumb, and tendinitis of the right forearm. In April 1985, the employer advised claimant in writing that it was accepting his claim for tendinitis of the right forearm. Under such circumstances, we conclude that the scope of the employer's acceptance was specifically limited to the right wrist tendinitis. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). Moreover, Dr. Harris diagnosed two separate orthopedic conditions. We find that the employer accepted only one -

the "tendinitis of the right forearm." See SAIF v. Abbott, 107 Or App 53 (1991).

As we have not found claimant's current condition compensable as an aggravation, we turn to claimant's alternative argument, not addressed by the Referee, that his osteoarthritis is compensable as an occupational disease.

Occupational Disease Claim

The employer first asserts that claimant's occupational disease claim is not ripe for consideration by this Board. We conclude, however, that because the employer denied the compensability of claimant's current right thumb condition under both occupational disease and injury theories and claimant's request for hearing included the theory of occupational disease, the issue of whether claimant's current right thumb arthritis is compensable as an occupational disease is properly before us.

In order to establish the compensability of an occupational disease under ORS 656.802(1)(c), claimant must prove by medical evidence supported by objective findings that his work exposure from 1979 through 1985 involved a series of traumatic events that were the major contributing cause of the disease or its worsening. We find that the issue of causation of claimant's right thumb arthritis is of sufficient medical complexity that we cannot decide it without expert opinion. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986).

The record contains five medical opinions regarding causation. Claimant relies on the opinions of Drs. Beck and Woodham, both of whom conclude that his work was the major contributing cause of the development of arthritis in the right thumb. The employer relies on the opinions of Drs. Button, Buehler, and Cottrell, who conclude that the major contributing cause of claimant's condition is the natural progression of an underlying disease process that was not materially affected by his job activities.

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 (1990). Ordinarily, we give greater weight to the opinion of the treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). In this case, we find there are such reasons.

We find the opinions of Drs. Button, Buehler, and Cottrell persuasive. Dr. Button examined claimant four times between June 1985 and September 1990, and had the opportunity to observe the progression of his arthritic disease process. Dr. Button recognizes that arthritic changes can occur after severe traumatic injury, such as fracture or dislocation of the affected joint. In reviewing claimant's medical records however, Dr. Button found, as do we, no evidence of an initial instability or ligamentous laxity in November 1984 which would be indicative of severe trauma. More importantly, Dr. Button explained that osteoarthritis of the CMC joint is usually genetic and has no occupational relationship, and frequently requires surgical reconstruction whether or not the joint has been overused. In this regard, Dr. Button noted that claimant is now developing a similar degenerative process of the CMC joint of his non-dominant left hand.

Similarly, Dr. Buehler testified that the major contributing cause of claimant's condition is the natural progression of his arthritis. He noted that there is no support in the medical literature for the theory that repetitive trauma leads to the development of arthritis at the basal joint of the thumb.

Rather, he found that this joint is the one most commonly affected by osteoarthritis.

Finally, Dr. Cottrell noted that claimant's work as a meatcutter over the years has not "caused" his degenerative arthritis. He explained that the cause of arthritis is not precisely known, and tends to occur spontaneously. Dr. Cottrell opined that in this case, the compensable injury is not the major contributing cause of claimant's present arthritis condition and need for treatment.

On the other hand, we give less weight to the opinions of Drs. Beck and Woodham, claimant's current and recent past treating physicians. While Dr. Beck initially indicated that a significant initial injury to the CMC joint, such as a fracture or dislocation, is required to begin the degenerative arthritic process, he also noted that claimant did not experience that level of trauma. Furthermore, Beck agreed that claimant already had early degenerative changes in the CMC joint at the time of his first post-injury visit. Subsequently, Dr. Beck concurred with claimant's counsel's statement that overuse and "microtrauma" during claimant's 1979 through 1984 work activities were the major contributing cause of claimant's osteoarthritis and current need for treatment. In light of Beck's earlier conclusion, however, we do not find his subsequent "check-the-box" opinion persuasive.

Dr. Woodham, who first treated claimant in January 1990, testified at hearing that he assumes that claimant must have sustained a significant "tearing" injury in November 1984, because everything has to have a "cause." He admitted that he is unaware whether or not claimant sustained a significant injury to his right thumb prior to November 1984. Further, Dr. Woodham noted that it takes a "substantial" period of time from the date of an initial injury for arthritic changes to appear on x-rays. However, after reviewing claimant's medical records, Dr. Woodham agreed that there was evidence of mild degenerative changes on the first post-injury visit. In response to questioning, Dr. Woodham then conceded that claimant could have had degenerative changes <u>before</u> the November 1984 injury.

We find Drs. Button, Buehler, and Cottrell's opinions more persuasive because they are well-reasoned, thorough, and based on complete information. By contrast, Dr. Beck's opinion, however, is conclusory and provides no explanation for his conclusions. Further, Drs. Beck and Woodham's opinions are internally inconsistent. <u>See</u> <u>David H. Olson Jr.</u>, 42 Van Natta 1336 (1990); <u>James S. Espinoza</u>, 43 Van Natta 908 (1991).

Accordingly, we find that claimant has not met his burden of proving that his work activities are the major contributing cause of his right thumb condition. Consequently, claimant's right thumb arthritis is not compensable as an occupational disease.

ORDER

The Referee's order dated June 27, 1991 is affirmed in part and reversed in part. Those portions of the order that set aside the self-insured employer's April 27, August 3, and December 12, 1990 denials of claimant's aggravation and occupational disease claims are reversed; the employer's denials are reinstated and upheld. The Referee's award of an attorney fee for prevailing against those denials is also reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
PATRICIA E. LEE, Claimant
WCB Case No. 90-19452
ORDER ON REVIEW
Kirkpatrick & Zeitz, Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Westerband, Moller, and Gunn.

Claimant requests review of Referee Neal's order which found that claimant had failed to establish "good cause" for her failure to timely request a hearing from the self-insured employer's denial. On review, the issue is timeliness of the hearing request.

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

It is undisputed that claimant did not file a request for hearing within 60 days of receipt of the employer's denial. The Referee found that within the 60 day period, claimant told Dr. Blessing, her treating physician, that she wanted to pursue a workers' compensation claim, and Dr. Blessing responded by saying that he would support her. This finding is directly supported by Dr. Blessing's September 11, 1990 chart note (Ex. 15AA-2). The chart note states that "D.S." of Dr. Blessing's office "finally" made contact with claimant and advised her that an effort by claimant "to get back on workman's comp" would be "fine with him," and that although claimant would have to submit the claim, Dr. Blessing would support her by completing whatever paper work was sent to him. The chart note ends with "says it will take time but he [Dr. Blessing] feels they can work it out." (Ex. 15AA-2).

Under these circumstances, we agree with the Referee that claimant's purported reliance on Dr. Blessing's opinion as to the compensability of the condition did not demonstrate "good cause" for the untimely appeal.[1]

ORDER

The Referee's order dated June 24, 1991 is affirmed.

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[1] We agree with the dissent's basic proposition that an unrepresented worker who does not file a claim in reliance on the uncontroverted opinion of her doctor that a claim would not be medically supported, and who promptly submits a claim after her doctor reverses his position, establishes by such reliance, "good cause" for failing to timely file a claim in the first instance. To hold otherwise would penalize the employee who acts in accordance with the medical evidence and promote the filing of unmeritorious claims.

The problem here for claimant is the evidence and claimant's burden of proof. The chartnotes of claimant's treating physician to which the dissent takes exception on grounds of hearsay were received in evidence without objection. Claimant had the burden of proof. Thus, given the chartnotes, claimant had to establish that the conversation memorialized by the September 11, 1990 entry did not take place. Claimant testified that she talked with the doctor or with his nurse around the time of the entry, but she could not recall specifically with whom she talked or what was said. (Tr. 20). Furthermore, no evidence was offered by claimant that the chartnote was inaccurate. Accordingly, we are constrained to conclude that claimant has failed to carry her burden of proof on the question of whether her untimely filing was due to her reasonable reliance on her doctor's opinion.

Board member Gunn dissenting:

Upon de novo review of the record, I would find claimant had "good cause" for filing her request for hearing 64 days after she received the denial. I would reverse the Referee's order and find the claim compensable. The only bar to compensability raised by the employer is the timeliness of the hearing request.

The majority holds that claimant's reliance upon Dr. Blessing did not constitute "good cause" and that evidence supports that before expiration of the sixty day period in ORS 656.319(1), claimant knew or should have known that her condition was compensable and that she was supported by her treating doctor. Therefore, her purported reliance upon her doctor did not constitute "mistake, inadvertence, surprise or excusable neglect." ORCP 71(B); Brown v. EBI Companies, 289 Or 455 (1980).

Claimant testified that she was not informed that Dr. Blessing supported compensability of her condition until October 10, 1990. The temporal relationship between her October 10, 1990 doctor visit, where he instructed her to write to the Workers' Compensation Board to request review, and her October 11, 1990 letter to the Board, supports claimant's testimony. Further, on the record, her testimony is consistent and credible and was not rebutted. Also, the temporal relationship between the October 10th visit and claimant's request for hearing support her version of the events. I would defer to her reliable testimony on the issue.

The majority, in arriving at its conclusion, relies upon a chart note contained in Exhibit 15AA-2. Exhibit 15AA-2, in pertinent part, provides:

> "8/29/90 Pt. reports employer said she must take sick leave since she can only lift 10 - 15 lbs. She would like to get back on workman's comp. Dr. Bl. consulted. Advises it is fine with him. He thinks she should start all over by re-submitting the claim. He can't do the inquiries but is willing to do whatever paper work they send him. Says it will take time but he feels they can work it out ---------- D.S.
>
> "9/11/90 Finally connected with pt. et gave her this message. D.S."

Contrary to the majority's implications, this exhibit is not a chart note authored by Dr. Blessing. Therefore, it cannot be interpreted as reflecting any opinions of Dr. Blessing. Moreover, a close reading of the notation reveals that the actual content of any message purportedly transmitted to claimant from Dr. Blessing's office is not definitively disclosed in the chart note.

Significantly, the chart note was authored by someone identified only as "D.S." The record does not identify who "D.S." is; nor did "D.S." testify at hearing as to the validity of the representations made by him or her in the September 1990 chart note.

The chart note, therefore, is hearsay and accordingly, should not be considered in establishing the truth of what statements claimant made to her physician. Additionally, the chart note should be given little weight because it does not concern matters regarding medical diagnosis or treatment. Further, the hearsay statement should not be considered in establishing the truth of what statements Dr. Blessing allegedly made to "D.S." or what "D.S." allegedly reported to claimant. See Javier Carrasco, 42 Van Natta 1133 (1990); Pinky P. Holder, Jr., 42 Van Natta 568 (1990); Herbert D. Rustrum, 37 Van Natta 1291

1985) (An exhibit which is a hearsay statement on the central factual issue and the declarant is unavailable for cross-examination is accorded "very little weight"); James R. Rolandson, 44 Van Natta 205 (1992); Johnny C. Madison, 43 Van Natta 914 (1991); Lyle A. McManus, 43 Van Natta 863 (1991) (An exhibit authored by an unsworn and unavailable signator would be accorded little weight); Emery R. Miller, 43 Van Natta 1788 (1991) (Claimant's statements to his doctor that are not reasonably pertinent to diagnosis or treatment will be accorded little weight).

Once this chart note has been correctly discounted, the record establishes that the first time claimant knew that Dr. Blessing supported compensability of her condition was October 10, 1990, as demonstrated by Exhibits 16B and 16C. Exhibit 16B is a chart note that is authored by Dr. Blessing. The chart note expresses Dr. Blessing's opinion that he believes claimant's condition is work related. Exhibit 16C is claimant's October 11, 1990 letter to the Board requesting review. Claimant testified that she wrote this letter after being instructed to do so on October 10, 1990 by Dr. Blessing. The fact that claimant also relied upon Dr. Blessing's advice as depicted by her letter, further emphasizes the reliance she put upon his professional judgement in regards to her workers' compensation claim.

Therefore, inasmuch as the record establishes that claimant did not actually know or should have known, within the sixty day period, that Dr. Blessing supported compensability of her condition, claimant's reliance upon Dr. Blessing's opinion establishes "good cause" for her untimely request for hearing. This finding is further supported by precedent found in the following case law.

The Board has previously interpreted Brown v. EBI, 289 Or 455 (1980), "to mean that the question of what is 'good cause' within the meaning of ORS 656.319(1)(b) is a policy question for the Board to resolve under the McPherson v. Employment Division, 285 Or 541 (1979), line of cases;" thus, prior judicial constructions are not binding. Also see Anderson v. Publishers Paper co., 78 Or App 513 (1986); Gary D. Land, 35 Van Natta 363 (1983); Juanita Trevino, 34 Van Natta 632 (1982).

In McPherson, the court found that "good cause" is not a statutory term that meets a certain definable legal test. Rather, the term "good cause" calls for a value judgement which evaluates what are "good" reasons for a worker's actions. Id, at 550. In Fajardo v. Morgan, 15 Or App 454 (1973), the court interpreted "good cause" as a standard that represented the reasonable average worker similarly situated.

Applying that standard to the present case, the pivotal question is, what would the reasonable average worker in a similar situation have done in claimant's position? Logic dictates that the reasonable average worker, unrepresented and unexperienced in the workers' compensation arena, and whose doctor informs her that her condition is not compensable, would undoubtedly believe, there was good reason not to contest the denial. In such a situation as claimant was in, it is reasonable that the average unrepresented worker would rely upon her treating physician's opinion. Undeniably, a patient's trust in her physician's expert opinion and professional judgement is the quintessence of the doctor/patient relationship.

Claimant has demonstrated that she relied upon her physician's expertise. This reliance was reasonable. The reliance was the reason why claimant failed to timely request a hearing. Claimant's reliance upon her physician's expert opinion has thus, established "good cause." See Guy Stevenson, 36 Van Natta 1055 (1984) (Claimant had established "good cause" for his late request for

hearing inasmuch as his delay was due to his reliance on his physician's opinion).

The employer relies upon the holding in Anderson v. Publisher's Paper Co., 93 Or App 516 (1988). However, the employer has mischaracterized the court's findings. The employer contends that:

> "In that case, the Court of Appeals affirmed the Board's determination that claimant had not proven good cause. The Court held that claimant's explanations for his untimely appeal, i.e., that Dr. Button had told him his condition was not related to his past work for the employer, was insufficient." (Resp. Br. at 5).

The employer's analysis is incorrect. Admittedly, the court affirmed the Board by finding that claimant's "explanations for lack of diligence do not constitute good cause for failure to file a timely claim," however, the court did not find that claimant's untimely claim was due to his reliance on his physician's opinion. The court stated that:

> "The Board found, and we agree, that claimant received the denial letter, read it it, understood it and chose not to act within the 60 days, but not because of Button's advice or because Lawton was involved." (Emphasis supplied). Anderson, supra, at 519.

Therefore, the court's finding in Anderson is consistent with the Board's holding in Guy Stevenson. Accordingly, reliance upon a physician's opinion may establish "good cause" for an untimely request for hearing.

Finally, I emphasize that throughout the sixty day time period, claimant never filed a claim[2] nor was she represented by counsel. Throughout the time period in question, she operated pro se with respect to her legal determinations and decisions as to the claim. Further, although injured workers are encouraged to be represented by counsel, this suggestion is not a requirement. See OAR 438-06-100; Linnie L. Lockwood, 40 Van Natta 846, 847 (1989). Moreover, OAR 438-05-035 provides that:

> "It is the policy of the Board to expedite claim adjudication and amicably dispose of controversies. These rules shall be liberally construed in favor of the injured worker to carry out the remedial and beneficent purposes of the Workers' Compensation Law. The overriding principle is substantial justice. With respect to postponement or continuance of hearings, substantial justice requires consideration of the relative financial hardship of the parties. The unrepresented injured worker shall not be held strictly accountable for failure to comply with theses rules. Any individual who undertakes to represent a party in proceedings under these rules shall be required to comply with these rules."

Also see Charles N. Caywood, 39 Van Natta 83 (1987).

Here, we have a lay person in pain relying upon and frustrated by her employer and doctor. That evident frustration is best stated by claimant:

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[2] The Opinion and Order states that the employer filed the claim, claimant indicates the doctor "put her on workers' comp." It is clear from Exhibit 11 that she did not sign the 801 form. It should also be noted that the denial letter (Ex. 16) stated that both claimant's conditions were not a major contributing factor, a material standard is all that is required by law.

"Q. Ms. Lee, you seem kind of frustrated or unable to indicate why you really didn't just go ahead and appeal it after you talked to Dr. Blessing. I think you said if the doctor wasn't going to support it, why bother, right?

"A. Well, I -- you know, they kept throwing this staph at me like it was something that I did and I don't understand, you know -- when I went into the doctor, I was hurting so bad that -- I don't think anybody will ever realize how bad I was hurting. And because of the staph, there's -- it seemed like they keep throwing this at me that it's my fault, and I don't understand that part of it.

"Q. I'm not asking about how much pain you were in --

"A. -- Well I know --

"Q. -- I'm talking about in August, after the denial.

"A. I know, but I figured if I -- everytime I seem to talk to anybody they kept going back to the staph, this staph. Well, I don't know anything about staph. I don't know why I got it. I did and so I figured, why am I having to go through this now. This is the reason I guess I didn't do it. I don't like -- I'm not trying to get something I don't feel like that maybe I deserve. I don't know. I just, because of the staph -- I'm going to probably say is the biggest reason I did not go approach the denial."

In sum, here is a lay person in pain, who is told by both her doctor and employer that her condition is not compensable. Her "mistake, inadvertence, surprise or excusable neglect," is that she without legal knowledge of the consequences amicably relied upon her employer's representations and reasonably relied upon her doctor's expert judgement. It is noted that a claimant's inaction due to the fault of the claimant is not "excusable neglect." Burkholder v. SAIF, 11 Or App 334 (1972); Allen W. Hays, Jr., 37 Van Natta 1179 (1985). However, here claimant cannot be faulted for trusting and relying on her treating physician and employer's expertise in light of her inexperience and unsophistication in the mechanics of workers' compensation. Plainly, her conduct was no different than that of the reasonable average worker, unrepresented and in the same situation.

Under the circumstances, I believe her actions constitute "excusable neglect." Accordingly, I would set aside the self-insured employer's denial and find claimant's claim compensable.

In the Matter of the Compensation of
KENNETH W. McDONALD, Claimant
WCB Case No. 90-08924
ORDER ON RECONSIDERATION
Roger D. Wallingford, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

The insurer has requested reconsideration of that portion of our April 7, 1990 Order on Review that affirmed the Referee's conclusion that claimant had established the compensability of his psychological condition. On May 6, 1992, we abated our order to allow claimant an opportunity to respond. Claimant's response has been received.

On reconsideration, the insurer contends that our order is legally insufficient because the Referee's findings, which we adopted, are not supported by substantial evidence. It explains:

> "The Referee's findings regarding the cause of claimant's psychological disorder consists, in pertinent part, of the following:
>
> > 'Although the fact that [claimant] was not working and nonwork stressors were contributing causes of claimant's major depression, the major contributing cause was chronic pain, disability, and worry considering medical treatment in connection with his compensable low back condition (Ex. 69-36).'
>
> "This finding regarding causation is inadequate, because the documentary evidence upon which the referee purportedly relied, fails to support that finding." (Motion for Recon. at 2). (Citations and emphasis omitted.)

At the outset, we note that the Referee's citation to "Ex. 69-36" in support of his finding was in error, as Exhibit 69 is a one page document. We believe that the Referee was most likely referring to Exhibit 62A, a transcript of Dr. Roundtree's deposition which, as noted by claimant, clearly supports the finding of fact. It provides, in part:

> "Q: (By claimant's counsel) Will you agree that, had it not been for [claimant's] back accident, resultant disability and chronic pain, he would not have developed symptoms of major depression?
>
> "A: (By Dr. Roundtree) Well, I suppose something else could have come along that would have triggered this kind of reaction. But, to the best of my knowledge, or the best of my awareness, that was the major contributing cause." (Ex. 62A-36).

Accordingly, while the insurer evidently disagrees with the Referee's finding, the finding is supported by evidence in the record, notwithstanding the typographical error.

Citing Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498 (1990), the insurer also contends that our order is deficient because the Referee failed to identify a compensable cause as the major cause of claimant's psychological disorder. We disagree. In Vorderstrasse, the referee's order contained but one conclusory finding of fact and no express finding as to work connectedness. In contrast, the Referee here made nine separate findings of fact regarding compensability, including a finding that the major contributing cause of claimant's psychological disorder was chronic pain, disability, and concern over medical treatment in connection with his compensable low back condition. Because those three factors are related to claimant's compensable condition, our order, which adopted that finding, is adequate for review.

The insurer last contends that we should have relied on Dr. Beckstrom's opinion, rather than adopting the Referee's order that relied on the opinions of Drs. Worthington and Roundtree. We disagree. After a review of the conflicting medical opinions, the Referee found the opinions of Worthington and Roundtree most persuasive due to their comparatively long-term involvement with claimant and the logical force behind their conclusions. After further review of the record, we continue to agree with that determination. Somers v. SAIF, 77 Or App 259 (1986).

Accordingly, our April 7, 1990 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our April 7, 1990 order effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

May 28, 1992 Cite as 44 Van Natta 1054 (1992)

In the Matter of the Compensation of
ERNEST J. MEYERS, Claimant
WCB Case No. 90-19652
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Hooton and Gunn.

Claimant requests review of those portions of Referee Spangler's order that: (1) awarded interim compensation for the period from October 11, 1990 through October 17, 1990, but declined to award interim compensation for the period from September 6, 1990 through October 10, 1990; (2) did not assess penalties and attorney fees for the insurer's allegedly unreasonable failure to pay interim compensation; and (3) did not assess penalties and attorney fees for the insurer's alleged failure to timely accept or deny claimant's occupational disease claim for a degenerative disc condition. In its brief, the insurer argues that claimant's November 30, 1990 request for reconsideration by the Department of Insurance and Finance (DIF), concerning the amount of temporary disability ordered paid by an October 10, 1990 Determination Order under another claim, precludes claimant from raising the interim compensation issue on his occupational disease claim at this hearing. On review, the issues are jurisdiction, interim compensation and penalties and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The insurer argues that claimant's November 30, 1990 request for reconsideration by DIF precluded him from litigating the interim compensation issue at this hearing. In this regard, the insurer apparently contends that the Referee did not have jurisdiction over the issue, because it was pending elsewhere. We disagree.

Claimant requested reconsideration of an October 10, 1990 Determination Order which closed his February 1990 injury claim. His entitlement to temporary disability compensation under that injury claim is a different matter from his asserted entitlement to interim compensation under the occupational disease claim he filed in June 1990. Claimant's request for reconsideration concerning his award under the prior claim does not affect the Referee's jurisdiction to determine whether claimant is entitled to compensation under a new claim. Because claimant raised a matter concerning a claim, i.e., entitlement to compensation under a new claim, he properly invoked the Referee's jurisdiction. See ORS 656.704(3).

Interim Compensation

The question is whether claimant has proven entitlement to interim compensation under his new occupational disease claim. We conclude that he has established that entitlement.

The Referee awarded interim compensation for the period from October 11, 1990, the day after claimant's prior injury claim was closed, through October 17, 1990, the date the insurer denied the occupational disease claim. However, the Referee did not award interim compensation for the period from September 6, 1990, the date claimant became medically stationary under the injury claim, through October 10, 1990. The insurer offset temporary disability paid for periods after the September 6, 1990 medically stationary date against the permanent disability awarded by the October 10, 1990 Determination Order. Claimant now contends that he should receive interim compensation, under the occupational disease claim, for periods beginning on September 6, 1990.

Under a new injury or occupational disease claim, a worker is entitled to interim compensation for the period between the date the insurer receives notice that claimant left work for reasons related to the claim and the date of its formal denial. See ORS 656.262(2). The insurer must begin paying interim compensation no later than 14 days after it has notice or knowledge of the claim. ORS 656.262(4)(a).

Claimant contends that his attorney's June 26, 1990 letter to the insurer constituted a claim for an occupational disease. (See Ex. 11F). We agree. On review, the insurer accepts claimant's recitation of facts, (Resp. Brief p.1), which includes claimant's statement that his attorney filed the occupational disease claim via the June 26, 1990 letter. Inasmuch as the insurer does not dispute that the claim was filed, it is estopped from denying that it had notice of that claim. Accordingly, we find that the insurer had notice of the occupational disease claim by late June or early July 1990. Furthermore, we find that the insurer had notice that claimant was unable to work due to his claimed back condition.

For these reasons, we conclude that claimant has established entitlement to interim compensation under the occupational disease claim for the period from the insurer's July 1990 notice of the claim until the October 18, 1990 denial. We agree with the Referee's determination that claimant is not entitled to interim compensation payments under the occupational disease claim for those periods during which he received temporary disability benefits under the injury claim. See Fischer v. SAIF, 76 Or App 656 (1985). Accordingly, the order is modified so that the insurer is required to pay interim compensation under the occupational disease claim for the period beginning September 6, 1990, when payments under the injury claim ceased, until October 18, 1990, the date the insurer denied that claim.

Penalties and attorney fees

Claimant seeks penalties and attorney fees based on the insurer's failure to timely accept or deny the occupational disease claim and its failure to pay interim compensation pursuant to that claim.

The insurer did not accept or deny the occupational disease claim within 90 days as required by ORS 656.262(6). Neither did it begin paying interim compensation within 14 days of its notice or knowledge of time loss associated with the claim, as required by ORS 656.262(4)(a). See Bono v. SAIF, 298 Or 405, 408-10 (1984); Weyerhaeuser v. Bergstrom, 77 Or App 425 (1986); Donald L. Lowe, 41 Van Natta 1873 (1989). The insurer's nonaction delayed claimant's compensation

and is unreasonable as it is unexplained. Consequently, claimant is entitled to a penalty of 25 percent of the unpaid interim compensation under the occupational disease claim.

As we have stated, claimant seeks "penalty-related" attorney fees a well as penalties. Only one penalty of 25 percent may be assessed against claimant's unpaid compensation and that penalty is shared with claimant's attorney, in lieu of an attorney fee. ORS 656.262(10)(a). Moreover, only one attorney fee may be assessed for a single processing infraction. However, the insurer's failure to timely accept or deny the occupational disease claim is unreasonable conduct separate and distinct from its failure to pay interim compensation. By failing to respond to the claim, the insurer unreasonably resisted the payment of compensation. See ORS 656.382(1). Thus, claimant is entitled to an attorney fee on this basis, as well as a penalty based on the unpaid interim compensation. See Nicolasa Martinez, 43 Van Natta 1638 (1991).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services concerning the future to timely accept or deny the claim is $550, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by appellant's brief and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 21, 1991, as reconsidered March 8, 1991, is modified in part and affirmed in part. In lieu of the Referee's award of interim compensation for the period from October 11, 1990 through October 17, 1990, claimant is awarded interim compensation for the period from September 6, 1990 through October 17, 1990. Claimant's attorney is awarded an attorney fee of 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. For the insurer's unreasonable refusal to pay interim compensation, claimant is awarded a penalty in an amount equal to 25 percent of unpaid interim compensation, with one-half to be paid to claimant's attorney. Claimant is awarded an insurer-paid attorney fee of $550 for his services concerning the insurer's failure to timely accept or deny the occupational disease claim. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
MICKEY L. PLATZ, Claimant
WCB Case No. 91-11623
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Barber's order which set aside an Order on Reconsideration because it was invalidly issued and remanded this matter, on an interim basis, to the Appellate Unit of the Workers' Compensation Division (WCD) for further processing. On review, the issue is the validity of the WCD's Order on Reconsideration. We affirm, as modified.

FINDINGS OF FACT

On July 24, 1990, claimant sustained a compensable injury to her left shoulder. Her claim was closed by a May 22, 1991 Notice of Closure which awarded 17 percent (54.4 degrees) unscheduled permanent disability.

On July 15, 1991, claimant requested reconsideration of the Notice of Closure. Her request for reconsideration was made on a form provided by the Department of Insurance and Finance. On the form, claimant checked the box indicating that she disagreed with the impairment findings made by her attending physician at the time of claim closure.

On September 3, 1991, an Order on Reconsideration issued which affirmed the Determination Order in all respects. The order acknowledged that claimant was entitled to a medical arbiter as there was a dispute over the impairment findings. However, the order explained that the Director was required by a circuit court judge's injunction to issue a reconsideration order "regardless of whether the reconsideration process has been completed." Despite the issuance of the reconsideration order, the parties were further advised that claimant would still be scheduled for a medical arbiter review.

On September 21, 1991, subsequent to the issuance of the Order on Reconsideration, claimant was examined by the medical arbiter, Dr. Robert Fry, M.D. Dr. Fry issued his report the same day.

The Referee issued an Interim Order on November 26, 1991, setting aside the Order on Reconsideration as invalid and remanding this matter to the Appellate Unit. Claimant requested Board review on December 24, 1991. On January 7, 1992, we issued an Interim Order concluding that the Referee's order was an appealable final order and holding that we had authority to consider the matters raised by claimant's request for review. Mickey L. Platz, 44 Van Natta 16 (1992).

CONCLUSIONS OF LAW AND OPINION

Validity of Department's Order

Reasoning that ORS 656.268(7) requires the medical arbiter's report to be considered by the Department before it issues its Order on Reconsideration, the Referee set aside the Order on Reconsideration and remanded this matter to the WCD Appellate Unit. We agree that the arbiter's report had to be submitted to the Department and considered before a valid Order on Reconsideration could be issued.

Claimant became medically stationary after July 1, 1990. Therefore, the 1990 amendments to the Workers' Compensation Act apply to this case. See Oregon Laws 1990 (Special Session), 54(3). The Director's rules in effect at the time of the September 3, 1991 Order on Reconsideration are applicable. Former OAR 436-30-003(4) (WCD Admin. Order 7-1990, effective July 1, 1990).

ORS 656.268(7) provides, in part:

> "If the basis for objection to a notice of closure or determination order issued under this section is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter appointed by the director. . . . The findings of the medical arbiter shall be submitted to the department for reconsideration of the determination order or notice of closure. . . ." (Emphasis supplied).

We have recently interpreted this provision to mean that where a party requests reconsideration of a Notice of Closure or Determination Order and the basis for that request is a disagreement with the medical findings for impairment, then the Director is required to submit the matter to a medical arbiter or panel of arbiters prior to issuing an Order on Reconsideration. See Olga I. Soto, 44 Van Natta 697 (1992). However, where a party does not contest the medical findings of impairment, referral to an arbiter or panel of arbiters is not required. Doris C. Carter, 44 Van Natta 769 (1992).

Here, claimant requested reconsideration of the Determination Order on the basis that she did not agree with the impairment findings made by her attending physician at the time of claim closure. The Order on Reconsideration was issued before the medical arbiter had examined claimant and reported his findings. Thus, the medical arbiter's findings were not submitted to the department and considered before the Order on Reconsideration was issued as required by ORS 656.268(7).

Where the Director does not comply with the mandatory procedure of referring the claim to a medical arbiter and considering the arbiter's findings prior to issuing his Order on Reconsideration, and one of the parties objects to the order issued, the Order on Reconsideration is invalid. Olga I. Soto, supra. Here, although claimant challenged her physician's impairment findings thereby bringing into play the medical arbiter process, the Director issued his order prior to receiving and considering the medical arbiter's findings. Under such circumstances, the Order on Reconsideration is invalid.

In affirming the Referee's order, we note that the Referee had authority to find the Department's order invalid. However, the Referee was not authorized to "remand" the case to the WCD Appellate Unit. Since the Order on Reconsideration was found to be invalid, jurisdiction over the dispute remained with the Department. Under such circumstances, it would be the parties' responsibility to seek from the Department the issuance of a validly issued Order on Reconsideration.

ORDER

The Referee's order dated November 26, 1991, as modified herein, is affirmed.

May 28, 1992 Cite as 44 Van Natta 1058 (1992)

In the Matter of the Compensation of
MAX W. SANDERSON, Claimant
WCB Case No. 89-11005
ORDER ON REVIEW
Vick, et al., Claimant Attorneys
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Davis's order that declined to grant permanent total disability. On review, the sole issue is permanent total disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was capable of performing work at a gainful and suitable occupation. The Referee also found that claimant had not demonstrated a willingness to seek work since 1987. The Referee, therefore, concluded that claimant had not established that he was permanently and totally disabled.

We adopt the Referee's conclusions and opinion on the issue of permanent total disability, and we add the following supplementation.

On review, claimant contends that the Referee should not have discounted the vocational opinion of Mr. Hughes, claimant's vocational expert, on the basis that Mr. Hughes' opinion was inconsistent with the medical opinions regarding claimant's abilities. Claimant argues that the Referee found that his condition had not changed significantly since the last claim closure, and the restrictions identified by Dr. Tiley in a March 1991 report were very similar to the restrictions found by Dr. Melgard in February 1989. Under the circumstances, claimant contends that there was no reason for Mr. Hughes to review the most recent medical opinion, due to its similarity to the 1989 report.

We agree with the Referee's conclusion that the 1989 and 1991 reports were similar, especially in regard to the lifting restrictions. However, restrictions appear in the 1989 medical report that do not appear in the 1991 letter from Dr. Tiley (e.g., the 1989 report restricts claimant from any bending, restricts claimant to rarely twisting, frequently kneeling, never climbing ladders, rarely climbing steps, and rarely reaching above shoulder level). Under the circumstances, we do not agree with claimant that it was error for the Referee to discount Mr. Hughes' opinion on the basis that he had not reviewed the more recent report before formulating his opinion.

Claimant also argues that the Referee only took claimant's lifting capacity into account and did not consider the fact that he would require frequent breaks or changes of position. We disagree.

The Referee relied, in part, upon the opinion of Mr. Sakagawa, who was aware of Dr. Tiley's assessment of claimant's physical capacity. Dr. Tiley reported that claimant did not need to lie down regularly. However, Dr. Tiley did state that claimant should avoid sitting or standing for more than two hours at a time, and that he would need to have an opportunity to move around and change positions. Because we find that Mr. Sakagawa was aware of these restrictions, we do not agree with claimant that they were not taken into account in Mr. Sakagawa's opinion that claimant could work at the clerical, cashier and telephone solicitor jobs he identified.

Finally, although claimant concedes that he has not made any recent efforts to return to work, he contends that a work search would be futile. We disagree. Based upon the medical and vocational opinions within the record, we agree with the Referee's conclusion that claimant is capable of performing work at a gainful and suitable occupation. We, therefore, affirm the Referee on the issue of permanent total disability.

ORDER

The Referee's order dated August 30, 1991 is affirmed.

In the Matter of the Compensation of
MARCHETA M. WEST, Claimant
WCB Case No. 91-03115
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The self-insured employer requests review of those portions of Referee Davis's order that: (1) awarded an attorney fee for claimant's counsel's efforts in obtaining rescission of a "de facto" denial of her left arm condition; (2) awarded an attorney fee for an allegedly unreasonable resistance to the payment of compensation; and (3) awarded a penalty and attorney fee for failure to timely pay temporary disability benefits. On review, the issues are penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Rescinded denial

On review, the employer argues that claimant has identified only one allegedly late payment and it contends that a carrier is not required to issue a written acceptance of every medical bill it receives. The employer contends that no attorney fee is warranted as there has never been a formal or "de facto" denial in this case. We disagree.

A claim is denied "de facto" after the expiration of the statutory period within which to accept or deny the claim under ORS 656.262(6). See Barr v. EBI Companies, 88 Or App 132 (1987); Doris J. Hornbeck, 43 Van Natta 2397 (1991). Here, on August 22, 1990, the provider sent the employer a bill in the amount of $3,830.61 for claimant's elbow fracture. Over the two months following the initial statement, the employer also received chart notes that referred to claimant's elbow fracture sustained when she tripped over her "drop foot" which is a part of her compensable injury. However, the employer did not accept or deny claimant's claim until the time of hearing on June 5, 1991, which is far beyond the 90-day statutory time period for such acceptance or denial. The claim was, therefore, denied on a "de facto" basis until the employer properly accepted it at hearing.

Moreover, we agree with the Referee that, by requesting a hearing on the "de facto" denial and obtaining rescission of that denial, claimant's counsel was instrumental in obtaining compensation for claimant. Accordingly, we affirm the Referee on the issue of an assessed attorney fee awarded in conjunction with the rescission of the denial.

Unreasonable resistance to payment of compensation

We adopt the Referee's "Conclusions of Law and Opinion" on the issue of an assessed attorney fee for failure to timely provide discovery. See Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991) (attorney fee may be awarded for discovery violation even when no evidence violation delayed acceptance of claim).

Failure to timely pay temporary disability

We adopt the Referee's "Conclusions of Law and Opinion" on the issue of a penalty and attorney fee for the employer's failure to timely pay temporary disability benefits.

Although claimant has prevailed against the employer's request for review, the only issues on review involved penalties and attorney fees. Under the circumstances, no attorney fee may be awarded for claimant's counsel's services on Board review. Dotson v. Bohemia, Inc., 80 Or App 233 (1986); Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated August 16, 1991 is affirmed.

In the Matter of the Compensation of
RICHARD T. AVILA, Claimant
WCB Case Nos. 90-17969 & 90-00232
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Roberts, et al., Defense Attorneys
Bottini, et al., Defense Attorneys

Reviewed by Board Members Moller and Brazeau.

Claimant requests review of Referee Knapp's order that: (1) upheld Scott Wetzel Service's denial of claimant's cervical condition; (2) upheld AIAC's denial of claimant's injury/occupational disease claim for a neck, back, and arm condition; and (3) upheld Scott Wetzel's denial of claimant's palliative chiropractic treatment as neither reasonable nor necessary. On review, the issues are jurisdiction, compensability, and medical services.

We affirm and adopt those portions of the Referee's order which upheld Scott Wetzel's denial of claimant's cervical condition and upheld AIAC's denial of claimant's neck, back, and arm condition. We add the following supplementation.

Claimant contends that Scott Wetzel is precluded from denying his cervical condition because it previously accepted the condition as a result of a prior litigation. We disagree.

The prior Referee and Board orders each make references to claimant's mid back and thoracic pain, as well as to cephalgia. Nevertheless, the Board order, which affirmed the Referee's order finding Scott Wetzel to be responsible for claimant's condition, expressly identified the issue as compensability and responsibility for claimant's "current low back condition." Moreover, the Board order did not refer to claimant's cervical condition.

Under such circumstances, we conclude that Scott Wetzel is not precluded from denying claimant's current cervical condition. Furthermore, we agree with the Referee that the medical and lay evidence does not establish that claimant's 1982 compensable low back and lower extremity injury is a material contributing cause of his current neck condition. Consequently, we affirm the Referee's decision to uphold Scott Wetzel's denial.

In upholding AIAC's denial of claimant's injury claim for his neck, upper back, and arm condition, the Referee stated that the work incident "did not

result in any increased treatments by Dr. Kennedy nor was it significantly disabling to cause time loss." Claimant objects to the Referee's reasoning, contending that his claim is compensable because the work incident caused an increase in his symptoms which required medical care.

To establish the compensability of his neck, upper back, and arm injury claim, claimant must establish that the March 1990 work incident was a material contributing cause of his disability and need for medical treatment. ORS 656.005(7)(a); Mark N. Weidle, 43 Van Natta 855 (1991). After conducting our review, we agree with the Referee's conclusion that claimant's need for medical treatment was caused by his preexisting degenerative cervical condition. In other words, the work incident was not a material contributing cause of claimant's disability or need for medical treatment. Therefore, his claim is not compensable. See Taylor v. Multnomah County School Dist. No. 1, 109 Or App 499 (1991).

Finally, the Referee upheld Scott Wetzel's denial of claimant's palliative chiropractic treatment as neither reasonable nor necessary medical treatment. Subsequent to the Referee's order, we have held that ORS 656.327 provides a procedure for the resolution of disputes between the insurer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of [administrative] rules." Stanley Meyers, 43 Van Natta 2643 (1991). Therefore, original jurisdiction over disputes regarding the necessity or reasonableness of medical services now lies exclusively with the Director. Id. Consistent with the Meyers holding, we have further concluded that disputes concerning whether medical treatment is palliative or curative are also subject to the Director's original jurisdiction. See Gladys M. Theodore, 44 Van Natta 905 (1992).

Here, as previously noted, the dispute pertains to whether claimant's chiropractic treatments were reasonable and necessary. Thus, the issue is whether the disputed treatment is "excessive, inappropriate, or ineffectual." In accordance with the Meyers rationale, original jurisdiction for resolution of such a dispute rests with the Director under ORS 656.327. Accordingly, that portion of the Referee's order which upheld Scott Wetzel's denial of claimant's chiropractic treatments as neither reasonable nor necessary is vacated.

ORDER

The Referee's order dated February 5, 1991 is affirmed in part and vacated in part. That portion of the order which upheld Scott Wetzel's denial of claimant's chiropractic treatment as neither reasonable nor necessary is vacated. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
DAVID R. BOYLES, Claimant
WCB Case No. 91-05958
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Janice M. Pilkenton, Defense Attorney

Reviewed by Board Members Brazeau, Kinsley and Hooton.

The insurer requests review of that portion of Referee Podnar's order that directed it to pay temporary total disability compensation for the period from

June 17, 1991 through July 22, 1991. On review, the issue is temporary disability. We affirm in part, modify in part, and reverse in part.

FINDINGS OF FACT

The insurer commenced paying temporary disability compensation on March 11, 1991.

On or about May 1, 1991, claimant's union struck the employer's place of business.

On June 6, 1991, claimant's treating physician approved modified work which the employer offered to claimant. However, claimant did not report to work because he refused to cross the union's picket line.

The insurer stopped paying temporary total disability benefits on June 16, 1991. However, it paid an unspecified amount of temporary partial disability compensation thereafter. (See Ex 50; Tr. 41-42).

Claimant began working for another employer on July 22, 1991.

CONCLUSIONS OF LAW AND OPINION

The Referee awarded temporary disability compensation based on our holding in William J. Wilson, 43 Van Natta 288 (1991). In that case, we held that under former OAR 436-60-030(5), refusal by a worker to report for offered modified employment because he would not cross a picket line did not constitute a "refusal" of employment, as that term if used in the former rule. Subsequent to the Referee's Opinion and Order, however, the court reversed our order, holding that in the absence of legislative direction to the contrary, temporary total disability benefits are not available if the loss result from reasons other than the compensable injury. Roseburg Forest Products v. Wilson, 110 Or App 72, 75 (1991). On remand, we found that the worker was not entitled to temporary total disability where the reason for his absence from work was his election not to cross a picket line. William J. Wilson, 44 Van Natta 724 (1992).

Here, as in Wilson, supra, claimant was offered modified work and the job was approved by his attending physician. Claimant did not report to work because he was unwilling to cross the picket line. Therefore, in accordance with the court's decision in Wilson, we find claimant's failure to report for available work to be a refusal of wage earning employment. Consequently, the insurer was authorized to terminate payment of temporary total disability benefits when claimant failed to begin the offered employment. See ORS 656.268(3)(c).

ORDER

The Referee's order dated August 13, 1991 is affirmed in part, modified in part, and reversed in part. That portion of the order that directed the insurer to pay temporary total disability benefits for the period from June 17, 1991 through July 22, 1991 is reversed. That portion of the order that authorized the insurer to offset temporary partial disability compensation paid for the same period against temporary total disability awarded by the order is modified. The insurer is authorized to offset temporary partial disability compensation paid for that period against any future awards of permanent partial disability on this claim. The remainder of the order is affirmed.

Board Member Hooton dissenting.

I agree with the majority that the Court of Appeals decision in Roseburg Forest Products v. Wilson, 110 Or App 72, 75 (1991) holds that TTD benefits are not available to a worker who refuses to cross a picket line to accept a bona fide offer of employment. I do not, however, accept that Wilson requires the result here because there is sufficient evidence to establish that the work offer was not a bona fide offer of employment.

The employer allegedly offered claimant a light-duty position involving clerical duties. It is that position which claimant declined to accept because of the ongoing strike by the mechanics union of which he was a member. However, the evidence at hearing establishes that the employer had just terminated an employee from that same clerical position for lack of work. In addition, the evidence also indicates that the employer offered claimant a salary out of all proportion to the salary regularly paid for that work. In other words, the employer agreed to pay claimant his regular wage to accept a job which didn't exist. That is not an offer of employment. At the very best it is charity. (Charity, however laudable, is not "modified employment"). Why would an employer in the midst of a strike, with its attendant financial difficulties, choose such a course of action?

Under the rule developed by the Court of Appeals in Safeway Stores v. Owsley, 91 Or App 475 (1988), the employer may occasionally be tempted to return an employee to work at a light-duty job at his time-of-injury wage, rather than the wage regularly paid for that light-duty work, and then terminate the employee for reasons "unrelated to his injury" in order to avoid both the obligation to pay wages and the obligation to pay time loss. Where the wage at time of injury is very high, as here, the incentive to deprive claimant of his workers' compensation benefits in this manner may be overwhelming.

Wilson provides yet another avenue to accomplish that same end. Where, as here, the employer is reasonably certain that claimant will stand by the union, of which he is a member, he need not even find a reason "unrelated to the injury" as an excuse for the termination. All he has to do is offer the "employment."

While the legislature intended to benefit employers who reemployed injured workers, and therefore, provided incentives for reemployment, it did not intend to provide employers an opportunity to escape any responsibility for the claimant's temporary loss of earning power. Consequently, our application of the Owsley rule, ORS 656.268(3) and Wilson needs to be tempered by an understanding of the abuses which can and do occur.

That issue is raised in the present claim. If there really is no job, can there be a bona fide job offer? When that consideration is combined with the fact that the employer offered claimant a wage out of all proportion to the actual value of the work allegedly offered, is there evidence to support the contention that the employer knowingly set out to deprive claimant of his statutory right to temporary partial disability? I believe that the answer to the first question is no. There is not and never was a bona fide offer of employment. I further believe that there is sufficient evidence to support a conclusion that the employer intended to use the ruse of an offer of employment to deprive claimant of his temporary partial disability.

Because the majority does not even consider these questions, I must respectfully dissent.

In the Matter of the Compensation of
ESTER E. EDWARDS, Claimant
WCB Case No. 91-04178
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Terrall & Associates, Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Schultz's order that upheld the insurer's denial of claimant's right knee injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant is a 59-year-old youth and family counselor and therapist employed by the Mt. Hood YMCA, a branch office of the Columbia-Willamette YMCA Chapter. Claimant's job duties primarily involve providing counseling and therapy services at the Mt. Hood office. As part of those duties, she is expected to develop and maintain working relationships with other staff members and to attend a certain number of volunteer activities, such as dinner meetings, recruiting drives and fund-raising campaigns.

In February 1991, the director of the Mt. Hood YMCA organized a staff volleyball game with the Northeast YMCA office to build morale between the two branch offices and to allow the staff to get to know each other better. The game was scheduled to take place at the Northeast YMCA's office, and was announced to the Mt. Hood staff with the following memo:

"TO: Mt. Hood Staff
"FROM: ???????
"RE: Volleyball Game With Northeast YMCA

"On February 27th at 7:30pm the Mt. Hood YMCA Staff will be challenging the NE YMCA Staff to an action packed VOLLEYBALL GAME!!! Let's try to have all of our staff attend so we can show them what the Mt. Hood YMCA is really made of!!! After the game we will be having pizza provided by the losing team. If you would like to carpool meet at our office at 6:45 pm. For more info contact Tim, Lisa, Tammy of Laurie!!!

"LET"S GO MT. HOOD YMCA!!!!!!!!!!!!!!!" (Ex. B).

Approximately 80 percent of the Mt. Hood staff attended the game, including claimant. Claimant, a salaried employee, was not specifically paid for attending the game. She was, however, reimbursed for mileage.

After playing volleyball for about 40 minutes, claimant decided to take herself out of the rotation because she was having increasing right knee pain. Her symptoms continued following the game and, on March 4, 1991, she sought treatment from Dr. Hardiman. Hardiman ordered an MRI scan, which revealed a possible tear in the posterior medial corner of the medical meniscus. On April 15, 1991, Hardiman performed right knee surgery and discovered an incomplete tear of the meniscus and degenerative osteoarthritic changes in the patellofemoral joint. In a letter dated June 20, 1991, Hardiman opined that the volleyball game was a material contributing cause of claimant's need for surgery and subsequent disability.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had established, by a preponderance of the evidence, that the volleyball game was a material contributing factor in her

need for surgery. We agree and adopt that conclusion. The Referee held, however, that the injury was not compensable, because of the remote relationship between the volleyball game and claimant's regular work duties. We reverse.

A "compensable injury" is defined by ORS 656.005(7)(a) as "an accidental injury * * * arising out of and in the course of employment[.]" ORS 656.005(7)(a). Traditionally, the courts treated "arising out of" and "in the course of" as two separate tests, both of which had to be met for an injury to be compensable. In Rogers v. SAIF, 289 Or 633 (1980), the Court rejected this mechanistic two-step method of analysis and defined the ultimate inquiry as whether the relationship between the injury and the employment is sufficient to allow compensability. Before engaging in this unitary "work connection" analysis, however, we must first consider whether claimant's injury is statutorily excluded by ORS 656.005(7)(b)(B), which provides that a "compensable injury" does not include:

> "Injury incurred while engaging in or performing, or as the result of engaging in or performing, any recreational or social activities primarily for the worker's personal pleasure[.]"

We recently addressed this statutory exclusion in Michael W. Hardenbrook, 44 Van Natta 529 (1992). In that case, a worker injured his right knee while playing basketball during an unpaid lunch break. We first noted that the employer had initiated the opportunity for the basketball games on breaks and lunch periods in part to raise employee morale. We also noted, however, that the worker was not required to play and had testified that he did so because playing basketball was fun and that he loves to play. He also testified that it was an enjoyable way to relieve the stress and tension at work and break up the monotony of the work day. Based on that testimony, and in light of our finding that any benefit to the employer was incidental, we concluded that the worker's knee injury was incurred while he was engaging in activities "primarily" for his personal pleasure and,therefore, was not compensable under ORS 656.005(7)(b)(B).

We find Michael W. Hardenbrook, supra, distinguishable from this case. Claimant testified that she had not played volleyball "for many, many years" and that she did not attend the game for the benefit of exercise. (Tr. 41). Rather, she attended the game "because the staff was doing it together." Id. Moreover, the record reveals that, while claimant was not absolutely required to attend the game, she was expected to participate in a certain number of volunteer activities and the employer specifically encouraged all staff to attend the game. Finally, the employer sponsored the event and reimbursed claimant's travel costs. Under these circumstances, we conclude that playing volleyball had a close work nexus and was not performed "primarily" for claimant's personal pleasure. Accordingly, we hold that the statutory exclusion set forth in ORS 656.005(7)(b)(B) does not apply, and proceed to determine whether the injury is compensable under the unitary "work-connection" test.

In determining whether an injury is sufficiently work related, the courts have identified several factors to be considered, including: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employee; (3) whether the activity was an ordinary risk of, and incidental to, the employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed by or acquiesed in by the employer; and (7) whether the employee was on a personal mission. No single factor is dispositive. See Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571, rev den 300 Or 249 (1985).

While claimant testified that she enjoyed the camaraderie of getting together with her co-workers and benefited to a certain extent from attending the

game, there is little doubt that the employer also benefited from the activity. It organized the volleyball game to build morale between two branch offices and to allow the staff to get to know each other better. It also is clear that the activity was contemplated by the employer; it organized the activity and encouraged employees to participate.

Claimant was not specifically paid for attending the game. She was, however, reimbursed for travel expenses. Furthermore, while the game was not held at claimant's work site, it did take place at another branch office of the Columbia-Willamette YMCA Chapter and, consequently, the activity was on the employer's premises. Charles E. Nequs, 42 Van Natta 2399 (1990).

The employer clearly acquiesced in, if not actually directed the volleyball game. As noted above, it organized the activity specifically to improve relations between two branch offices and, while claimant was not absolutely required to attend the game, she was expected to participate in a certain number of volunteer activities. Further, the employer specifically encouraged all staff to attend the game. Moreover, claimant's participation in the volleyball game was not a personal mission, but rather a group activity with her co-workers.

Considering all of the factors listed above, we conclude that there is a significant work-connection between the volleyball game and claimant's employment. Accordingly, we hold that claimant's knee injury arose out of and in the course of her employment and, therefore, is compensable.

Claimant is entitled to an assessed attorney fee for prevailing against a denial of compensation. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $3,600, 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 appellant's brief, statement of services and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated July 19, 1991 is reversed. The insurer's denial is set aside and the claim is remanded for further processing according to the law. For services rendered at hearing and on Board review, claimant's counsel is awarded an assessed fee of $3,600, to be paid by the insurer.

May 29, 1992 Cite as 44 Van Natta 1067 (1992)

In the Matter of the Compensation of
JEFF N. GRAY, Claimant
WCB Case Nos. 89-25569 & 90-02702
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys
David Schieber (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of that portion of Referee Mongrain's order which upheld the SAIF Corporation's denial of claimant's injury claim. On review, the issues are subjectivity and course and scope of employment. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

SAIF denied claimant's claim on the basis that his injuries did not arise out of or in the course and scope of his employment. The Referee found that claimant was not a subject employee because his employment was casual under ORS 656.027(3)(a) and could be considered gardening, maintenance, repair or remodeling about a private home under ORS 656.027(2).

Subjectivity

We disagree with the Referee's analysis of claimant's employment for Trevett as either casual employment under ORS 656.027(3) or as coming within the "householder" exception of ORS 656.027(2).

ORS 656.027(3)(a) excludes from coverage:

> "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 non-subject employer."

In order to analyze claimant's employment as "casual," the "playhouse-moving" incident would have to be isolated from the rest of claimant's employment for Trevett's landscaping business. Because claimant's usual employment for Trevett involved landscaping work, which is in the course of Trevett's trade, business or profession, claimant's employment as a whole does not fit the definition of "casual" employment. Consequently, we conclude that ORS 656.027(3) is inapplicable.

ORS 656.027(2) is likewise not applicable. It excludes from coverage workers who are employed to do gardening, maintenance, repair, remodeling or similar work in or about the private home of the person employing the worker. Claimant was employed by Trevett to do landscaping work for Trevett's business and not to work primarily at Trevett's private residence.

Because neither ORS 656.027(3) nor ORS 656.027(2) applies, the appropriate inquiry is whether claimant's injury occurred within the course and scope of his employment in Trevett's landscaping business. Accordingly, we analyze the evidence to determine whether claimant's injury arose out of and in the course of his employment for Trevett.

Course and Scope

Claimant has the burden to prove that his injury arose out of and in the course and scope of his employment. ORS 656.005(7)(a). If the injury has a sufficient relationship to work, it is compensable. Rogers v. SAIF, 289 Or 633 (1980).

Seven factors are evaluated to determine whether or not a particular injury has a sufficient relationship to work: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employee either at the time of hiring or later; (3) whether the

risk was an ordinary risk of, and incidental to, the employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed by or acquiesced in by the employer; and (7) whether the employee was on a personal mission of his own. Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571, 575, rev den 300 Or 249 (1985). All of the factors may be considered; no one factor is dispositive. Id.

Moving the playhouse did not benefit the employer's landscaping business, although it may have benefitted the employer in a personal sense, because the playhouse was a present for his son. The activity was not contemplated by the employer and employee as a part of claimant's employment. Moving a playhouse for the employer's child is not an ordinary risk of, and incidental to, claimant's employment as a landscaper. McTaggert, Foltman and claimant believed they were being paid for moving the playhouse. However, it was never established that they were ever actually paid by Trevett for the activity. The activity did not occur on the employer's premises. The activity was directed by and acquiesced in by Trevett who participated and used his own truck to move the playhouse. Claimant was not on a personal mission when he participated in moving the playhouse, but rather felt that it was part of his employment for which he was being paid.

After considering the factors, we conclude that they preponderate against a finding of a sufficient work connection to establish the compensability of the claim. Trevett's business did not benefit from moving the playhouse, it was not an ordinary risk of the employment, the activity was not contemplated by the employer, it was not established that claimant was paid for the activity and the activity did not occur on the employer's premises. While the activity was directed by the employer and while claimant was not on a personal mission, these factors are insufficient in this case to establish the work connectedness of claimant's injury.

ORDER

The Referee's order dated June 20, 1991 is affirmed.

In the Matter of the Compensation of
WILLIAM R. HODSON, Claimant
WCB Case No. 91-06067
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of that portion of Referee McCullough's order which directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree. On review, claimant requests that SAIF be directed to pay interest on all compensation stayed pending Board review. Claimant also cross-requests review of that portion of the Referee's order which affirmed the Order on Reconsideration award of 5 percent (6.75 degrees) scheduled permanent disability for loss of use or function of the right foot. On review, the issues are rate of scheduled permanent disability, extent of scheduled disability, and interest on stayed compensation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Rate of Scheduled Permanent Disability

We adopt the Referee's "Conclusions and Opinion" on the issue of rate of scheduled permanent disability. Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991).

Extent of Scheduled Permanent Disability

The Referee found that claimant had scheduled impairment only to his right foot which was due to loss of plantar sensation. Former OAR 436-35-200 (1). We agree.

On review, claimant argues that his scheduled impairment is not limited to his right foot. He argues that he is also entitled to an impairment rating for his right leg due to a loss of sensation in the right L5 dermatome. Surface sensation loss in the leg is not considered disabling and is not ratable. Former OAR 436-35-230(1). However, claimant argues that this sensation loss creates a chronic condition that is ratable. We disagree.

Former OAR 436-35-010(8) provides, in pertinent part, that a "worker may be entitled to scheduled chronic condition impairment when a preponderance of medical opinion establishes that the worker is unable to repetitively use a body part due to a chronic and permanent medical condition. . . ." Given the requirement that medical opinion must establish that a chronic condition limits repetitive use of a body part, claimant's testimony is insufficient to establish this impairment. See William K. Nesvold, 43 Van Natta 2767 (1991).

Here, there is no medical opinion that establishes that claimant is unable to repetitively use his right leg due to the hypoesthesia in the right L5 dermatome, or any other medical condition. The parties stipulated to the correctness of the opinion of Dr. Collada, treating surgeon, as noted in the Order on Reconsideration. (Ex. 16-1). However, Dr. Collada offers no opinion regarding any inability of claimant to repetitively use his right leg. Furthermore, Dr. French released claimant for full-time, full-duty work and noted no restrictions in the repetitive use of his leg. (Exs. 13, 14). On this record, we find that claimant has not established any ratable impairment in his right leg.

Relying on former OAR 436-35-240(4), the Referee found that, because claimant had impairment only in his right foot, he was not entitled to have that foot impairment value converted to a leg impairment value. We agree.

Former OAR 436-35-240(4) provides for the calculation of multiple losses in the leg, foot, and toes. It states, in pertinent part, that "[w]hen two or more sections of the same body part are impaired, the rating for each part is converted to a rating for the part closest to the body." Here, claimant's scheduled impairment consists of partial loss of plantar sensation in the right foot. This impairment is rated as 5 percent loss of use or function of the foot. Former OAR 436-35-200(1). Because only one section of the lower extremity is impaired, no provision is made for converting this foot value to a leg value. Accordingly, we agree with the Referee that claimant is entitled to an impairment value of 5 percent for loss of use or function of the right foot.

Interest on Stayed Compensation

Claimant requests interest on the compensation stayed pending appeal. We find this issue is not ripe for adjudication.

Pursuant to ORS 656.313(1)(B)(b), when benefits withheld pending appeal are found payable under a final order, a carrier is required to pay the interest that accrued on those benefits. Pending appeal, however, a carrier's obligation to pay interest is not ripe for adjudication, because there is no final order. See Gilbert T. Hale, 44 Van Natta 729 (1992).

If and when benefits are found payable under a final order, a carrier's duty to process the claim according to law will include the obligation to pay any interest accrued. Here, if a dispute subsequently arises regarding the payment of interest, the matter will then be ripe for adjudication.

Attorney Fees on Review

Inasmuch as SAIF has requested review and claimant's compensation has not been disallowed or reduced, claimant is entitled to a reasonable attorney fee award. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services on review concerning the rate of scheduled permanent disability issue is $200, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 29, 1991, as reconsidered on October 3, 1991, is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $200, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
IMRE KAMASZ, Claimant
WCB Case No. 90-15489
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Norman Cole (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Kinsley.

The SAIF Corporation requests review of that portion of Referee Knapp's order that awarded claimant benefits for 52 percent (166.4 degrees) unscheduled permanent partial disability for a respiratory condition, whereas a Determination Order had awarded no permanent disability. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's "FINDINGS OF FACT."

CONCLUSIONS OF LAW AND OPINION

The issue in this case is the extent of claimant's permanent disability resulting from a compensable respiratory condition. The Referee found that claimant suffers permanent impairment as a result of his compensable condition and, after determining the appropriate values assigned by the "standards" for claimant's age, education, adaptability and impairment, concluded that claimant was entitled to an award of 52 percent unscheduled permanent disability.

On review, SAIF first challenges the Referee's conclusion that claimant has sustained permanent impairment due to his compensable exposure to welding fumes. It relies on the opinion of Dr. Montanaro, independent examining allergist, who reported in June 1989:

> "It is my opinion that [claimant] may have suffered an irritant reaction as a result of his welding at Gunderson Steel. These exposures led to a transient, aggravation of symptoms of his underlying disorder, but the effects of the workplace exposure have long since resolved." (Ex. 64-5).

Dr. Keppel, claimant's treating pulmonologist, agreed in July 1989 and June 1990. In June 1990, Dr. Keppel also stated that the effects of the August 1988 exposure no longer influenced claimant's underlying asthma as of December 21, 1988. However, as noted by the Referee, it had previously been ordered in February 1989 that claimant's underlying respiratory condition was caused by his work exposure to smoke and fumes in August 1988. (Exs. 36, 96A). Accordingly, the doctor's further conclusion that claimant's asthma preexisted his employment conflicts with the law of the case and, as a legal matter, is wrong. See Kuhn v. SAIF, 73 Or App 768 (1985).

Moreover, even if we assume that claimant's condition was not caused, but rather was only made symptomatic by his occupational exposure, Dr. Keppel subsequently opined in April and June 1991 that claimant's continuing symptomatic asthma required medication at all times and multiple hospitalizations. (Exs. 100, 101-20). Dr. Keppel further stated that the injurious exposure in 1988 remained the major contributing cause of his symptomatology. (Ex. 100). Accordingly, based on Dr. Keppel's more recent uncontradicted opinion, we would nonetheless conclude that claimant's impairment, which SAIF does not dispute, is causally related to his compensable work exposure.

SAIF next challenges the Referee's conclusion that claimant was entitled to a value of 1 for training. SAIF contends that the proper value for training is 0, because claimant attended a trade school in Hungary and was trained as a welder. We agree.

Whether claimant is entitled to a value for training under former OAR 436-35-300(5) is dependent upon whether he has demonstrated competence in a specific vocational pursuit that would allow him to perform suitable work other than at an entry level position. Larry L. McDougal, 42 Van Natta 1544 (1990). The rule applies even if the vocational pursuit is no longer within claimant's physical capabilities. Patsy O'Bryant, 44 Van Natta 490 (1992); Jimmie L. Wilson, 42 Van Natta 2526 (1990). Here, claimant had training as a welder sufficient to perform something other than an entry level job and, accordingly, has competence in a specific vocational pursuit. The proper value for training is 0.

Accordingly, we rate the extent of claimant's unscheduled permanent disability as follows. The appropriate value for claimant's age of 44 years is 1. Former OAR 436-35-290. Claimant has attended five years of trade school; therefore, the appropriate value for claimant's formal education is 0. Former 436-35-300(3). The highest specific vocational pursuit level demonstrated by claimant during the ten years preceding the date of hearing was that of a welder (DOT # 810.384-014). Therefore the appropriate value for skills is 2. Former OAR 436-35-300(4). Those values are added to claimant's training value of 0 for a sum of 3.

Claimant returned to modified work. Therefore, his adaptability value is determined from a matrix of values provided by former OAR 436-35-310(3)(a). Claimant's usual and customary work required the physical capacity to do heavy

work. Claimant's modified work required the physical capacity to do sedentary work. Therefore, the appropriate value for adaptability under the matrix is 3. That value is multiplied by claimant's age and education value of 3, for a product of 9. When that value is added to claimant's undisputed impairment value of 40 percent, the result is 49 percent unscheduled permanent partial disability.

ORDER

The Referee's order dated August 1, 1991 is modified. In lieu of the Referee's increased award, claimant is awarded 49 percent (156.8 degrees) for his unscheduled permanent partial disability. Claimant's attorney fee shall be adjusted accordingly.

May 29, 1992 Cite as 44 Van Natta 1073 (1992)

In the Matter of the Compensation of
ERIC A. SOLMONSON, Claimant
WCB Case No. 90-14686
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Hooton and Brazeau.

Claimant requests review of those portions of Referee Bethlahmy's order that: (1) affirmed a Determination Order award of 22 percent (33 degrees) scheduled permanent partial disability for the left leg (knee) and 5 percent (7.5 degrees) scheduled permanent partial disability for the right forearm; and (2) declined to award claimant unscheduled permanent partial disability. The self-insured employer cross-requests review of that portion of the order that directed it to pay claimant's scheduled disability award at the rate of $305 per degree. On review, the issues are extent of scheduled and unscheduled permanent partial disability and rate of scheduled disability. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND REASONING

Extent of 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). Because claimant's condition became medically stationary on May 16, 1990, we apply the "standards" effective at that time in rating claimant's permanent disability. Former OAR 436-35-001 et seq. Former OAR 436-35-010 through 436-35-260 apply to the rating of claimant's scheduled permanent disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent disability.

Scheduled Disability--Left Leg

The Referee found that claimant was entitled to benefits for the following scheduled disability in his left leg:

(1) 5.5 percent for 15 degrees loss of retained knee flexion;
(2) 1 percent for 5 degrees loss of knee extension;
(3) 5 percent for knee joint instability; and
(4) 5 percent for loss of foot dorsiflexion.

Neither party challenges the amount awarded by the Referee for any of the elements listed above. After our review of the record, we agree with those values and adopt the Referee's conclusions and address only claimant's specific contentions.

Claimant contends that the Referee erred in failing to award him benefits for vascular damage under former OAR 436-35-230(6)(d). He argues that the nature of the injury, which resulted in a loss of muscle mass, necessarily caused vascular damage for which he is entitled to benefits. As noted by the employer, however, nothing in this record supports that contention. The original operative report indicates that: "Doppler pulses were checked at the end of the cases, and demonstrated intact dorsalis pedis and posterior tibial pulses." (Ex. 5-3). Moreover, no subsequent medical report has documented vascular damage. Inasmuch as there is no medical evidence in this record to support claimant's assertion that he has sustained vascular damage, the Referee properly refused to award claimant benefits under the standards for such damage to the left leg.

Claimant next contends that the Referee erred in failing to award him benefits for the shortening of his left leg pursuant to former OAR 436-35-230(2). Noting that Dr. Vessely reported a "[s]econdary equinus contracture of the left leg requiring heel cord lengthening with still a limitation of tibio-taler motion," (Ex. 37-3), he argues that this condition, combined with the leg fractures, constitutes a shortening of the leg. We disagree. There is no medical evidence in this record that the fractures sustained by claimant, or the condition noted by Vessely, caused a shortening of claimant's leg. Accordingly, no award of scheduled permanent disability is warranted under former OAR 436-35-230(2).

We last address claimant's contention that the standards set forth in former OAR 436-35-010 through 436-35-260 were "not developed to account for damage to a worker that is pulled through paper rolls with resulting injuries." (App. Brief at 7). Either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by claimant is more or less than the entitlement indicated by the "standards". ORS 656.283(7) and 656.295(5). To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 402 (1987).

Here, claimant suffered a severe contusion to his lower leg and lost a significant amount of calf muscle. He has major deformities due to the muscular loss and has arthritic changes in the knee which will worsen and eventually require significant attention. Relying on those factors, Vessely found that claimant's impairment "rates to a 20 percent in regard to the fracture and resultant degenerative change," with "20 percent in regard to the significant ligamentous injuries of his left knee," and concluded that the "impairment of his left lower extremity is approximately in the 60 percent range in regard to the leg as a whole." (Ex. 37-3).

Based on Vessely's unrebutted report we find it highly probable that claimant's loss of use or function of the left leg exceeds the 16.5 percent allowed under the standards. In light of the severity of the injury and resulting loss of musculature and degenerative changes, we agree with Vessely's

conclusion and hold that claimant is entitled to a total award of 60 percent scheduled disability. Therefore, we modify the Determination Order's 22 percent award.

Scheduled Disability--Right Arm

The Referee found that claimant was entitled to benefits for 5 percent scheduled disability for a chronic condition limiting the repetitive use of the right arm. After our review, we agree and adopt her conclusions and reasoning.

Unscheduled Disability

Claimant contends that the Referee erred in failing to award him benefits for unscheduled permanent disability for a chronic lumbar back strain. He relies on the depositional testimony by Dr. Duwelius, who noted that claimant has an altered gait that will continue to aggravate his low back. (Ex. 45-6). However, Duwelius did not state, with a degree of medical probability, that claimant's altered gait had caused his back strain. As the employer points out, he merely acknowledged the possibility of a causal relationship because he had not found any other cause. He also noted that back strains exist in the general population with no known cause. Accordingly, we agree with the Referee that the medical evidence is insufficient to establish a sufficient casual relationship between the October 1990 lumbar strain and the August 1988 compensable injury. Gormley v. SAIF, 52 Or App 1055 (1981).

Even assuming a causal relationship, we add that there is no evidence that claimant has sustained any rateable impairment as a result of the lumbar strain. In his November 29, 1990 letter, Duwelius indicated that he did not believe that claimant's lumbar back strain would result in any long term disability, explaining that there were no motor or sensory deficits indicating a disc problem and that claimant had normal range of motion. Without measurable impairment, there is no basis for an award of unscheduled permanent partial disability. Former OAR 436-35-270(2).

Rate of Scheduled Disability

The Referee ordered the employer to pay claimant's scheduled award at the rate of $305 per degree. We agree and adopt her conclusions and reasoning. Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991).

Attorney Fee on Board Review

The employer initiated the cross-request for review regarding the rate of scheduled disability, and we have not disallowed or reduced compensation awarded to claimant. Although ORS 656.382(2) authorizes the assessment of an attorney fee under such circumstances, no fee is warranted here because claimant's attorney filed no cross-respondent's brief on Board review. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated July 24, 1991 is affirmed in part and modified in part. In addition to the Determination Order award of 22 percent (33 degrees) scheduled permanent partial disability for the loss of use or function of the left leg, claimant is awarded 38 percent (57 degrees) scheduled permanent partial disability for the loss of use or function of the left leg, giving him a total award of 60 percent (90 degrees). Claimant's attorney is entitled to a reasonable fee equal to 25 percent of the increased compensation made payable by this order, not to exceed $3,800. The remainder of the order is affirmed.

In the Matter of the Compensation of
TERESA L. WHEELER, Claimant
WCB Case No. 90-21503
ORDER ON RECONSIDERATION
Nancy F.A. Chapman, Claimant Attorney
Terrall & Associates, Defense Attorneys

The self-insured employer requests reconsideration of that portion of our April 29, 1992 Order on Review which modified a Referee's order which assessed penalties and attorney fees for an unreasonable unilateral termination of claimant's temporary total disability benefits. Contending that our order contains "a significant flaw," the employer seeks reconsideration and clarification.

The employer accurately notes that the Referee's order provided that "[c]laimant's attorney be paid 25 percent of the late paid and unpaid time loss and her attorney a separate attorney fee of $500 for unreasonable claims processing." (Emphasis added). This provision pertained to the Referee's conclusion that the employer unreasonably terminated claimant's temporary total disability and unreasonably failed to timely provide claims documents.

On review, we agreed with the Referee's determination that the employer had unreasonably terminated claimant's compensation, but we disagreed that the employer had unreasonably failed to provide claims documents. In addition, we concluded that, pursuant to ORS 656.262(10), the 25 percent penalty should be equally shared by claimant and his attorney. Thus, we reversed those portions of the Referee's order which awarded a $500 attorney fee for the discovery violation and a $600 attorney fee for the unilateral termination. Finally, we awarded claimant's attorney one-half of the penalty assessed by the Referee's order.

Although the Referee found that the employer's unilateral termination was unreasonable, the Referee's "order" neglected to expressly assess a penalty. Instead, as noted above, the Referee "ordered" that "claimant's attorney [sic] be paid 25 percent of the late paid and unpaid time loss . . . " In light of the Referee's reasoning and our own findings, we conclude that the aforementioned reference was erroneous. To correct this misstatement, we make the following conclusion concerning the penalty issue.

The employer is assessed a penalty for its unreasonable termination of claimant's temporary total disability. This penalty shall be equal to 25 percent of the untimely paid and unpaid temporary disability benefits found due as a result of our prior order. This penalty, which shall be equally divided between claimant and her attorney, shall be paid by the employer to claimant and her attorney.

Accordingly, our April 29, 1992 order is withdrawn. On reconsideration, as supplemented and modified herein, we adhere to and republish our prior order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MAURILIA PACHECO, Claimant
WCB Case No. 91-01912
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Westerband and Moller.

The SAIF Corporation requests review of Referee Harri's order that set aside its denial of claimant's medical services claim for chiropractic care. On review, the issue is medical services. We vacate.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Medical Services--Jurisdiction

A threshold question not raised by either party is whether, in light of the 1990 amendments to the workers' compensation law, the Board has jurisdiction to resolve this dispute regarding medical services that were allegedly administered by an unauthorized medical service provider. Specifically, we must determine whether this dispute is subject to the resolution procedure set forth in ORS 656.327, so that original jurisdiction over this matter rests with the Director pursuant to ORS 656.704(3).

Subsequent to the Referee's order, we have held that ORS 656.327 provides a procedure for the resolution of disputes between the insurer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of [administrative] rules." Stanley Meyers, 43 Van Natta 2643 (1991). Therefore, original jurisdiction over disputes regarding the necessity or reasonableness of medical services now lies exclusively with the Director. Id.

We recently applied the Meyers reasoning to a dispute concerning whether treatment had been provided by an attending physician. In Julie M. Harper, 44 Van Natta 820 (1992), we held that the Hearings Division lacked original jurisdiction to consider a dispute regarding whether chiropractic treatment had been approved by an "attending physician." Relying on several Director rules addressing the term "attending physician" (OAR 436-10-005(1) and 436-10-005(27)), we reasoned that the parties' dispute pertained to whether the disputed chiropractic treatment was "in violation of the rules regarding the performance of medical services" as set forth in ORS 656.327.

Here, as in Harper, the dispute pertains to whether chiropractic treatment has been approved by an "attending physician." "Attending physician" and "non-attending physician" are defined in the Director's rules. See OAR 436-10-005(1); 436-10-005(27). Consequently, in accordance with the Harper rationale, we conclude that this is a dispute concerning whether the treatment at issue is "in violation of the rules regarding the performance of medical services." Thus, original jurisdiction for resolution of this dispute rests with the Director under ORS 656.327.

Accordingly, the Referee's order is vacated.

ORDER

The Referee's order dated June 3, 1991 is vacated. The Referee's $1,250 attorney fee award is vacated.

May 15, 1992 Cite as 44 Van Natta 1078 (1992)

In the Matter of the Compensation of
LEONA J. CUNNINGHAM, Claimant
WCB Case No. 90-22042
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Paul L. Roess, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee Livesley's order which set aside its "de facto" denial of claimant's pain center treatment. On review, the issue is medical services. We vacate.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the last sentence.

CONCLUSIONS OF LAW AND OPINION

The employer argues that claimant's pain center treatment cannot be considered curative, because she has been declared medically stationary and her claim has been closed. We need not address the employer's contention, because we conclude that we lack jurisdiction over this medical services dispute.

The threshold issue not raised by either party is whether, in light of the 1990 amendments to the workers' compensation statutes, this forum has jurisdiction to resolve this dispute over medical services that the employer contends are palliative and, therefore, not compensable under ORS 656.245 and the relevant administrative rules. We conclude that original jurisdiction over this dispute lies with the Director and vacate the Referee's order.

As a general matter, the Board, and thus our Hearings Division, has jurisdiction over matters concerning a claim, which are defined as those matters in which a claimant's right to receive compensation, or the amount thereof, is directly at issue. ORS 656.704(3); ORS 656.726(2); see Ashley v. University of Oregon, 100 Or App 588 (1990). However, under the 1990 amendments to the workers' compensation law, "matters concerning a claim" do not include any dispute regarding medical treatment or fees "for which a resolution procedure is otherwise provided" in ORS Chapter 656. ORS 656.704(3).

In this regard, ORS 656.327 provides, in part:

> "(1)(a) If an injured worker, an insurer or self-insured employer or 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, self-insured employer shall so notify the parties and the director."

The phrase "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services" is not statutorily defined and the scope of its plain meaning is significant. Thus, in construing the provision, we have relied on legislative history, which indicated that the purpose of ORS 656.327 was to remove questions concerning the appropriateness of medical treatment from the litigation process and allow such decisions to be made by a physician rather than a referee. See Minutes, Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 3, Side A at 75. Accordingly, we have concluded that ORS 656.327 provides a resolution procedure for those medical treatment disputes that are appropriate for review by a medical panel, such as the reasonableness and necessity of medical treatment for a compensable condition. See Stanley Meyers, 43 Van Natta 2643 (1991). For the same reason, we have also concluded that ORS 656.327 does not govern medical treatment disputes that primarily involve legal analysis, such as the causal relationship between the need for the treatment and the compensable injury. See Michael A. Jaquay, 44 Van Natta 173 (1992).

The dispute at issue here involves the question of whether claimant's medical treatments are palliative, rather than curative. If found palliative, such care is generally not compensable without prior approval from the carrier or Director. ORS 656.245(1)(b). We recently held that such a dispute generally concerns the effectiveness and appropriateness of the medical treatment at issue and, therefore, the legislature intended that these matters be resolved by a physician, rather than a referee. Gladys M. Theodore, 44 Van Natta 905 (1992).

Accordingly, because a procedure for resolving this medical treatment dispute is otherwise provided in ORS 656.327, we hold that original jurisdiction lies exclusively with the Director. Consequently, because the denial did not raise a matter concerning a claim within the jurisdiction of the Hearings Division, we vacate the Referee's order.

ORDER

The Referee's order dated August 2, 1991 is vacated. The Referee's $2,200 attorney fee award is vacated.

May 28, 1992 Cite as 44 Van Natta 1079 (1992)

In the Matter of the Compensation of
SHEILA K. WAGNER, Claimant
WCB Case No. 91-03143
ORDER ON REVIEW
Burt, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of Referee Garaventa's order that: (1) upheld the insurer's partial denial of claimant's request to treat with an out-of-state physician; and (2) upheld the insurer's partial denial insofar as it denied her request for reimbursement for costs associated with treatment by an out-of-state physician. On review, the issues are jurisdiction and medical services. We vacate the Referee's order and dismiss claimant's request for hearing.

FINDINGS OF FACT

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

Claimant requested a hearing in this matter on March 14, 1991; the hearing was held on June 7, 1991. At hearing, the insurer moved to dismiss for lack of subject matter jurisdiction. The Referee concluded that she retained jurisdiction over this medical services dispute. However, on the merits, she found claimant's out-of-state medical treatment not compensable.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Accordingly, we analyze this matter under the Workers' Compensation Act effective July 1, 1990. See Or Laws 1990 (Special Session), chapter 2, section 54(2); Ida M. Walker, 43 Van Natta 1402 (1991).

Medical Services--Jurisdiction

On review, the insurer does not renew its jurisdictional challenge. We conclude, however, that a threshold issue for our review is whether, in light of the 1990 amendments to the workers' compensation law, the Referee had jurisdiction to resolve this medical services dispute. Specifically, we must determine whether this dispute is subject to the resolution procedure set forth in ORS 656.327.

Subsequent to the Referee's order, we held that ORS 656.327 provides a procedure for the resolution of disputes between the insurer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of [administrative] rules." Stanley Meyers, 43 Van Natta 2643 (1991). Therefore, original jurisdiction over disputes regarding the necessity or reasonableness of medical services now lies exclusively with the Director. Id.

We recently applied the Meyers reasoning to a dispute concerning whether treatment had been provided by an "attending physician." In Julie M. Harper, 44 Van Natta 820 (1992), we held that the Hearings Division lacks original jurisdiction to consider a dispute regarding whether chiropractic treatment has been approved by an "attending physician." Relying on several Director's rules addressing the term "attending physician" (OAR 436-10-005(1) and 436-10-005(27)), we reasoned that the parties' dispute pertained to whether the treatment in question was "in violation of the rules regarding the performance of medical services" as set forth in ORS 656.327.

Here, the dispute concerns whether Dr. Sims, claimant's family physician, has authorized Dr. Thoman, an out-of-state physician, to provide medical services to claimant. "Attending physician" and "non-attending physician" are defined in the Director's rules. See OAR 436-10-005(1); 436-10-005(27). Consequently, consistent with Harper, we conclude that this is a dispute concerning whether the treatment at issue is "in violation of the rules regarding the performance of medical services." Thus, the dispute is not a "matter concerning a claim" over which the Hearings Division has jurisdiction. Rather, original jurisdiction lies with the Director.

Accordingly, the Referee's order is vacated.

ORDER

The Referee's order dated June 26, 1991 is vacated. Claimant's request for hearing is dismissed for lack of subject matter jurisdiction.

In the Matter of the Compensation of
RONALD A. MARTIN, Claimant
WCB No. 91-18054
ORDER OF ABATEMENT
Rick W. Roll, Claimant Attorney
Terrall & Associates, Defense Attorneys

On April 20, 1992, the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of a stated sum, claimant released his rights to future workers' compensation benefits, except medical services, for the compensable injury. As the disposition complied with statutory requirements and applicable administrative rules, we approved the agreement on May 21, 1992.

On June 1, 1992, the Board received a copy of Referee Howell's letter to the parties in WCB Case No. 91-18054 informing them that, because a claim disposition agreement releasing claimant's rights to aggravation benefits had been approved by the Board, no bona fide dispute existed regarding claimant's entitlement to aggravation benefits. Referee Howell's letter further stated that he therefore declined to approve the parties' Disputed Settlement Agreement, which purported to resolve a dispute as to claimant's entitlement to benefits arising from an aggravation of his compensable injury.

Pursuant to OAR 438-09-035, we may reconsider final orders under ORS 656.236, provided that the motion for reconsideration is filed within 10 days of mailing of the final order. Here, we find that the Referee's letter was filed with the Board within 10 days of mailing of our final order. Under the circumstances, we treat the letter as a request by the parties that we reconsider our final order approving the claim disposition agreement.

In order to allow sufficient time to consider the motion, the above-referenced Board order is withdrawn and the parties are requested to submit their positions regarding reconsideration within 14 days of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
HAROLD F. SCHULTZ, Claimant
Own Motion No. 92-0009M
OWN MOTION ORDER ON RECONSIDERATION
Margaret M. Maginnis, Claimant Attorney

On April 27, 1992, we abated our March 27, 1992 Own Motion Order that denied reimbursement to the employer from the Reopened Claims Reserve on the basis that we lacked evidence of a causal relationship between claimant's compensable injury and his current right carpal tunnel condition. After further consideration of the matter, we withdraw our prior order and issue the following order.

The self-insured employer voluntarily reopened the above-referenced claim for a worsening of claimant's compensable shoulder, neck and low back injury. Claimant's aggravation rights expired on July 22, 1988. The employer requests authorization for reimbursement from the Reopened Claims Reserve pursuant to ORS 656.625.

After we abated our Own Motion Order, the Court of Appeals issued its decision in SAIF v. Holmstrom 113 Or App 242 (1992). The court held that the Board lacks the authority to grant or deny reimbursement from the Reserve. Id. Accordingly, we are unable to grant the employer's request."

Inasmuch as we have no authority to grant or deny reimbursement from the Reserve, we find no basis to award an attorney fee to claimant's attorney for obtaining reimbursement for the employer.

Our March 27, 1992 Own Motion Order is withdrawn. The parties' rights to reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

June 3, 1992 Cite as 44 Van Natta 1082 (1992)

In the Matter of the Compensation of
TODD N. HELLMAN, Claimant
WCB Case No. 90-14077
ORDER ON REVIEW
Francesconi, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Brazeau, Moller and Neidig.

Claimant requests review of Referee Bethlahmy's order that upheld the insurer's denial of claimant's left knee condition claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant compensably injured his right knee in June 1987. Dr. Puziss, orthopedic surgeon, first treated claimant on July 31, 1987 and performed surgery in August 1987 on claimant's right knee. Puziss continued to treat claimant through April 1988. In January 1989, Dr. Rusch, orthopedic surgeon, became claimant's treating physician. (Ex. 49-2).

In June 1989, claimant began complaining of pain in his left knee. (Ex. 52A-1). Dr. Rusch initially diagnosed synovitis, (id. at 3), then concluded that claimant had overuse syndrome, (Ex. 57). Dr. Puziss, who conducted a followup examination at the request of the insurer, also diagnosed overuse syndrome. (Ex. 56-4). Dr. Duff, orthopedic surgeon, found that the medical evidence did "not support any specific diagnosis in regard to the left knee" and that the right knee injury was not the major contributing cause of the left knee symptoms. (Ex. 60-3).

On June 27, 1990, the insurer denied the compensability of claimant's left knee condition on the basis that it was not causally related to his right knee injury. (Ex. 53).

CONCLUSIONS OF LAW AND OPINION

Claimant first challenges the Referee's conclusion that he did not establish a compensable claim with medical evidence supported by objective findings. ORS 656.005(7)(a) requires that a compensable injury be "established by medical evidence supported by objective findings[.]" In order to carry this burden, claimant must offer evidence that a physician has examined him and determined that he suffers from a disability or a physical condition that requires medical

services. Suzanne Robertson, 43 Van Natta 1505 (1991). That determination may be based on purely objective factors, or on the worker's description of the pain that he is experiencing, as long as the physician indicates that the worker in fact experiences symptoms and does not merely recite the worker's complaints of pain. ORS 656.005(19); Suzanne Robertson, supra.

Here, in regards to his left knee pain, claimant was evaluated by Drs. Barnhouse, M.D., Rusch, Puziss, and Duff. Dr. Barnhouse diagnosed "probable patellofemoral syndrome of the left knee." (Ex. 51-2). He ordered an MRI of the left knee and advised claimant to continue exercising. (Id.) Dr. Rusch initially diagnosed "left knee pain, due to synovitis of the left knee." (Ex. 52A-3). Rusch recommended a treatment program and released claimant from work for one week. (Id.) Dr. Puziss diagnosed "mild over use syndrome," finding that claimant's right knee pain caused him to overuse his left knee. (Ex. 56-4, 5). Rusch subsequently "agree[d] with Dr. Puziss that it is primarily an overuse syndrome in response to excessive demands because of his right knee." (Ex. 57).

The reports of Barnhouse, Rusch and Puziss indicate that claimant, in fact, experienced the symptoms for which he was seeking treatment; in evaluating claimant's left knee symptoms, the physicians provided diagnoses and recommended treatment. Their opinions constitute "objective findings" under Suzanne Robertson, supra. Even Dr. Duff, who could find no "objective medical evidence" to "support any specific pathological process," (Ex. 60-3), provides no indication that claimant does not experience left knee symptoms, since he diagnoses "left knee pain" and states that "some degree of early patellofemoral change * * * may possibly be somewhat symptomatic here." (Id.)

Claimant next challenges the Referee's conclusion that claimant did not prove that his left knee condition is a compensable consequence of his right knee injury.

Under ORS 656.005(7)(a)(A), "no injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition." In Julie K. Gasperino, 43 Van Natta 1151, 1153 (1991), we held that the "major contributing cause" standard applies to "secondarily consequential conditions" while the "material contributing cause" standard remains to prove "primarily consequential conditions." Because claimant asserts that his left knee condition arose as a consequence of the injury he sustained to his right knee, as distinguished from resulting from the accident, we find that claimant's condition properly is characterized as a secondarily consequential condition. See id. We, therefore, agree with the Referee that claimant must prove that his right knee injury was the major contributing cause of his left knee condition.

The record provides opinions from Drs. Rusch, Puziss and Duff regarding the cause of claimant's left knee symptoms. Rusch initially stated that "the causative factors of [claimant's] left knee pain have not been established. Therefore, it is difficult to determine the 'major contributing cause' of [claimant's] left knee complaints." (Ex. 55). Puziss, however, explicitly found that the "right knee probably qualifies as a 'major contributing cause' to the left knee symptomotology (sic)[.]" (Ex. 56-5). Puziss also concluded that claimant would continue to experience left knee pain "if he overuses his left knee due to the right knee pain." (Id.).

Rusch, after reviewing Puziss' report, agreed that claimant was experiencing an overuse syndrome "in response to excessive demands because of his right knee." (Ex. 57). During his deposition, Rusch reiterated his opinion that claimant's symptoms were the result of an overuse of his left knee to compensate

for pain in his right knee, (Ex 61-15), explaining that, at the time he submitted Exhibit 55, he was in the process of determining the exact cause of claimant's symptoms, (Id. at 16). Rusch further stated that, because the diagnostic test results eliminated other possible causes except overuse syndrome, and based on claimant's history, he determined that this was the appropriate diagnosis. (Id. at 16, 19). Rusch also explained how claimant's right knee condition would cause overuse of the left knee in that claimant's right knee pain decreased his mobility, thus weakening his left knee muscles. (Id. at 21). When claimant was required to walk, however, there were increased demands on his left knee. (Id. at 21-22).

Finally, Dr. Duff, after seeing claimant once during an independent medical examination, stated that "there is nothing about [claimant's] work activities [demonstrating] * * * that his right knee problems contribute in anyway (sic) to his left knee symptoms. Specifically, the right knee injury of June 8, 1987 is not the major contributing cause of [claimant's] left knee symptoms." (Ex. 60-3). Duff also found that, in the year prior to the onset of left knee symptoms, claimant was physically inactive, using crutches and performing light duty work. (Ex. 61-38). Duff, therefore, found it unlikely that it was necessary for claimant to put weight on his left knee. (Id.)

When the medical evidence is divided, we give greater weight to the conclusion of claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 801, 814 (1983). Here, we find no persuasive reasons not to give greater weight to the opinion of Dr. Rusch. Although Rusch initially stated that he could not state that claimant's right knee condition was the major contributing cause of the left knee symptoms, as explained above, this report was submitted before Rusch had examined and eliminated other possible causes of claimant's condition. We, therefore, do not find that Rusch's earlier report contradicts his later opinion that claimant's symptoms were due to overuse.

Furthermore, medical evidence need not consist of a specific incantation or mimic the statutory language in order to satisfy claimant's burden of proof concerning causation. Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109, 112 (1991). Although Rusch never explicitly states that the major contributing cause of claimant's left knee symptoms is his right knee condition, the record as a whole supports such an inference. Rusch stated that overuse syndrome was the cause of claimant's symptoms, based on claimant's history and the elimination of other possible causes. Rusch also described how claimant overused his left knee. Moreover, Rusch's opinion is supported by the opinion of claimant's former treating physician, Dr. Puziss.

In conclusion, we find that the claim is established by medical evidence supported by objective findings and that the opinions of Drs. Rusch and Puziss outweigh the opinion of Dr. Duff, thus proving that claimant's right knee condition was the major contributing cause of his left knee symptoms.

Finally, because claimant prevailed in his review to the Board, claimant is entitled to a reasonable attorney fee. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review is $3,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 28, 1991 is reversed. The insurer's denial is set aside, and the claim is remanded to the insurer for processing according to law. For services at hearing and on review concerning the compensability of claimant's left knee condition, claimant's counsel is awarded an assessed attorney fee of $3,000, payable by the insurer.

Board Chair Neidig specially concurring.

The result reached in this case is correct under Suzanne Robertson, 43 Van Natta 1505 (1991), which I feel constrained to follow under the principle of stare decisis. However, I respectfully submit that the result in this case demonstrates that the Board's interpretation of "objective findings," as defined by Robertson, has led to an overly inclusive standard under which any comment written by a physician will qualify.

In the present case, the claimant has been diagnosed with "significant functional overlay" and fixation with his knee condition. Additionally, although Dr. Rusch, claimant's treating physician, eventually ruled out other causes of his condition and arrived at a diagnosis of overuse syndrome, he initially was unable to define the cause of the claimant's knee symptoms. More importantly, Drs. Rusch, Duff, and Puziss have all agreed that there are no objective findings of impairment in this claimant's case.

Under the circumstances, I believe that the conclusion that a diagnosis of left knee pain constitutes "objective findings" as required by ORS 656.005(7)(a), illustrates that the Robertson decision has effectively taken away any meaning from the statutory requirement that claimant establish an injury by "objective findings."

In conclusion, I would agree that, in a case in which a claimant demonstrates measurable impairment, he has established "objective findings" sufficient to establish the threshold requirement for a compensable injury. However, the present case involves both an absence of measurable impairment and a reason to question the claimant's subjective complaints of pain. Therefore, although I concur in the result, I note that the application of Robertson in this case illustrates the problem with the broad approach of accepting such subjective reports as "objective findings," merely because a physician has noted the complaints of pain in a chart note.

In the Matter of the Compensation of
HANAN G. ALI, Claimant
WCB Case No. 91-00486
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Moller and Westerband.

The insurer requests review of that portion of Referee Livesley's order that set aside its partial denial of claimant's right shoulder calcific tendinitis condition. In her brief, claimant contends that the Referee erred in upholding the insurer's denial of her aggravation claim for a right shoulder injury. On review, the issues are compensability and aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's current right shoulder condition was compensable. He further concluded, however, that claimant had not established a compensable aggravation. The threshold issue is, therefore, whether claimant's current condition, diagnosed as calcific tendinitis, is compensable. If it is compensable, then we determine whether claimant has established a compensable worsening under ORS 656.273. Lareta C. Creasey, 43 Van Natta 1735 (1991).

Compensability

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

In this case, the medical evidence established that claimant's current condition is a result of her right shoulder injury and preexisting right shoulder calcific tendinitis. Because the injury combined with a preexisting condition to cause a need for treatment and disability, the appropriate statute for determining compensability is ORS 656.005(7)(a)(B). Creasey, supra. Under ORS 656.005(7)(a)(B), claimant must prove that the compensable injury is the major contributing cause of her disability or need for treatment. Bahman M. Nazari, 43 Van Natta 2368, 2370 (1991). We conclude that claimant has sustained this burden.

We agree with the Referee that claimant's preexisting calcific tendinitis was asymptomatic prior to the compensable injury. We further agree with his reliance on Dr. Matteri's opinion that the compensable injury rendered claimant's preexisting condition symptomatic. Moreover, we agree that claimant has established that the compensable injury was and remains the major contributing cause of her current disability and need for medical treatment. See LaDonna F. Burk, 44 Van Natta 781 (1992); Nazari, supra.

In reaching this conclusion, we note that Dr. Matteri did not quantify the degree of causation in terms of "major contributing cause." "Magic words," however, are not required. McClendon v. Nabisco Brands, 77 Or App 259 (1986). Matteri clearly attributed the onset of claimant's calcific tendinitis symptoms to the compensable injury. He suggested no other cause for either the onset of those symptoms or their continuation. Moreover, he did not opine that claimant's condition had reached a point to which it would have naturally progressed in the absence of the compensable injury. Under these circumstances, we

find that Dr. Matteri's opinion is sufficient to establish that the compensable injury is the major contributing cause of claimant's current symptomatic condition.

Finally, we wish to emphasize that we are finding claimant's current resultant disability and medical treatment compensable. This is not a determination that claimant's calcific tendinitis is itself compensable. Rather, it is a conclusion that claimant's current disability and need for treatment is attributable to her symptoms from the preexisting calcific tendinitis, the major cause of which remains, at this time, the compensable injury.

Aggravation

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

Attorney Fee/Board Review

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. 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 attorney's services on review concerning the compensability issue is $650, 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 May 3, 1991 is affirmed. For services on review concerning the compensability issue, claimant's counsel is awarded an assessed attorney fee of $650, payable by the insurer.

June 4, 1992 Cite as 44 Van Natta 1087 (1992)

In the Matter of the Compensation of
DALE P. BALLOU, Claimant
WCB Case No. 90-21265
ORDER ON REVIEW
William H. Skalak, Claimant Attorney
Susan Ebner (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of that portion of Referee Podnar's order which set aside its partial denials of claimant's current left hip avascular necrosis and femoral head condition. Alternatively, SAIF requests remand for consideration of additional medical evidence. On review, the issues are compensability and remand. We deny the remand motion and affirm.

FINDINGS OF FACT

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

The record closed on July 11, 1991, following a hearing on February 6, 1991. During the interim, additional medical evidence was received, including the deposition of Dr. Swanson taken on February 28, 1991, letter reports by Dr.

Woolpert dated May 28 and 29, 1991, and an opinion letter by Dr. Swanson dated June 10, 1991.

On September 20, 1991, claimant was seen by Dr. Swanson for a repeat evaluation of his condition.

On November 1, 1991, SAIF filed an Amended Motion to Remand with the Board, seeking to have the chart note of claimant's September 20, 1991 visit with Dr. Swanson admitted into evidence.

CONCLUSIONS OF LAW AND OPINION

Motion for Remand

SAIF has filed a Motion for Remand for admission of additional medical evidence from Dr. Swanson, consisting of a chart note dated September 20, 1991. We deny the motion.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand for consideration of additional evidence, it must clearly be shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986).

Here, Dr. Swanson evaluated claimant's condition in an office visit on September 20, 1991, some 2 months after the record closed. SAIF contends the chart note of this visit should be admitted because of Dr. Swanson's opinion regarding the collapse of the femoral head. However, the record already contains an explanation by Dr. Swanson of his opinion regarding the collapse of the femoral head, including several opinion letters and a 51-page deposition in which SAIF's counsel had ample opportunity to cross-examine Dr. Swanson with respect to his opinion. Thus, we find that the medical evidence SAIF seeks to admit is merely cumulative. We conclude that the record has been sufficiently developed so that remand is not warranted.

Moreover, we find that the evidence could have been obtained with due diligence by the moving party prior to its submission to the Board. Following the February 6, 1991 hearing, the record remained open for receipt of additional medical evidence until July 11, 1991, a period of over 5 months. During this time, Dr. Swanson's deposition was taken in February, and SAIF obtained an additional, independent medical report. Under such circumstances, we conclude that the evidence SAIF seeks to admit was obtainable with due diligence. Accordingly, we deny the motion for remand.

Compensability

The Referee found that claimant's compensable injury on December 9, 1988 was the major contributing cause of the collapse of the necrosed left femoral head which resulted in disability and the need for treatment. We agree with the Referee's conclusion, and we supplement his reasoning with the following.

Subsequent to the Referee's order, we held that in cases involving preexisting conditions, whether a claim is compensable is a two-part test. Bahman M. Nazari, 43 Van Natta 2368 (1991). First, claimant must establish that she suffered an accidental injury arising out of and in the course of employment, which was a material contributing cause of her disability or need for medical treatment. See ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). Then, if it is determined that there is a preexisting condition and that the condition combined with the injury to cause or prolong disability or need for treatment,

claimant is entitled to disability compensation and treatment only to the extent that her injury remained the major contributing cause of her resulting disability. ORS 656.005(7)(a)(B); Bahman M. Nazari, supra.

Because SAIF accepted claimant's December 9, 1988 neck and low back strain as a compensable injury, we need not address whether claimant has established a compensable injury under the first prong of this two-part test. However, as to the second prong of the test, we find that the cause of claimant's current disability is a complex medical question requiring expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Here, the record contains the opinions of Dr. Swanson, claimant's treating orthopedist; Dr. Woolpert, an orthopedist who conducted an independent review of the medical record at SAIF's request; neurologist Dr. Gancher and orthopedist Dr. Gritzka, both of the Western Medical Consultants, who conducted an independent medical examination at SAIF's request; and Dr. Strukel, SAIF's in-house medical advisor. The Referee found, and the medical reports uniformly establish, that claimant's avascular necrosis of the left femoral head is an idiopathic condition that preexisted his compensable injury.

The Referee further found that the work injury is the major contributing cause of the collapse of the necrosed femoral head, which resulted in claimant's disability and need for treatment. The opinions of Drs. Swanson and Woolpert are in conflict with this finding.

Neither the Western Medical Consultants nor Dr. Strukel directly addressed this issue. Dr. Gancher opined that claimant's current low back complaints are referrable to his left hip aseptic necrosis, that the industrial injury is not a contributing factor to his current condition, and that claimant's symptoms are due to his hip pathology. (Ex. 16-3). We do not find this opinion persuasive, because Dr. Gancher had no x-rays to aid his diagnosis and discussion, and his opinion does not focus on the relevant issues: whether the work injury was the major contributing cause of the collapse of the necrosed femoral head, and whether that condition resulted in claimant's disability and need for treatment.

For similar reasons, we also do not rely on Dr. Strukel's opinion. Dr. Strukel's report discusses the etiology of avascular necrosis in general terms, and concludes that claimant's work injury "would be woefully inadequate to cause avascular necrosis." (Ex. 17-2). This conclusion is not in dispute; the medical evidence is in agreement that the work injury did not cause the avascular necrosis. However, Dr. Strukel does not address the questions of whether the work injury contributed to the collapse of necrosed bone, and whether the collapse resulted in claimant's disability and need for treatment. Therefore, we do not rely on the opinions of Dr. Strukel or the Western Medical Consultants.

We now turn to the opinions of Dr. Swanson and Dr. Woolpert. Dr. Swanson opined that claimant's keg lifting incident of December 9, 1988 was the major contributing cause of the onset of the symptoms he experienced after that date for which he required medical treatment. (Exs. 18-42 to 18-43). It is Dr. Swanson's opinion that an MRI done on September 10, 1990 confirms the collapse of the necrotic bone, which was caused by claimant's work activity on December 9, 1988, and which resulted in claimant's need for medical treatment. (See Exs. 16B, 18-24, 18-35, 21). Dr. Swanson agreed that claimant's work activity did not cause the underlying avascular necrosis, but he opined that the work activity did cause the collapse of the necrotic bone area on the day of the injury. (Ex. 16B).

Dr. Swanson agreed that the major contributing cause of claimant's current problems is the preexisting avascular necrosis disease. However, he further explained that the avascular necrosis disease can be thought of as a continuum: some event produces the dead bone, then subsequently, in most cases, the bone collapses, which is usually the inciting event that produces symptoms. (Ex. 18-37). Dr. Swanson found the following to be the most logical and probable scenario in this case: the ball of claimant's femoral head was intact until the keg-carrying incident, at which time there was a collapse of the bone, whether a micro or macro collapse, so that the ball was no longer intact; from that time on claimant had problems. (Ex. 18-39).

Dr. Woolpert disagreed that the keg carrying incident was the major contributing cause of the collapse of the necrosed bone; indeed, he believed the work incident was not related at all. (Ex. 19-3). Dr. Woolpert interpreted the MRI as showing disintegration of the bone, rather than collapse, which he considered to be "due to the usual disintegration of bone from the ischemic causes." (Ex. 20). Dr. Woolpert explained that he believes that collapse will occur regardless of trauma, and that the work injury was not significant with respect to the hip because of the delay in symptoms and claimant's minimal hip complaints at the time of the injury. (Ex. 19-3).

When medical evidence is in conflict, we generally give greater weight to the conclusions of the treating physician, absent persuasive reasons not to do so. Weiland v SAIF, 64 Or App 810, 814 (1983). After considering SAIF's arguments to the contrary, we find no persuasive reason not to defer to the treating physician. The area of dispute comes down to whether and to what extent the keg lifting incident of December 1988 played a role in claimant's subsequent need for treatment. We find Dr. Swanson's opinion more persuasive because he has seen claimant in treatment since July 1990, whereas Dr. Woolpert has never examined claimant, and because Dr. Swanson provides a more thorough and logical explanation of the nature and onset of claimant's symptoms from the time of the keg-lifting incident in December 1988, taking into account claimant's history of ongoing, intermittent low back symptoms since that time. In reaching this conclusion, we note that Dr. Swanson was aware of claimant's recreational bowling activity, and indicated he did not have a problem with claimant bowling, as he considered it a relatively benign activity. (Ex. 18-32).

We conclude, relying on Dr. Swanson's opinion, that the work injury of December 1988 combined with claimant's preexisting necrosis condition and resulted in a collapse of necrotic bone in the left femoral head, which caused claimant's disability and need for medical treatment. We further find, again relying on Dr. Swanson's opinion, that the work injury was the major contributing cause of the resultant condition, the collapse of the necrotic bone. Accordingly, we find that the compensable injury combined with the preexisting necrosis condition, and that the resultant condition is compensable because the compensable injury was the major contributing cause of claimant's disability and need for medical treatment. See ORS 656.005(7)(a)(B).

Because SAIF initiated the request for 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), we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $1,250, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief, response to the Motion for Remand, and statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 1, 1991 is affirmed. For services on review, claimant's counsel is awarded $1,250, to be paid by the SAIF Corporation.

June 4, 1992 Cite as 44 Van Natta 1091 (1992)

In the Matter of the Compensation of
JOHN L. LAW, Claimant
WCB Case Nos. 91-00219 & 90-20445
ORDER ON REVIEW
Aller & Morrison, Claimant Attorneys
Gail M. Gage (Saif), Defense Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by the Board en banc.

Cigna Insurance Companies request review of Referee Mongrain's order that: (1) set aside its denial of claimant's "new injury" claim for a low back condition; (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for a low back condition; and (3) awarded a $2,500 attorney fee to be paid by Cigna. On review, the issues are responsibility and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

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

On September 21, 1990, Cigna denied responsibility for claimant's low back strain on the basis that his condition was an aggravation of his 1985 injury. (Ex. 43).

On December 10, 1990, SAIF denied both responsibility and compensability of claimant's condition. (Ex. 48). Because SAIF denied compensability, an order designating a paying agent under ORS 656.307 did not issue. On the day of hearing, SAIF withdrew its denial of compensability. The only issue raised and litigated at hearing was a determination of the responsible carrier for claimant's compensable condition.

CONCLUSIONS OF LAW AND OPINION

Responsibility

The Referee found that claimant's July 12, 1990 work activity with Cigna's insured was a material contributing cause of his disability and need for services. Therefore, relying on our order in Ricardo Vasquez, 43 Van Natta 1678 (1991), the Referee concluded that responsibility shifted from SAIF, the original carrier, to Cigna, the later carrier, since claimant had sustained a "new compensable injury involving the same condition" under section 49(1) of the new law (now codified in ORS 656.308).

Cigna asserts that this case is distinguishable from Vasquez in that claimant here did not fully recover from the effects of his original injury in 1985. Cigna contends that, because there is evidence that claimant's 1990 injury while working for its insured combined with the preexisting 1985 injury, we should apply ORS 656.005(7)(a)(B). Cigna therefore alleges that responsibility

remains with SAIF unless SAIF proves that the 1990 injury was the major contributing cause of claimant's current condition.

We recently rejected a similar argument in Rosalie S. Drews, 44 Van Natta 36 (1992). In Drews, we held that ORS 656.005(7)(a)(B) is not applicable in the assignment of responsibility context. We reasoned that ORS 656.005(7)(a)(B) only determines compensability of further disability or need for treatment once initial compensability is favorably decided; resolution of such an issue is not relevant to the assignment of responsibility. Id. at 38; see also Ronald L. Rushton, 44 Van Natta 124 (1992). In accordance with the Drews rationale, responsibility shifts from the original carrier if the new compensable injury is a material contributing cause of disability or need for treatment. The injury also must be established by medical evidence supported by objective findings. See ORS 656.005(7)(a).

Furthermore, we reject Cigna's contention that a prior, compensable injury constitutes a "preexisting disease or condition" under ORS 656.005(7)(a)(B). The language of ORS 656.005(7)(a)(B), provides that its applicability is contingent on "a compensable injury combin[ing] with a preexisting disease or condition." (Emphasis added). We interpret that language as evidencing an intent to limit a carrier's liability only in cases when a claimant suffers from a noncompensable preexisting condition that combines with a compensable injury.

Moreover, the language of ORS 656.308 also supports our interpretation of ORS 656.005(7)(a)(B). ORS 656.308 provides that, "[w]hen a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability" and, "[i]f 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." This language demonstrates an intent to compensate a worker who sustains a compensable injury, whether "new" or not. The importance of categorizing the claimant's condition as a "new compensable injury" only relates to assignment of responsibility.

Construing a "compensable injury" under ORS 656.308 to include a "preexisting condition" under ORS 656.005(7)(a)(B), however, would contravene the intent of ORS 656.308 to provide compensation for a worker who sustains a "new compensable injury." In such cases, the later carrier would be assigned responsibility but could then avoid that responsibility with application of ORS 656.005(7)(a)(B). Such a result would be in direct contravention of the intent of ORS 656.308 to assign responsibility and compensate a worker who sustains a compensable injury.

We therefore determine that ORS 656.005(7)(a)(B) is not applicable when a claimant sustains a compensable injury followed by another compensable injury involving the same condition. Consequently, if a worker sustains a "new compensable injury" and responsibility shifts to a later carrier, that carrier is responsible for processing claims for medical services and disability involving that condition and cannot avoid future responsibility for those benefits on the basis that a prior compensable condition is the major contributing cause of that condition. Only when a worker suffers from a noncompensable preexisting condition, and that noncompensable preexisting condition combines with the "new compensable injury," is it possible that the carrier's liability may be limited by ORS 656.005(7)(a)(B).

Here, we agree with the Referee that the medical evidence proved that claimant's work with Cigna's insured materially contributed to his current condition and, therefore, claimant sustained a "new compensable injury." Because we also reject Cigna's request to disavow our order in Vasquez, we conclude that

responsibility shifts to Cigna. Furthermore, Cigna's liability for claimant's condition insofar as that condition relates to SAIF's injury is not limited by ORS 656.005(7)(a)(B).

Attorney Fees at Hearing

Cigna next contends that the Referee erred in awarding a fee to claimant's attorney payable by Cigna rather than SAIF. Cigna asserts that, pursuant to Karen J. Bates, 39 Van Natta 42 (1987), rev'd on other grounds SAIF v. Bates, 94 Or App 666 (1989), SAIF should be ordered to pay claimant's attorney fee. For the reasons that follow, we agree that claimant is entitled to an assessed fee payable by SAIF. In addition, we conclude that claimant is entitled to an approved fee, payable by Cigna, out of claimant's award of compensation.

The dispositive statute in this regard is ORS 656.386, which provides:

> "(1) In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee. 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.
>
> "(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."

Here, compensability was initially at issue as a result of SAIF's December 10, 1990 denial. However, following SAIF's prehearing compensability concession (Cigna had denied only responsibility), the only issue raised and litigated at hearing involved which carrier was responsible for providing benefits. (Tr. 3-4). In this regard, SAIF's counsel stated at hearing that "responsibility is the only condition -- issue at this time so it would be between SAIF Corporation and Cigna. Compensability is no longer at issue." (Tr. 4). Counsel for Cigna agreed with SAIF's counsel's statement. Therefore, there was no question but that claimant would receive compensation. The only issue litigated was which carrier would be responsible for providing that compensation. Claimant's counsel took no position as to which carrier was responsible, stating "that's more appropriate to be advocated between the two employers." (Tr. 3). Under these circumstances, ORS 656.386(1) does not authorize the award of a fee for services at the hearing. See Petshow v. Farm Bureau Ins. Co., 76 Or App 563 (1985), rev den 300 Or 722 (1986). However, ORS 656.386(1), as amended in 1991, does provide for a fee for claimant's counsel's prehearing services resulting in SAIF's rescission of its compensability denial. See Jones v. OSCI, 108 Or App 230 (1991). We first discuss claimant's entitlement to an assessed fee for services at hearing.

In Petshow, supra, the carriers conceded that the claim was compensable. Therefore, the issue was whether claimant was entitled to an assessed attorney fee for litigating the issue of responsibility between carriers. Claimant's counsel asked some questions relevant to the responsibility issue; however claimant did not take a position as to which insurer was responsible. Under

these circumstances, the court held that ORS 656.386(1) did not allow for the award of an assessed attorney fee. The court reasoned that:

> "[a]lthough it is literally true that claimant ultimately prevailed on a denied claim, he is not entitled to attorney fees for overcoming that denial. When, as here, the insurers concede compensability and only deny the claim on the basis of responsibility, the claimant will always prevail on one of the denied claims."

In reaching its decision, the court distinguished two prior cases where carriers took a position which threatened the claimant's right to compensation. In Hanna v. McGrew Bros. Sawmill, 44 Or App 189, modified 45 Or App 757 (1980), the claimant was required to appear at the hearing to contest the insurer's contention that his claim was not enforceable, because he had not appealed that insurer's denial. In Nat. Farm Ins. v. Scofield, 56 Or App 130 (1982), the insurer contended that claimant's claim was barred by his failure to file it timely or because he had not proven a compensable aggravation. The Petshow court noted that an ORS 656.386(1) fee was appropriate in both cases "because the claimants were required to appear to protect their rights to compensation." Petshow, 76 Or App at 570.

Since Petshow, the court has reiterated on a number of occasions that a fee pursuant to ORS 656.386(1) is only proper where claimant's entitlement to compensation is at risk.[1] In Dilworth v. Weyerhaeuser Co., 95 Or App 85, rev den 307 Or 658 (1989), compensability of medical services was at risk based on Weyerhaeuser's cross-request for Board review. Citing Petshow, the court concluded that an assessed fee was proper given that claimant's attorney "justifiably and actively participated in the proceeding before the Board."

Subsequently, in Howard v. Willamette Poultry, 101 Or App 584, (1990) the issue was whether claimant was entitled to an assessed fee on Board review where the only issue was responsibility. There, claimant actively participated on Board review, arguing that the Referee should be reversed and the insurer with the higher temporary disability benefits should be found responsible. Nevertheless, despite claimant's obvious interest in the outcome of the responsibility determination, the court concluded that no fee was due under either ORS 656.382(2) or 656.386(1). With regard to an ORS 656.386(1) fee, the court stated:

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[1] The dissent attempts to distinguish the caselaw on the basis of the presence in those cases and the absence in this case of an ORS 656.307 order. However, the existence or nonexistence of an ORS 656.307 order does not determine whether claimant's entitlement to compensation is at risk. Rather, it is the defenses raised by the carriers that determine the risk to claimant's benefits. Here, SAIF initially raised a defense that put claimant's compensation at risk and claimant is entitled to a carrier-paid fee for prevailing over that challenge. However, by the time of hearing, neither carrier raised a defense which put claimant's entitlement to compensation at risk; instead both carriers merely pointed to one another as the party responsible for paying claimant his uncontested benefits. As reflected by the hearing record, claimant was a nominal party to that determination. Cf. Karen J. Bates, 39 Van Natta 42 (1987), rev'd on other grounds SAIF v. Bates, 94 Or App 666 (1989) (challenge by one carrier to timeliness of claim placed claimant's entitlement to compensation at risk both at hearing and on Board review). Similarly, a claimant's entitlement to compensation may be at risk where a ".307" order has previously issued, as was the case in both Hanna v. McGrew Bros. Sawmill, supra, and Nat. Farm Ins. v. Scofield, supra.

> "In SAIF v. Phipps, 85 Or 436, 737 P2d 131 (1987), we allowed attorney fees under ORS 656.386 for services before the Board. The issue was which insurer was responsible. The claimant took a position before the Board on responsibility that would have resulted in increased time loss benefits. Phipps, however, does not refer to Shoulders v. SAIF, supra, and predates Short v. SAIF, supra, 305 Or at 545, which makes it clear that whether a claimant is entitled to an award of attorney fees under ORS 656.386(1) does not depend on the amount of compensation that claimant may receive. See also Petshow v. Farm Bureau Ins. Co., 76 Or App 563, 710 P2d 781 (1985), rev den 300 Or 722 (1986)." Id. at 587, ft nt 4 (1990).

Phipps, cited in the court's footnote in Howard, supra, was overruled by the court in Mercer Industries v. Rose, 100 Or App 252, modified on recon 103 Or 96 (1990). In Mercer, both carriers agreed that claimant was entitled to compensation but disputed which was responsible for his present condition. The Board declined to award an employer-paid attorney fee on the responsibility issue. Initially, the court reversed on the attorney fee issue and remanded the matter to us to determine whether claimant's attorney's participation constituted "active litigation." However, on reconsideration, the court held that, where entitlement to receive compensation is resolved before the hearing, no fee may be awarded under ORS 656.386(1), because claimant did not seek review from an order denying compensation. See also Davis v. Aetna Casualty Co., 102 Or App 132, 137, ft nt 5 (1990).

Accordingly, claimant's entitlement to an assessed attorney fee under ORS 656.386(1), for services at hearing, depends on whether compensability of the claim remains at issue. Where compensability is no longer contested at hearing by the carriers, no fee may be awarded under ORS 656.386(1) for services at hearing. Moreover, the court opinions do not depend on whether the Director has issued an ORS 656.307 order designating a paying agent pending resolution of the responsibility issue. To the contrary, the determinative inquiry is whether compensability is contested. Where it is not contested, and the only issue is responsibility for payment of the compensation, no fee is proper under ORS 656.386(1). Here, claimant's entitlement to compensation was not at risk at hearing; therefore, no fee for services at hearing may be awarded.

However, in 1991, the legislature amended ORS 656.386(1) to allow for the award of a carrier-paid attorney fee even where claimant has not finally prevailed at a hearing on a denied claim for compensation so long as claimant's attorney is "instrumental in obtaining compensation for a claimant." Here, as a result of SAIF's prehearing compensability concession, claimant's entitlement to compensation was assured. Moreover, the record is clear that claimant's counsel was instrumental in obtaining compensation for claimant through rescission of SAIF's denial of compensability. Therefore, claimant's counsel is entitled to an assessed fee for his prehearing services.

Here, we find that claimant's attorney is entitled to an attorney fee in the amount of $1,500, payable by SAIF, pursuant to amended ORS 656.386(1). In reaching this conclusion, we have considered the factors set forth in OAR 438-15-010(4), particularly the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney might go uncompensated.

Finally, we note that the only other statute potentially providing for the award of an assessed attorney fee is ORS 656.307(5). However, that provision expressly refers to cases in which the director has, by order, designated who shall initially pay the claim and an arbitrator has been appointed to determine the ultimately responsible carrier. Here, the director had not issued a ".307"

order, nor had an arbitrator been appointed to determine the responsibility issue. Therefore, ORS 656.307(5) cannot provide the basis for the award of an assessed attorney fee. See Ray Schulten's Ford v. Vijan, 105 Or App 294 (1991). Moreover, even if that section were applicable, ORS 656.307(5) provides for the award of a reasonable attorney fee only where claimant's counsel "actively and meaningfully" participates in the responsibility determination. Because claimant took no position with regard to the responsibility determination, he would not be entitled to an assessed attorney fee under ORS 656.307(5). See Petshow, supra, decided prior to enactment of ORS 656.307(5); Frances R. Keenon, 42 Van Natta 1325 (1991).

Although the statutes do not allow for a carrier-paid attorney fee in this case, claimant's counsel does not go uncompensated for his services on claimant's behalf at hearing. Because no fee is otherwise statutorily authorized, this is one of the "all other cases" under ORS 656.386(2) in which a claimant must pay the attorney from the award of compensation. Petshow, supra.

ORDER

The Referee's order dated October 9, 1991 is affirmed in part and modified in part. In lieu of the Referee's $2,500 attorney fee payable by Cigna, SAIF shall pay claimant's attorney an assessed fee of $1,500. In addition, claimant's attorney is awarded an approved fee of 25 percent of any increased compensation created by the Referee's order, payable directly by Cigna to claimant's counsel, in an amount not to exceed $1,050. The remainder of the order is affirmed.

Board Members Hooton, Gunn and Kinsley concurring in part and dissenting in part.

We concur with the holding that an insurer may not deny benefits in an accepted claim pursuant to ORS 656.005(7)(a)(B) on the basis that a prior responsible compensable injury or disease is the major contributing cause of the claimed benefit. ORS 656.308(1).

We further concur that claimant is entitled to an assessed attorney fee payable by SAIF with regard to SAIF's rescission of the compensability portion of its denial prior to hearing. ORS 656.386(1); Jones v. OSCI, 108 Or App 230 (1991).

Finally, we also agree that claimant is entitled to an attorney fee with regard to the overturning of Cigna's denial of responsibility. However, while the majority finds that this fee is payable out of claimant's compensation under ORS 656.386(2), we find the fee should be paid by Cigna under ORS 656.386(1).

Cigna has contended, however, that pursuant to Karen J. Bates, 39 Van Natta 42 (1987), rev'd on other grounds SAIF v. Bates, 94 Or App 666 (1989), SAIF should be ordered to pay claimant's entire attorney fee. The Bates case was similar to this case in that insurer 1 denied responsibility only, while insurer 2 denied compensability and responsibility. Since compensability was contested, no order was issued pursuant to ORS 656.307. Ultimately, insurer 1 was found responsible for the claim. The Board awarded an assessed attorney fee to the claimant payable by insurer 2 on the compensability issue. However, no attorney fee for the claimant was found to be due on any basis on the responsibility issue. Since all Board members agree in the instant case that claimant's attorney is entitled to some fee on the responsibility issue, Bates is disavowed insofar as it held that no fee should be allowed on that issue.

We accept the majority's premise that, in order for claimant to be entitled to an assessed fee payable by Cigna under ORS 656.386(1), claimant's attorney must have been instrumental, or prevail finally, in protecting claimant's entitlement to receive compensation. For the following reasons, we find that claimant's attorney has fulfilled that requirement in this case.

In an arbitration held under ORS 656.307, the claimant is a necessary party, but may elect to be only a nominal party. ORS 656.307(5). The involved insurers, not the claimant, have the responsibility to request designation of a paying agent, which results in an order issued pursuant to ORS 656.307. OAR 436-60-180(5). Claimant need not even request an arbitration to assure that he or she will receive benefits. By order of the Compliance Section, the case is automatically referred to the Board for an arbitration proceeding. OAR 436-60-180(12). See also ORS 656.307(2). Meanwhile, without taking any further action, the claimant is assured of continued payment of benefits by the designated paying agent unless and until the paying agent is relieved of the responsibility by an order of the arbitrator. OAR 436-60-180(13).

However, where the issue is responsibility between insurers, but Compliance has not issued an order designating a paying agent, the obligations of the claimant, and the attendant risks, are much different. In that situation, the claimant must request a hearing from each of the responsibility denials within the applicable appeal period or face the risk that the denials will become final. In the meantime, no insurer is obligated to pay any benefits on the claim. Additionally, the claimant has the burden to gather and submit the evidence for the hearing and/or monitor the evidence, if any, submitted by the insurers.[2] If there is no evidence presented at the hearing to overturn one or the other of the denials, each of the denials would be affirmed and the claimant would receive no compensation.[3] Consequently, even though the insurers have indicated that the only issue is responsibility, the claimant must still establish

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[2] In support of our position that claimant's compensation remains at risk, and that claimant has the burden to go forward with the evidence we note specifically the provisions of OAR 438-06-071(2) which provides that:

> "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." (Emphasis added).

This rule makes it clear that claimant's entitlement to compensation remains at risk unless claimant appears at the hearing and is ready to go forward with the evidence. This remains the case even if one of two insurers ultimately accepts the burden of proof and proceeds to present the necessary evidence. The belief that an insurer will eventually go forward in every case is not sufficient to support the conclusion, present in the majority opinion, that claimant's compensation is not at risk unless one of the insurers raises a defense to compensability.

[3] In Harris v. SAIF, 292 Or 683, 690 (1982) the Supreme Court noted that "[t]he general rule is that the burden of proof is upon the proponent of a fact or position, the party who would be unsuccessful if no evidence were introduced on either side." (Emphasis added).

the necessary causal relationship to one or more of the potentially responsible employers in order to overcome the rejection of the right to receive compensation. See Castle and Cooke v. Alcantar, 112 Or App 392 (1992). These differences show that, unlike a case where an order has been issued pursuant to ORS 656.307, the claimant's entitlement to compensation is not assured and remains in doubt until a referee issues an order requiring an insurer to accept the claim and that order becomes final. It is essential for the claimant to be active in that entire proceeding to ensure entitlement to compensation. Therefore, we find that if the claimant is successful in securing that compensation, he or she should be entitled to an assessed attorney fee pursuant to ORS 656.386(1).

The majority cites several cases in support of its position to the contrary. However, Petshow v. Farm Bureau Ins. Co., supra, Howard v. Willamette Poultry, supra, Mercer Industries v. Rose, supra, and Davis v. Aetna Casualty Co., supra, all had orders issued pursuant to ORS 656.307. As shown above, an arbitration under ORS 656.307 is substantially different from a responsibility hearing under ORS 656.283 where the claimant retains the burden of proof and under which there remains the potential that the claimant may go uncompensated. Hanna v. McGrew Bros. Sawmill, supra, and Nat. Farm Ins. v. Scofield, supra, also had orders issued pursuant to ORS 656.307, however, despite the order, in each case an insurer had raised an issue that, if successful, would have deprived the claimant of entitlement to compensation. As the majority correctly notes, the court found in those cases that the claimant was entitled to an assessed attorney fee. In Dilworth v. Weyerhaeuser Co., supra, there was no order issued pursuant to ORS 656.307 and the court held that the claimant was entitled to the award of an assessed attorney fee because the attorney "justifiably and actively participated in the proceeding before the Board." 95 Or App 85, 92 (1989).

The majority has also cited Petshow v. Farm Bureau Ins. Co., supra, and Frances R. Keenon, supra, as support for their opinion that claimant would not be entitled to the award of an assessed fee because claimant failed to take a position as to which insurer was responsible. However, these cases are distinguishable because an order had been issued pursuant to ORS 656.307. The basis for the denial of the assessed fee in those cases was that, in a simple arbitration, unless the claimant takes a position regarding which insurer is responsible and actively litigates that position, the claimant's role is merely that of a witness. However, unlike this case, those claimants did not have the responsibility to press forward with litigation with the risk that entitlement to compensation would be in jeopardy if they did not do so. In this case, from the initial obligation of filing timely requests for hearing and until there is a final order requiring payment by an insurer, claimant's role is much more than merely that of a witness, despite the fact that claimant did not take a position on which was the responsible insurer. Therefore, we do not find that claimant's failure to take a position on that point is fatal to the award of an assessed attorney fee.

To conclude, we would order the award of an assessed attorney fee pursuant to ORS 656.386(1) payable by Cigna because claimant has prevailed in overturning its denial of responsibility. Claimant's attorney was instrumental in preserving claimant's entitlement to compensation by timely filing requests for hearing against each insurer, monitoring the evidence submissions to ensure that there was evidence against one or both of the insurers so that the denials would not be affirmed, attending and participating in the hearing to ensure that the proper issues were raised, that the appropriate evidence was admitted and that the matter would not be dismissed, and continuing to follow that matter to a

final order ultimately entitling claimant to the payment of benefits. In this manner, claimant's attorney justifiably and actively participated in the proceeding on his client's behalf.

June 4, 1992 Cite as 44 Van Natta 1099 (1992)

In the Matter of the Compensation of
SHIRLEY S. SCAPARRO, Claimant
WCB Case Nos. 91-05952 & 91-07759
INTERIM ORDER DISMISSING CROSS-REQUEST FOR REVIEW
James L. Edmunson, Claimant Attorney
Terrall & Associates, Defense Attorneys

Claimant has moved for dismissal of the self-insured employer's cross-request for Board review. We grant the motion.

FINDINGS OF FACT

On February 27, 1992, the Referee issued an Opinion and Order. The Referee upheld the employer's denial of claimant's thoracic outlet syndrome and set aside its denial of claimant's left arm conditions. The Referee also awarded a carrier-paid attorney fee of $1,500.

On March 12, 1992, the employer moved for reconsideration of the Referee's order. Specifically, the employer sought reduction of the $1,500 attorney fee award.

On March 23, 1992, claimant mailed by certified mail her request for Board review of the Referee's February 27, 1992 order. On March 25, 1992, the Hearings Division received claimant's response to the employer's motion for reconsideration.

On March 26, 1992, the Referee issued an Order on Reconsideration. After addressing the employer's motion and claimant's response, the Referee adhered to the February 27, 1992 order.

On March 30, 1992, the Board mailed a computer-generated letter acknowledging claimant's request for Board review.

On April 23, 1992, the employer mailed by certified mail a request for Board review of the Referee's February 27, 1992 order, as reconsidered March 26, 1992. On May 4, 1992, the Board mailed a letter acknowledging the employer's "cross-request" for review.

CONCLUSIONS OF LAW

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). When one party timely requests Board review, the other parties have at least the remainder of the 30-day period and, in any event, no less than 10 days within which to cross-request review. ORS 656.289(3); Robert Casperson, 38 Van Natta 420 (1986).

Here, the employer sought reconsideration of the Referee's February 27, 1992 order prior to the expiration of the 30-day statutory period and before either party had requested Board review. Nevertheless, by the time the Referee

issued the March 26, 1992 Order on Reconsideration, claimant's March 23, 1992 request for Board review had already been filed. OAR 438-05-046(1)(b). Under such circumstances, jurisdiction over this case vested with the Board on March 23, 1992. See Ramey S. Johnson, 40 Van Natta 370 (1988). Consequently, the Referee's March 26, 1992 Order on Reconsideration was a nullity.

Inasmuch as the Referee's reconsideration order was a nullity, the employer had until April 2, 1992 to file its cross-request for Board review of the Referee's February 27, 1992 order. See ORS 656.289(3). Since the employer's cross-request was not filed until April 23, 1992, the request is untimely and will be dismissed. In doing so, we note that a respondent may raise additional issues not addressed by an appellant, notwithstanding the lack of a cross-request. Kenneth Privatsky, 38 Van Natta 1015 (1986); Jimmie Parkerson, 35 Van Natta 1247, 1249-50 (1983). However, a respondent accepts the risk that the appellant may choose to withdraw the request for Board review, thereby terminating the Board's jurisdiction. Jimmie Parkerson, supra, at page 1250.

We retain jurisdiction over this case pursuant to claimant's request for Board review. Therefore, this order shall be interim and will be incorporated into our eventual final order.

Finally, the employer has submitted an "appellant's brief." Contending that the employer is not the appellant, claimant requests that the brief be stricken. In light of our prior reasoning, we grant claimant's request. Yet, as previously discussed, should the employer include the contentions raised in its stricken brief in a timely submitted respondent's brief, those contentions will receive consideration.

As a result of this order, 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 brief shall be due 21 days from the date of mailing of claimant's brief. Claimant's reply brief shall be due 14 days from the date of mailing of the employer's brief. Thereafter, this case will be docketed for review.

IT IS SO ORDERED.

In the Matter of the Compensation of
LAURA A. WARD, Claimant
WCB Case No. 91-05366
ORDER ON REVIEW
Carney, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of that portion of Referee Spangler's order which upheld the insurer's denial of her current chronic pain syndrome, narcotic dependency and depression. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant was compensably injured on August 26, 1987 when she fell down some stairs at work. (Ex. 1). She twisted her back and neck and landed on her right elbow and hip. (Ex. 2). The insurer accepted her claim as "multiple constusions [sic] and myositis of c-spine." (Ex. 4).

Claimant's claim was closed by an August 19, 1988 Determination Order, awarding 26 percent unscheduled permanent disability. (Ex. 15-1). On January 7, 1991, claimant notified the insurer that she suffered from chronic pain syndrome, narcotic dependency and depression as a result of her 1987 compensable injury. (Ex. 38A).

Dr. Erickson, claimant's treating physician, treated claimant for neck, shoulder, hip and groin pain. (Ex. 1). Dr. Takacs, a consulting osteopathic physician, diagnosed myofascial pain syndrome on October 12, 1987 and noted that claimant had a high risk of developing chronic pain syndrome as well. (Ex. 5-2). Dr. Erickson diagnosed chronic pain syndrome on February 26, 1988. (Ex. 7B). The Western Medical Consultants performed an independent medical examination and also diagnosed chronic pain syndrome. (Ex. 9-4). An April 1988 MRI revealed a mild bulge at the L5-S1 level and a mild bulge at the L4-5 level with a differential diagnosis of a small herniated disc. (Ex. 9A). After reviewing the MRI findings, the Western Medical Consultants noted that the MRI findings were consistent with claimant's complaints and opined that there was no curative treatment for claimant's condition. (Ex. 10).

To alleviate claimant's pain, Dr. Erickson prescribed Vicodin, a narcotic pain reliever. (Ex. 33). Claimant took Vicodin continuously from 1987 through the date of the hearing, except for a period of approximately three months after leaving the Emanuel Pain Center. (Tr. 18 and 19). Ingestion of Vicodin develops physical dependency within a period of a few days to a few months. (Exs. 46-10 and 46-66).

When claimant first started taking Vicodin, she took 30 tablets in approximately 10 to 20 days. (Tr. 18). After attending the Emanuel Pain Center, she tapered off to 30 tablets per month. Id. Claimant became addicted to and dependent on Vicodin. (Exs. 25 and 33). Before her 1987 injury, she never had taken drugs nor had she ever been treated for any type of drug addiction. (Tr. 18).

Following her injury, claimant began to suffer from depression. As a result of her depression, Dr. Erickson prescribed anti-depressant medications, Xanax and Asendin. (Ex. 27). Claimant's addiction to Vicodin exacerbated and perpetuated claimant's chronic pain syndrome and depression. (Exs. 36-6, 41-2, 46-8, and 46-48).

At the request of Dr. Erickson, claimant sought psychiatric treatment for her depression. (Tr. 20). However, after making an appointment with a psychiatrist, the insurer refused to authorize treatment. Id. Claimant was without funds to pay for treatment so her appointment was cancelled. Id.

While claimant had experienced some depression prior to the compensable injury, it was not significant and she did not seek or receive psychiatric treatment. (Exs. 38-1, 41-2 and Tr. 18).

Claimant does not have a preexisting personality disorder.

On April 30, 1991, claimant filed a request for a hearing regarding the insurer's "de facto" denial of her chronic pain syndrome, narcotic dependency and depression. On July 8, 1991, the insurer denied claimant's three conditions. (Ex. 44). Claimant filed a supplemental request on the denial letter. A hearing was held on July 26, 1991.

Claimant's 1987 compensable injury was the major contributing cause of her consequential chronic pain syndrome, narcotic dependency and depression.

CONCLUSIONS OF LAW AND OPINION

Compensability

As a preliminary matter, we note that claimant requested a hearing after May 1, 1990 and the hearing was held after July 1, 1990. Accordingly, we analyze this matter under the Workers' Compensation Act effective July 1, 1990. See Or Laws (Special Session), ch. 2, Section 54(2); Ida M. Walker, 43 Van Natta 1402 (1991).

Relying on the opinion of Dr. Klecan, the Referee found that claimant suffers from a preexisting personality disorder and concluded that her personality disorder was the major contributing cause of her chronic pain syndrome, narcotic dependency and depression. We disagree.

ORS 656.005(7)(a)(A) provides in relevant part, that "[n]o injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition." In Julie K. Gasperino, 43 Van Natta 1151 (1991), we interpreted the phrase "consequential condition" to include only problems that arise from conditions previously deemed compensable ("secondarily consequential" conditions requiring proof of a major contributing cause), as opposed to conditions that arise directly from the injurious event ("primarily consequential" conditions requiring proof of a material contributing cause).

Here, claimant's initial injury claim was accepted as multiple contusions and myositis or inflammation of the spine. (Ex. 4). Dr. Erickson, claimant's treating physician, diagnosed chronic pain syndrome on February 26, 1988. (Ex. 7B). To alleviate claimant's pain, Dr. Erickson prescribed Vicodin, a narcotic pain reliever. (Ex. 33). Claimant became addicted to Vicodin. (Exs. 25 and 33). Before her 1987 injury, she never had taken drugs nor had she ever been treated for any type of drug addiction. (Tr. 18). While claimant had experienced some depression prior to her compensable injury, it was not significant and she had never sought or received psychiatric treatment. (Exs. 38-1 and 41-2 and Tr. 18). Dr. Erickson noted on February 26, 1988 that claimant was depressed as a result of her chronic pain. (Ex. 7B). Dr. Crumpacker, claimant's treating neurologist, also noted that claimant was depressed "because of her situation." (Ex. 26-3). On these facts, we find that claimant's chronic pain syndrome, narcotic dependency and depression are properly classified as

"secondary consequential" conditions. Consequently, in order to establish compensability, claimant must prove that her compensable injury was the major contributing cause of her chronic pain syndrome, narcotic dependency and depression.

The issue of whether claimant's chronic pain syndrome, narcotic dependency and depression were caused, in major part, by her compensable injury is a complex medical question the resolution of which turns, in part, on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986).

The only medical reports addressing the causal relationship between claimant's compensable injury and these consequential conditions are the opinions of Dr. Erickson, claimant's treating physician, Dr. Crumpacker, claimant's treating neurologist, and Dr. Klecan, a psychiatrist who performed an independent medical examination. In response to claimant's counsel's letter, Dr. Erickson, who ultimately diagnosed chronic myositis of the cervical, thoracic and lumbar spine, opined that the major contributing cause of claimant's chronic pain syndrome was her 1987 injury. (Ex. 41-1). Although Erickson noted that claimant had some depression before her injury, he stated, "I do believe that [her compensable injury] is probably a major contributing cause to [sic] current state, i.e. her level of depression." (Ex. 38-1). He also noted some resulting narcotic addiction but did not expressly relate the dependence to her injury. (Ex. 41-2). While Dr. Crumpacker was not aware of claimant's narcotic dependency, he opined that claimant was depressed "because of her situation" and attributed claimant's pain and depression to her compensable injury. (Exs. 26-3 and 39).

On the other hand, Dr. Klecan opined that claimant's chronic pain, addiction and depression were caused, in major part, by claimant's "preexisting lifelong personality traits" which in turn was caused, in part, by her "painfully traumatic experiences in childhood and adolescence." (Ex. 41-1).

Where there is dispute between medical experts, we generally give greater weight to those opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). We give greater weight to the opinion of the treating physician absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983).

The Referee found Dr. Klecan's opinion most persuasive because Klecan is a psychiatrist. While it is true that Klecan is the only psychiatrist to render an opinion, we do not share the Referee's assessment of Klecan's opinion. Dr. Klecan's opinion is premised on the assumption that claimant has a preexisting personality disorder. We have herein found to the contrary. Additionally, Dr. Klecan only examined claimant one time. For these reasons we do not find Dr. Klecan's opinion persuasive.

However, we do find the opinions of Dr. Erickson and Dr. Crumpacker persuasive. Both Erickson and Crumpacker have treated claimant. Moreover, Dr. Erickson has treated claimant since the compensable injury and, therefore, was in the best position to address the causal relationship between the compensable injury and claimant's current condition. See Kienow Food Stores v. Lyster, 79 Or App 416, 421 (1986). Accordingly, we conclude that claimant has established that her 1987 injury is the major contributing cause of her chronic pain syndrome and depression.

Finally, we note that Crumpacker was unaware of claimant's narcotic dependency and Erickson did not expressly relate her dependency to her compensable injury. However, we nonetheless conclude, based on this record, that claimant's

compensable injury was also the major contributing cause of her narcotic dependency. In reaching this conclusion we note that claimant was initially given Vicodin, which is addictive within a short period of time, for her chronic pain syndrome pain, which we found was caused in major part by her compensable injury. We also note that the record establishes that claimant had never taken drugs, been addicted to drugs and had never been treated for drug dependency prior to her compensable injury.

Accordingly, we hold that claimant has carried her burden of establishing that her 1987 compensable injury was the major contributing cause of her narcotic dependency.

Attorney Fee

Claimant is entitled to an assessed attorney fee for her counsel's services at hearing and on review concerning the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $3,000 is a reasonable fee, 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 value of the interest involved, the complexity of the issue, and the risk that claimant's attorney may go uncompensated.

ORDER

The Referee's order dated August 22, 1991 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review concerning the compensability issue, claimant's counsel is awarded an assessed attorney fee of $3,000, to be paid by the insurer.

In the Matter of the Compensation of
ROBERT A. BROOKS, JR., Claimant
WCB Case No. 90-17093
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of those portions of Referee McWilliams' order which: (1) set aside its denial of claimant's low back strain injury claim; and (2) awarded claimant's attorney a penalty-related attorney fee under ORS 656.382(1) for an unreasonable denial. On review, the issues are compensability, penalties and attorney fees. We affirm in part, modify in part, and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found that claimant proved that he sustained a low back injury at work on July 11, 1990, which was established by medical evidence supported by objective findings, and which was a material contributing cause of his disability and need for medical treatment. ORS 656.005(7)(a). We affirm and adopt the Referee's findings and conclusion with respect to this issue.

Penalties and Attorney Fees

Claimant requested a hearing in this matter after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, we apply the 1990 amendments to the workers' compensation law. Or Laws 1990 (Special Sessions), ch 2, section 54; see Ida M. Walker, 43 Van Natta 1402 (1991).

The Referee found that SAIF's failure to pay interim compensation constituted an unreasonable resistance to the payment of compensation. Based on this finding, the Referee assessed SAIF a penalty equal to 25 percent of unpaid interim compensation to be equally shared by claimant and his attorney. See ORS 656.262(10).

The Referee also found that SAIF's denial of the claim was unreasonable. On the basis of this finding, the Referee assessed SAIF another penalty equal to 25 percent of unpaid interim compensation, payable entirely to claimant. In addition, the Referee awarded claimant's counsel a separate, assessed, penalty-related attorney fee pursuant to ORS 656.382(1) for SAIF's unreasonable denial.

Thus, the Referee assessed penalties for two separate claims processing violations. While we agree that both violations warranted the assessment of penalties, there is no legal authority for assessing penalties totalling more than 25 percent of the compensation then due. ORS 656.262(10)(a); Mollie E. Barrow, 43 Van Natta 617, 618 (1991). Furthermore, ORS 656.262(10)(a) provides that if a worker is represented by an attorney, as is the case here, "the worker's attorney shall receive one-half the additional amount, in lieu of an attorney fee." There is no authority for awarding the full penalty amount to the worker. Accordingly, we reverse that portion of the Referee's order which assesses SAIF a second 25 percent penalty based on unpaid interim compensation.

The second penalty the Referee assessed, based on unpaid interim compensation, was for SAIF's unreasonable denial. However, subsequent to the Referee's order, we have held that the basis for a penalty for an unreasonable denial is all compensation due at the time of the hearing; that is, all compensation that becomes due by reason of the Referee's order finding the claim compensable. Kim S. Jeffries, 44 Van Natta 824, 826 (1992) (all compensation due at the time of the hearing includes medical services, regardless of the date when rendered). Accordingly, we assess a penalty for SAIF's unreasonable denial equal to 25 percent of any compensation due at the time of the hearing, less the amount of unpaid interim compensation, to be shared equally by claimant and his attorney. ORS 656.262(10).

With respect to SAIF's unreasonable denial, the Referee also awarded claimant's counsel a separate, assessed attorney fee under ORS 656.382(1). However, subsequent to the Referee's order, we have held that, when the factual basis in support of the penalty under ORS 656.262(10) is identical to the factual basis for which an attorney fee under ORS 656.382(1) might be awarded, the simultaneous assessment of an attorney fee and a penalty would contravene the legislative intent expressed in amended ORS 656.262(10)(a) that the claimant's attorney receive one-half the penalty "in lieu of an attorney fee." Nicolasa Martinez, 43 Van Natta 1638 (1991); Shirley J. Sanderson, 44 Van Natta 481 (1992).

That is the case here. Under such circumstances, claimant's attorney is not entitled to an attorney fee for an unreasonable denial under ORS 656.382(1) in addition to one-half the penalty award. Accordingly, we reverse the Referee's $350 assessed fee award.

Inasmuch as SAIF requested review and we have affirmed the Referee's order finding the claim compensable, claimant is entitled to an assessed attorney fee. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $900, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and the attorney's statement of services), the complexity of the issue, and the value of the interest involved. In addition, we have considered that claimant is not entitled to an attorney fee for defending against the penalty and attorney fee issue. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated April 22, 1991, as amended August 2, 1991 and August 8, 1991, is reversed in part, modified in part, and affirmed in part. The Referee's $350 assessed attorney fee for an unreasonable denial is reversed. In lieu of the Referee's penalty assessments, SAIF is assessed the following: (1) a penalty equal to 25 percent of claimant's unpaid interim compensation, to be paid in equal shares to claimant and his attorney, for unreasonable failure to pay interim compensation; and (2) a penalty equal to 25 percent of all compensation due at the time of the hearing, less unpaid interim compensation, to be paid in equal shares to claimant and his attorney, for an unreasonable denial. The remainder of the order is affirmed. For services on Board review concerning the compensability issue, claimant's attorney is awarded $900, to be paid by SAIF.

In the Matter of the Compensation of
J. ALTON CLARK, Claimant
Own Motion No. 66-0291M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

Claimant submitted his request for medical benefits relating to his alleged worsening of a July 27, 1965 industrial injury to his right knee while working at Evans Products, whose insurer at that time was allegedly Argonaut Insurance Company, Claim No. 05-XO-16178.

Prior to January 1, 1966, not all workers were covered under the Worker's Compensation Act. Former ORS 656.024 permitted an employer to reject workers' compensation insurance coverage by filing a written notice of rejection with the State Industrial Accident Commission (SIAC), the Board's predecessor. See Or Laws (1959), Ch 448, 10. In the event an employer rejected coverage under former ORS 656.024, the employer was liable for an injury to a worker cause by the employer's negligence, defalt or wrongful act "as if [the workers' compensation] statutes had not been passed." Or Laws 1959, ch 448, 2. Accordingly, an injured worker employed by an employer who had rejected coverage did not sutatain a "compensable" injury and was not entitled to benefits afforded under the Workers' Compensation Act. See Nadeau v. Power Plant Engr. Co., 216 OR 12, 18, 1959; Donald R. Beyerlin, 43 Van Natta 870, (1991).

Here, our review of the SIAC files reveals no evidence that claimant was covered by the Workers' Compensation Act on the date of his injury. Thus, we have no evidence that claimant sustained a "compensable" injury that would qualify him for workers' compensation benefits. Consequently, we are unable to assert our jurisdiction over claimant's claim. Accordingly, claimant's request for own motion relief is dismissed.

In the Matter of the Compensation of
ANGIE J. GALLO, Claimant
WCB Case Nos. 91-01795 & 91-05383
ORDER ON REVIEW
Kelley & Kelley, Claimant Attorneys
David Fowler (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Brazeau's order that: (1) declined claimant's motion to reopen the record for the admission of affidavits from claimant and her former employer; (2) upheld the SAIF Corporation's denial of claimant's femoral hernia injury claim; and (3) declined to assess penalties and attorney fees for an allegedly unreasonable denial. On review, the issues are the Referee's procedural ruling, compensability, penalties, and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exceptions, corrections, and supplementation. We do not adopt the first and last sentence of the fourth paragraph and the fifth paragraph.

Vicki Cain worked with claimant for six to eight months at the Stage Coach Restaurant. Ms. Cain left the restaurant in April 1990. (Tr. 35, 36).

Mr. and Mrs. Andersen bought the Stage Coach Restaurant about the first week of October 1990. The Stage Coach Restaurant did not have workers' compensation insurance for the period in question. The SAIF Corporation is the claims processor for the Stage Coach Restaurant as a noncomplying employer. Claimant, Carol Taylor, Debra Applebee, and Grace Wyland remained on as employees at the time of the restaurant purchase.

Ms. Taylor worked about four months with claimant and was terminated in November 1990. (Tr. 31). Ms. Applebee worked eight months to a year with claimant and quit on December 31, 1990 to go to a different job and because of differences of opinion with a manager. (Tr. 40, 42, 43).

At the time of the hearing, Ms. Wyland was employed by Mr. Andersen at another restaurant. (Tr. 73). Ms. Wyland worked with claimant for approximately five months.

Claimant did not suffer from a preexisting hernia condition. On October 18, 1990, claimant injured herself at work while lifting a cast iron stove grate. This injury resulted in an incarcerated left femoral hernia which required medical treatment.

CONCLUSIONS OF LAW AND OPINION

Procedural Ruling

A Referee has discretion to reopen the record for consideration of new material evidence. OAR 438-07-025(1). A party seeking reopening of the record for reconsideration must provide an explanation why such new evidence could not have reasonably been discovered and produced at the hearing. OAR 438-07-025(2); Renia Broyles, 42 Van Natta 1203 (1990). Our review of such Referee rulings is for abuse of discretion. Rodney D. Jacobs, 44 Van Natta 417 (1992); Renia Broyles, supra.

Following the hearing and the issuance of the Referee's order, claimant moved for reopening of the record and reconsideration. Specifically, claimant requested that Ms. High, her former employer, be permitted to testify concerning claimant's work activities and Ms. High's recollection that claimant never complained of a prior hernia condition. Claimant based her request on an affidavit from Ms. High, as well as claimant's own affidavit stating that she was unaware that compensability of her claim would be contested on the basis of a prior noncompensable condition until the date of the hearing and that she did not know Ms. High's whereabouts until after the Referee's order.

Inasmuch as claimant's injury claim had been denied, she had the burden of establishing the compensability of her claim. Commensurate with such a burden, claimant would be required to establish that a work incident, as opposed to a preexisting condition, was the cause of her hernia disability and need for medical treatment. Moreover, by the time of hearing, claimant was aware that SAIF and her employer were presenting testimony which suggested that claimant had represented to the owners and a co-worker that she suffered from a preexisting hernia condition. Yet, claimant asserted neither surprise nor prejudice at the hearing nor sought a continuance. Instead, following the closure of the record and the issuance of the Referee's decision, claimant requested reopening of the record for the introduction of her former employer's testimony.

Under such circumstances, we hold that the Referee did not abuse his discretion in declining to reopen the record to introduce testimony from claimant's former employer to rebut testimony from the owners and a former co-worker regarding claimant's complaints of a preexisting condition. Consequently, we affirm the Referee's rejection of claimant's motion to reopen the record.

Compensability

To establish the compensability of her hernia injury claim, claimant must establish that the October 1990 work incident was a material contributing cause of her disability and need for medical treatment. ORS 656.005(7)(a); Mark N. Weidle, 43 Van Natta 855 (1991). In addition, if it is determined that claimant had a preexisting condition and that condition combined with a compensable injury to cause or prolong disability or need for treatment, claimant must further establish that her compensable injury was the major contributing cause of the resultant disability or need for medical treatment. ORS 656.005(7)(a)(B); Bahman M. Nazari, 43 Van Natta 2368 (1991).

The Referee found claimant not credible with regard to whether she had a preexisting hernia condition. This finding was not based on claimant's demeanor. Rather, it was based on the Referee's conclusion that Grace Wyland, the employer's witness, was more credible than claimant's witnesses. In reaching this conclusion, the Referee: (1) discounted the testimony of claimant's co-worker witnesses, finding that all three had left work due to being terminated or over disagreements with the employer; and (2) found that Ms. Wyland no longer worked for the employer. We disagree with the Referee's assessment of the evidence that was the predicate for his credibility finding. Consequently, we disagree with the Referee's credibility finding.

As of the date of hearing, Ms. Wyland continued to be employed by the employer at another restaurant. (Tr. 73). Ms. Wyland was a co-worker of claimant at the time of the alleged work incident and worked with claimant about five months. Ms. Wyland testified that, before the Andersens bought the restaurant in October 1990, claimant had told her that she had had a hernia condition for several years. (Tr. 69, 73). She also testified that it had been obvious that claimant was not feeling well, and in response to Ms. Wyland's query, claimant stated that she was not feeling well because she needed a hernia operation. (Tr. 74). Ms. Wyland also stated that claimant's sister told her that claimant had a hernia condition that should have been operated on years ago. (Tr. 83).

The Andersens testified that, after the alleged stove incident, claimant told them that she had had a hernia condition for five to eight years. (Tr. 48, 49, 55, 66, 68).

Claimant denied having a preexisting hernia condition and denied telling the Andersens or Ms. Wyland that she had such a condition. (Tr. 16, 21, 81). Claimant's sister also denied that claimant had a hernia condition prior to the work incident and denied discussing her sister's health with Ms. Wyland. (Tr. 76, 79). Claimant and her sister reside in the same house. Therefore, claimant's sister would be in a position to know about any health problems claimant might exhibit.

Both Carol Taylor and Debra Applebee were claimant's co-workers at the time of the alleged work incident. Ms. Taylor worked with claimant about four months and testified that claimant had never complained about any groin pain or a hernia condition. (Tr. 30). Ms. Taylor was terminated in November 1990. (Tr. 31). Ms. Applebee worked with claimant from eight months to a year and testified that claimant: (1) never complained of any groin pain or any hernia problem before the work incident; and (2) never acted as if she were in pain. (Tr. 41).

Vicki Cain worked with claimant for six to eight months. She left the restaurant in April 1990, about six months before the Andersens bought it. (Tr. 35, 36). Ms. Cain testified that claimant was in good health, never complained

of groin pain, and never acted as if she were in pain. (Tr. 36). She also testified that she did not see claimant socially.

Even if Ms. Taylor's testimony is discounted based on an assumption that she is biased against the employer due to her termination, no such bias exists with respect to the testimony of Ms. Applebee and Ms. Cain. Ms. Applebee testified that she quit on December 31, 1990 to take a different job and because of a difference of opinion with a manager. (Tr. 42, 43). There was no evidence of any animosity towards the employer.

In any event, Ms. Cain's testimony supports claimant's statements regarding the lack of a preexisting condition. Ms. Cain never worked with the current owners and there is no evidence of any personal friendship between claimant and Ms. Cain. Therefore, there is no evidence of any bias on Ms. Cain's part. On this basis, we find Ms. Cain's testimony most credible in supporting claimant's statement that she had no preexisting hernia condition.

In addition, there is no persuasive medical evidence of any preexisting hernia condition. The medical evidence regarding causation consists of two reports. Dr. Strukel, orthopedist, performed a record review and concluded that the major contributing cause of claimant's need for treatment was a preexisting condition. (Tr. 4, 5, Ex. 10). Dr. Strukel based his opinion on the following: (1) a traumatic hernia would have been so painful that claimant would have immediately sought medical treatment; (2) there was no evidence of freshly traumatized tissue in the operative report; and (3) claimant did not have acute findings. (Ex. 10).

In a concurrence with a telephone conversation summary, Dr. Burnham, treating surgeon, opined that the work incident was the major contributing cause of claimant's need for treatment. (Ex. 11). He based his opinion, in part, on claimant's history of lifting the stove grate at work with immediate left groin pain and swelling. (Exs. 2, 11). As discussed below, we find this history to be accurate. Dr. Burnham noted that he performed hundreds of hernia operations a year and that it is not true that a traumatic hernia injury will immediately disable a patient. He also noted that he cannot distinguish freshly traumatized tissue in making hernia repairs. (Ex. 11). Furthermore, he stated that claimant could easily have suffered an acute injury in the described incident and continued for several days with increasing symptoms before seeking treatment. Thus, Dr. Burnham rebuts each basis of Dr. Strukel's conclusion that the major cause of claimant's condition was a preexisting condition.

The Board generally gives greater weight to the conclusions of a treating physician; however, it will not so defer when there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds, 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986). Here, there are no persuasive reasons not to defer to Dr. Burnham's opinion. In addition, as a surgeon who repairs hundreds of hernias a year, we defer to Dr. Burnham's expertise in this area over that of Dr. Strukel, an orthopedist without special expertise in the area of hernia repair. See Abbott v. SAIF, 45 Or App 657, 661 (1980).

On this record, we find that claimant has established that she did not suffer from any preexisting hernia condition. Therefore, in order to establish compensability, she must prove that the October 1990 work incident was a material contributing cause of her disability and need for medical treatment.

Both owners testified that claimant reported various causes for her injury. Mrs. Andersen testified that claimant reported the injury as caused by lifting the stove top, lifting a bag of potatoes, and bringing groceries into

her own home. (Tr. 53, 54, 55). Mr. Andersen testified that claimant told him, at various times, that she injured herself bringing in supplies at work, lifting a bag of potatoes, and lifting the entire stove, not just the cast iron grate. (Tr. 66). We note that claimant testified that she helped unload supplies at work after the stove grate incident and that this activity added to her injury. (Tr. 20, 28).

Because we find claimant's testimony credible regarding the lack of any preexisting hernia condition, we also find it credible regarding the October 1990 work incident. This incident was unwitnessed. However, claimant testified that she reported the incident on October 18, 1990, the day it happened. (Tr. 20). This is corroborated by Mrs. Andersen who testified that claimant told her about the stove grate incident and that this could have been reported on October 18, 1990. (Tr. 55).

Claimant's testimony is also corroborated by that of Ms. Taylor and Ms. Applebee. Ms. Taylor testified that when claimant came out from the kitchen she was white with pain and, when Ms. Taylor asked what was wrong, claimant said that "she got hurt back there on a stove." (Tr. 30). SAIF contends that Ms Taylor's testimony is not persuasive because she came on duty at 2:00 p.m., about the same time that claimant went off duty. Therefore, SAIF argues, because claimant testified that the injury occurred around 6:00 a.m. when she was setting up the kitchen, Ms. Taylor could not have received a contemporaneous report. However, claimant's and Ms. Taylor's shifts overlapped, making it likely that they encountered each other. (Tr. 8, 32). Also, Ms. Taylor did not claim that this was a contemporaneous report. Rather, the reported events occurred when Ms. Taylor first saw claimant the day of the work incident.

Ms. Applebee testified that she first learned that claimant was claiming she sustained a hernia at work when Ms. Applebee came into work, although she did not remember the date. (Tr. 45). Again, even if Ms. Taylor's testimony is discounted because of alleged bias due to being fired, Ms. Applebee's testimony supports claimant's testimony.

In addition, claimant's sister testified that claimant told her that she injured herself lifting a grill to reattach a pipe on the stove. (Tr. 77). Claimant also reported to her physicians a lifting incident at work as the cause of her injury. (Exs. 1, 2). On this record, we find that claimant has established that she was injured at work. Accordingly, based on claimant's credible testimony and the persuasive opinion of Dr. Burnham, we find that claimant has established that the October 18, 1990 work incident is a material contributing cause of her need for treatment.

Unreasonable Denial - Penalty and Attorney Fee

Claimant argues that SAIF's denial was unreasonable because it was based solely on the statement of the noncomplying employer. We disagree.

The standard for determining an unreasonable denial is whether the carrier has a legitimate doubt as to its liability. Unreasonableness and "legitimate doubt" are to be considered in the light of all the evidence available at the time. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988), citing Norgard v. Rawlinsons, 30 Or App 999, 1003 (1977).

At the time of the denial, SAIF had information from the employer that claimant had reported that her hernia condition was due to a nonwork related, preexisting condition. We find that this information created legitimate doubt as to the compensability of claimant's claim. Accordingly, we do not find that

SAIF's denial was unreasonable. Therefore, we decline to assess a penalty or attorney fee on that basis.

Attorney Fees at Hearing and on Review

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $2,500, to be paid by the SAIF Corporation, on behalf of the noncomplying employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by appellant's brief and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 29, 1991, as reconsidered June 14, 1991, is affirmed in part and reversed in part. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing in accordance with law. Claimant's attorney is awarded $2,500 for services at hearing and on review concerning the compensability of claimant's claim, to be paid by SAIF, on behalf of the noncomplying employer. The remainder of the order is affirmed.

June 5, 1992 Cite as 44 Van Natta 1112 (1992)

In the Matter of the Compensation of
DALE J. LINDAMOOD, Claimant
WCB Case No. 91-05970
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Daughtry's order which declined to recalculate claimant's rate of pay and award additional temporary disability benefits. On review, the issues are rate of temporary disability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the contingent attorney fees from claimant's pre-employment cases should not be included with her $2,000 monthly salary when computing her wages for temporary disability compensation. We agree.

Claimant, an attorney, has an accepted stress claim with the employer. From November 1986 to September 1987, she was an independent contractor who performed work on a case-by-case basis for the employer, a law firm. Claimant was paid a percentage of the contingent attorney fees on the cases assigned to her when and if the firm was paid such a fee. On September 15, 1987, claimant became a salaried employee of the firm receiving a monthly salary of $2,000. Claimant continued to receive contingent fees from her pre-employment cases throughout the period she was a salaried employee. Claimant received some contingent fees from pre-employment cases after she left the firm.

Under ORS 656.210(1), a worker who is temporarily totally disabled due to a compensable injury is to receive "compensation equal to 66 2/3 percent of wages." As defined in ORS 656.005(27), "'Wages' means the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, including reasonable value of board, rent, housing, lodging or similar advantage received from the employer, and includes * * * tips * * *" (Emphasis added).

Here, the contract of hiring contemplated a monthly wage of $2,000. The contingent fees on the pre-employment cases were not wages for which claimant's services were recompensed under the contract of hiring. Rather, the contingent fees were generated by cases claimant was assigned while she was an independent contractor, prior to becoming an employee of the firm. These fees bore no relationship to her work as an employee of the firm, but were the fruits of her labor as an independent contractor. Consequently, we conclude that the contingent fees generated by the pre-employment cases were not "wages" under the contract of hiring in force at the time of claimant's occupational disease and should not be included when calculating the rate of temporary total disability.

Finally, claimant argues that her temporary total disability wages should be calculated under OAR 436-60-025(4). However, OAR 436-60-025(4)(a), (h) and (k) which deal with varying wages, bonuses and commissions are not applicable because we have found that the contingent attorney fees are not "wages" as defined by ORS 656.005(27).

Because we have concluded that claimant's temporary total disability rate was correctly calculated, penalties and attorney fees are not appropriate.

ORDER

The Referee's order dated September 6, 1991 is affirmed.

June 5, 1992 Cite as 44 Van Natta 1113 (1992)

In the Matter of the Compensation of
JERRY B. MATHEL, Claimant
WCB Case No. 90-18752
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Moller and Brazeau.

The insurer requests review of that portion of Referee Mongrain's order that set aside its denial of claimant's myocardial infarction claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The insurer first asserts that the Referee improperly analyzed the claim as an accidental injury and that, because claimant contends that his myocardial infarction was caused by job stress, it should be treated as a claim for occupational disease. As an occupational disease, the insurer maintains that the applicable statute for analyzing the claim is ORS 656.802(1)(b), as construed by

Ronald V. Dickson, 42 Van Natta 1102 (1990), aff'd Dickson v. Carolina Casualty, 108 Or App 499 (1991). Dickson held that physical conditions resulting from job-related "stress" are not compensable unless a mental disorder has been diagnosed as the underlying condition.

We agree with the Referee that the claim properly is analyzed as one for an accidental injury. The medical evidence is in agreement that claimant's episode of acute hypertension on August 23, 1990 was the cause of claimant's myocardial infarction. (Exs. 5, 7-1, 8-1). Although claimant suffered from hypertension since 1984, the condition had been stable due to a program of exercise and home monitoring of his blood pressure. (Ex. 4-1). However, we have adopted the Referee's findings that claimant had been extremely fatigued for the two days prior to August 23 and that he was frustrated and anxious on that date. Moreover, on the date he had the myocardial infarction, claimant experienced an episode of malignant hypertension, which was described as "fairly abrupt [in] onset." (Id. at 2). We therefore conclude that claimant's condition was sudden and unexpected, and the claim properly is treated as an accidental injury. See Morrow v. Pacific University, 100 Or App 198, 202-03 (1990).

As an accidental injury, claimant must prove that work activities were a material contributing cause of his need for medical services and disability in order to establish compensability. See e.g. Mark N. Wiedle, 43 Van Natta 855 (1991). The medical opinions regarding causation include that of Dr. Crowley, M.D., claimant's treating physician, and Dr. Kremser, M.D., who conducted an independent medical examination.

Dr. Kremser found that claimant "had an acute cardiac event in August due to malignant hypertension, which is a result of renal artery stenosis." (Ex. 5). Kremser based her opinion on early test results showing evidence of significant renal artery stenosis. However, after claimant underwent more extensive and accurate testing, those results proved that he did not have renal artery stenosis. (Exs. 6-1, 7-1). Having been based on information that was later proved to be inaccurate, we give little weight to the opinion of Dr. Kremser. See Somers v. SAIF, 77 Or App 259 (1986).

As evidenced by his January 28, 1991 concurrence with a letter from claimant's attorney, Dr. Crowley concluded that "the cause of [claimant's] heart attack was stress-caused hypertension directly related to his [job] duties and responsibilities[.]" (Ex. 8-1). In view of the fact that this opinion is both unrebutted by any persuasive evidence and is from claimant's treating physician, we conclude that it is sufficient to prove that claimant's work activities were a material contributing cause of his heart attack. Therefore, claimant has established a compensable claim.

Finally, claimant's attorney is entitled to an assessed attorney fee for prevailing against the insurer's request for review. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is $1,000, 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 to claimant of the interest involved.

ORDER

The Referee's order dated April 30, 1991, as reconsidered on July 12, 1991, is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
GREGORY A. ARELLANO, Claimant
WCB Case No. 91-01594
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Hooton and Brazeau.

The insurer requests review of Referee Lipton's order that: (1) set aside its denial of claimant's medical services claim for surgery and ongoing treatment; (2) set aside its partial denial of claimant's spondylolisthesis and spina bifida conditions; and (3) awarded a penalty and a separate attorney fee for the insurer's allegedly unreasonable denial. On review, the issues are compensability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

On Friday, June 1, 1990, claimant experienced an onset of low back pain after shoveling and lifting rocks while working at a gravel plant. He did not seek medical treatment and returned to work Monday, June 4, 1990, at which time a rock fell from a conveyor belt and hit him in his upper back. He sought medical treatment at the Columbia Health Care Center, where physicians diagnosed a thoracic spine contusion and noted the presence of spina bifida at L5-S1. On June 18, 1990, the insurer accepted a claim for a "dorsal spine contusion," and claimant received conservative treatment. (Ex. 1).

Claimant was subsequently examined by Dr. Weeks, an orthopedic surgeon, who provided the first narrative medical report. Dr. Weeks reported that the spina bifida at L5-S1 was a preexisting condition "but should be considered [an] on the job aggravation." (Ex. 8). He also reported the presence of grade 1 spondylolisthesis with intermittent nerve root irritation by history.

In July 1990, claimant moved to Portland and came under the care of Dr. Flemming, M.D., who also diagnosed spondylolisthesis. He recommended physical therapy for the condition and expected claimant to be a candidate for surgical correction.

On August 23, 1990, Dr. Watson and Dr. Clarke examined claimant at the offices of the Orthopaedic Consultants. They concluded that the spina bifida and spondylolisthesis conditions were unrelated to claimant's injury but that the conditions "appear to have been made symptomatic and/or aggravated by the work activities of [claimant]." (Ex. 15). Dr. Flemming subsequently concurred with their report and recommended further treatment for the L5-S1 condition.

On January 7, 1991, the insurer denied the compensability of ongoing treatment and surgery "based on the fact that your work activities are no longer the major contributing cause for the need for treatment or surgery." (Ex. 21). It further indicated that the denial did not affect the accepted portion of the claim. On April 5, 1991, the insurer clarified its earlier denial, explaining that it was denying compensability of the spondylolisthesis and spina bifida as unrelated to claimant's work activities. The insurer further explained that it also was asserting that claimant's current treatment and need for surgery was not due in major part to his work activities with the insured. (Ex. 22).

CONCLUSIONS OF LAW AND OPINION

Compensability

The issue presented on review is whether the Referee erred in setting aside the insurer's denial dated January 7, 1991, as clarified on April 5, 1991.

The Referee first concluded that the denial was an improper preclosure denial under Roller v. Weyerhaeuser, 67 Or App 583 (1984). We disagree.

We have recently held that in light of ORS 656.005(7)(a)(B), a pre-closure denial is not prohibited in cases concerning preexisting conditions where the compensable injury is not the major contributing cause of the claimant's resultant disability or need for medical treatment. Daniel R. Bakke, 44 Van Natta 831 (1992). In any event, Roller is not pertinent to this case. The insurer originally accepted an injury claim for a "dorsal spine contusion," which occurred on June 4, 1990, when a rock fell from a conveyor belt and hit claimant's upper back. The insurer's subsequent denial does not purport to terminate future responsibility for that compensable condition. In fact, the denial, as originally issued on January 7, 1991 states: "This denial does not affect the accepted portion of your claim." (Ex. 21-1).[1] From a reading of the record, it is clear that the insurer does not dispute responsibility for claimant's dorsal contusion. Rather, the dispute involves the compensability of claimant's current low back condition, which claimant relates to his onset of low back pain on June 1, 1990, while the insurer contends it is caused by claimant's preexisting spondylolisthesis and spina bifida conditions. Nonetheless, we agree with the Referee's alternative conclusion that the denial is improper on the merits and affirm.

An injury is compensable if it arises out of and in the course of employment and results in disability or the need for medical services. ORS 656.005(7)(a). A worker bears the burden of proving that the accident is a material contributing cause of the disability or need for treatment. Mark N. Wiedle, 43 Van Natta 855 (1991). However, a worker who suffers from a preexisting condition or disease that combines with the injury to cause or prolong disability will be compensated for disability and treatment only if the compensable injury is the major contributing cause of that disability or particular treatment. ORS 656.005(7)(a)(B); Bahman M. Nazari, 43 Van Natta 2368 (1991).

On this record, we first conclude that claimant has established a compensable injury. There is no dispute that, while shoveling and lifting rocks on June 1, 1990, claimant experienced an onset of low back pain. Moreover, all physicians agree that those work activities were a contributing cause of his need for medical services.

We also conclude that claimant is entitled to compensation for his ongoing medical treatment and proposed surgery. Dr. Flemming, the attending physician, explained that, while claimant has underlying low back problems, he had no back problems until performing heavy manual labor in a rock quarry. In light of that history, Flemming concluded that the repetitive lifting and shoveling of rock is the major contributing cause of claimant's current need for treatment and disability. We find his opinion well-reasoned and persuasive. Somers v. SAIF, 77 Or App 259 (1986).

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[1] We note that a portion of the April 5, 1991 clarification contains a misstatement of law. In the third paragraph, the insurer stated that treatment for claimant's spinal contusion remained covered to the extent that the compensable injury remained the "major contributing cause." That language was added presumably in response to the 1990 legislative addition of subsection (B) to ORS 656.005(7)(a). That subsection, however, limits only the amount of compensation for a "resultant condition," i.e., the combination of a compensable injury and a preexisting condition. See Bahman M. Nazari, 43 Van Natta 2368 (1991). The standard of proof required to establish the compensability of medical services under ORS 656.245(1) for a compensable condition remains "material contributing cause."

In reaching our conclusion, we are not persuaded by the contrary report of Dr. Watson. As noted by the Referee, Watson had originally reported that claimant's underlying condition had been worsened by his repetitive work activities. Moreover, he fails to explain how claimant's current condition is caused by the preexisting condition, which had been asymptomatic for years.

In short, we defer to the opinion of Dr. Flemming, the attending physician, which, when read as a whole, supports a finding that claimant's work related injury is the major contributing cause of his need for treatment and disability. McClendon v. Nabisco Brands, 77 Or App 412 (1986); Weiland v. SAIF, 64 Or App 810 (1983). Accordingly, we conclude that claimant is entitled to compensation for his ongoing medical treatment and proposed surgery.

Penalties and Attorney Fees

The Referee found that the insurer's denial was unreasonable and awarded a penalty and a separate carrier-paid attorney fee. We disagree and reverse.

A penalty is assessable under ORS 656.262(10) if an insurer "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 the denial. Brown v. Agronaut Insurance Co., 93 Or App 588 (1988). The standard for determining whether a denial is unreasonable is whether the carrier had a legitimate doubt as to its liability for the claim.

In this case, the insurer denied the claim based on medical evidence that suggested that claimant's preexisting conditions were the primary cause of the need for treatment. Given that evidence, and in light of the recent amendments to the definition of a compensable injury set forth in ORS 656.005(7)(a), we believe that the insurer had a legitimate doubt as to its liability. Accordingly, because the denial was not unreasonable, the Referee's award of a penalty was not warranted.

For similar reasons, the Referee's award of a separate attorney fee was improper, in addition to our subsequent determination that a the simultaneous assessment of an attorney fee under ORS 656.382(1) would contravene the legislative intent expressed in ORS 656.262(10) that claimant's attorney receive one-half the penalty "in lieu of an attorney fee." Nicolasa Martinez, 43 Van Natta 1638 (1991).

Attorney Fees on Review

Because the insurer initiated the request for review and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel 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 attorney's services on review concerning the compensability issue is $1,000, 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 May 22, 1991 is affirmed in part and reversed in part. The Referee's assessed penalty and separate attorney fee for the insurer's allegedly unreasonable denial is reversed. The remainder of the order is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
ROBERT F. CURTIS, Claimant
WCB Case No. 90-19714 & 89-09574
ORDER ON RECONSIDERATION
Philip H. Garrow, Claimant Attorney
Williams, et al., Defense Attorneys

Claimant requests review of our May 15, 1992 Order on Review. Specifically, claimant contends that: (1) we erred in holding that that insurer was not required to issue another denial following Dr. Kendrick's request for surgery; (2) there is no substantial evidence to support that claimant's exacerbation and need for time loss was a waxing and waning contemplated by the September 12, 1990 Determination Order; and (3) our decision in this matter is inconsistent with our previous decision in Gary L. Waldrupe, 44 Van Natta 702 (1992).

After reviewing claimant's memorandum in support on the first two issues, we have nothing to add to our prior order. As to claimant's argument that the decision in this matter is inconsistent with our decision in Waldrupe, supra, we disagree.

In Waldrupe, supra, we held that, where a claimant's aggravation claim is based solely on the need for surgery and the reasonableness and necessity of that surgery is at issue, the referee must defer hearing on the aggravation claim until the Director determines whether the proposed surgery should be performed. 44 Van Natta at 705. In reaching this decision, we emphasized that, where an aggravation claim is "based on a theory that a claimant's condition (irrespective of a proposed surgery) constitutes a worsening of a compensable injury," the referee may proceed to consider the claimant's aggravation claim. Id. Here, both at hearing and on review claimant contended that his current condition (irrespective of his proposed surgery) constituted a worsening of his compensable injury since the last award of compensation. Therefore, Waldrupe is inapplicable to the case at hand.

Accordingly, our May 15, 1992 order is withdrawn. On reconsideration, as supplemented herein, we republish our May 15, 1992 order. The parties rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES ELBON (Deceased), Claimant
WCB Case Nos. 90-16206 & 89-16870
ORDER ON REVIEW
Rex Q. Smith, Claimant Attorney
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Bethlahmy's order that upheld the SAIF Corporation's denials of claimant's occupational disease claims for contact dermatitis and acquired immunodeficiency syndrome (AIDS). Claimant contends that the Referee erred by: (1) refusing to enforce her ruling allowing claimant to cross-examine doctors who had submitted medical reports at SAIF's request; and (2) refusing to appoint an insurer-paid independent medical examiner to address the compensability of the AIDS condition. On review, the issue is evidence.

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

FINDINGS OF FACT

This matter originally came before a prior referee for hearing on SAIF's denial of the contact dermatitis claim. That referee postponed the hearing and ordered SAIF to allow claimant to depose Drs. Kazmierski, Matheson and Brown at SAIF's expense. The doctors had written reports, at SAIF's request, addressing the compensability of the dermatitis condition, which was denied on July 21, 1989. (Exs. 19, 20, 21).

The parties were unable to schedule those depositions before this matter came before Referee Bethlahmy for hearing on May 31, 1990. At that hearing, claimant argued that the scope of the depositions should include cross-examination on the issue of the compensability of the AIDS condition, while SAIF argued that the scope should be limited to the dermatitis condition. The Referee ruled that the scope of the depositions be limited to the compensability of the dermatitis condition. (Tr. 30-31). At that same hearing, claimant made a claim for AIDS and AIDS-related symptoms for the first time. (Tr. 35-36). That claim was denied by SAIF on August 7, 1990.

The parties deposed Dr. Kazmierski, dermatologist, on February 12, 1991. During the course of that deposition, claimant's counsel asked the doctor a question concerning the relationship between the treatment for claimant's dermatitis and the onset of the AIDS condition. Based on the advice of SAIF's counsel, the doctor refused to answer the question, and the deposition was terminated. SAIF subsequently attempted to schedule a deposition with Dr. Matheson, but it was cancelled when claimant's counsel indicated he would not attend. Claimant did not seek any further depositions.

Claimant then moved the Referee to appoint an insurer-paid independent medical examiner to address the compensability of the AIDS condition. The motion was denied. After SAIF submitted its closing argument, and claimant had indicated that no further evidence would be submitted, the record was closed, and the Referee issued her order upholding the denials based on consideration of the reports from Drs. Kazmierski, Matheson and Brown.

CONCLUSIONS OF LAW AND OPINION

A referee is generally given great discretion in evidentiary matters, except insofar as the discretion is limited by our rules of procedure. See ORS 656.283(7). OAR 438-07-005(3) provides that medical reports offered by an insurer shall not be admitted unless the medical expert is made available for cross-examination at claimant's request.

We conclude that the aforementioned rule was satisfied in this case. The scope of the cross-examination of Dr. Kazmierski was properly limited to the issue of the compensability of the dermatitis condition, because that was the issue to which his report was directed. (See Ex. 20). Although Dr. Kazmierski also mentioned AIDS in his report, it was discussed only as a potential cause of claimant's skin condition. Dr. Kazmierski did not, as claimant argues, discuss the causation or work connection of the AIDS condition itself. Therefore, claimant's attorney's question concerning the contribution of the dermatitis treatment to the AIDS condition was outside the permissible scope of cross-examination.

On the other hand, Dr. Matheson did discuss whether the AIDS condition occurred as a complication of the dermatitis. (Ex. 21). However, by refusing

to appear for Dr. Matheson's deposition and indicating that he would not submit further evidence at hearing, claimant waived the right to cross-examine both Dr. Matheson and Dr. Brown. Accordingly, the Referee complied with OAR 438-07-005(3) in considering the doctors' reports.

Additionally, the Referee did not abuse her discretion in refusing to appoint an insurer-paid independent medical examiner. The record includes medical reports from Drs. Matheson and Loveless addressing the compensability of the AIDS condition. (Exs. 21, 22). Accordingly, the record was adequately developed on that issue, and the Referee properly declined to further supplement it.

ORDER

The Referee's order dated June 17, 1991 is affirmed.

June 9, 1992 Cite as 44 Van Natta 1120 (1992)

In the Matter of the Compensation of
PETER C. FALKENSTEIN, Claimant
WCB Case No. 91-05909
ORDER ON REVIEW
Robert Guarrasi, Claimant Attorney
Marcia L. Barton (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

The SAIF Corporation requests review of that portion of Referee Gruber's order that directed it to pay claimant's scheduled permanent partial disability (PPD) award at the rate of $305 per degree. Claimant cross-requests review of that portion of the order that declined to assess penalties and a penalty-related attorney fee for SAIF's allegedly unreasonable resistance to the payment of compensation at the "correct" rate. In his brief, claimant appears to request this Board to order SAIF to pay claimant's PPD award at the rate of $305 per degree while SAIF's appeal is pending, and to award additional penalties at the Board level for SAIF's allegedly unreasonable withholding of the disputed compensation "until all appeals are exhausted." On review, the issues are rate of scheduled PPD award, stay of compensation, and penalties and penalty-related attorney fees. We affirm.

FINDINGS OF FACT

We adopt the "Stipulated Facts" and supplement with the following facts.

On November 1, 1991, SAIF timely filed a Request for Board Review of the Referee's order. Pursuant to ORS 656.313, SAIF notified the Board that it would stay the payment of compensation awarded by the Referee's order pending Board review.

CONCLUSTIONS OF LAW AND OPINION

Rate of Scheduled Permanent Disability

We adopt the Referee's reasoning and conclusion on this issue.

Stay of Compensation

The filing of a request for hearing, Board review, or court appeal by an employer/insurer stays payment of the compensation to claimant. Amended ORS 656.313(1)(a).

Here, SAIF timely filed a request for Board review, and apparently has exercised its statutory right to stay payment of claimant's scheduled PPD award pending issuance of a final order. Pursuant to ORS 656.313(1)(a), SAIF would have no obligation to pay claimant's PPD award at the rate of $305 per degree until such time as the order becomes final. See Gilbert T. Hale, 44 Van Natta 729 (1992) (pending appeal, a carrier's obligation to pay interest on stayed compensation is not ripe for adjudication).

Penalties and Penalty-Related Attorney Fee

At Hearing

We adopt the Referee's reasoning and conclusion on this issue.

On Board Review

Claimant also requests penalties for SAIF's withholding of the compensation awarded by the Referee until SAIF exhausts all appeals. To begin, our review is confined to the issues presented at hearing. Since this issue was not raised before the Referee, we shall not consider it on Review. Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). However, were we to address the issue, we would find that SAIF was authorized under ORS 656.313(1)(a) to stay claimant's compensation pending review. It follows, then, that no penalties would be due for SAIF's election to stay payment of compensation as awarded by the Referee.

Although claimant did not prevail on his cross-appeal, claimant's attorney is entitled to an assessed attorney fee for prevailing against SAIF's request for review. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is $150, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated October 22, 1991 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $150, to be paid by the SAIF Corporation.

June 9, 1992 Cite as 44 Van Natta 1121 (1992)

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of **SUSIE A. FIMBRES**, Claimant

GIBBONS SUPPLY COMPANY & LIBERTY NORTHWEST INS. CORP.Petitioner,

vs.

SUSIE A. FIMBRES, Respondent

AGENCY NOTICE OF WITHDRAWAL OF ORDER FOR REVIEW

(CA A72309; WCB Case No. 90-16803)

Robert Webber, Claimant Attorney

Alexander Libmann, Defense Attorney

Pursuant to ORS 183.482(6) and ORAP 4.35, notice is hereby given that the Workers' Compensation Board hereby withdraws its Order on Review dated October 8, 1991. The order is being withdrawn so that the Board may reconsider its

decision to: (1) address the applicability of amended ORS 656.262(6) on the insurer's previous stipulated acceptance of claimant's cervical spondylosis condition; and (2) further consider the preclusive effect of the parties' prior stipulation on their current dispute regarding claimant's current cervical spondylosis condition. The Board shall file an order on reconsideration within 90 days after the filing of this notice or within such other time as the court may allow.

Dated this 9th day of June, 1992.

Thomas C. Gunn, Board Member
Workers' Compensation Board

Rudolph S. Westerband, Board Member
Workers' Compensation Board

June 9, 1992 Cite as 44 Van Natta 1122 (1992)

In the Matter of the Compensation of
JOANN FRYMAN, Claimant
WCB Case Nos. 88-05650, 88-10557 & 88-10556
ORDER ON REMAND
Karen M. Werner, Claimant Attorney
Cowling & Heysell, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Stone Container v. Fryman, 112 Or App 8 (1992). The court reversed our prior order, which found that claimant had established that her work activity was a material contributing cause of her low back condition, and therefore, had proved a compensable occupational disease claim. The court remanded for reconsideration in light of Aetna Casualty Co. v. Aschbacher, 107 Or App 494, rev den 312 Or 150 (1991), which held that a claimant must establish that her employment was the major contributing cause of a claimed condition or its worsening in order to prove a claim for an occupational disease under former ORS 656.802(1)(c).

FINDINGS OF FACT

We republish the Board's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

In Donna E. Aschbacher, 41 Van Natta 1242 (1989), we held that, under the 1987 amendments to former ORS 656.802(1), a claimant could prove a compensable claim under former ORS 656.802(1)(c) by merely showing that work was a material contributing cause of a claimed condition or a worsening of the symptoms of a preexisting disease. In the present case, the Referee found that claimant had not shown that work activities were the major cause of the worsening of her preexisting degenerative disc disease condition. The Referee, therefore, concluded that claimant's condition was not compensable. We found that the medical reports established that claimant's work activities contributed to her increased symptoms which caused increased disability and a need for medical services. Relying upon Aschbacher, supra, we reversed the Referee on the issue of compensability.

The Court of Appeals subsequently reversed our order in Aschbacher, holding that the legislature had not intended to change the standard of proof necessary to prove a claim under former ORS 656.802(1)(c) and that a claimant was still required to show that the work activity was the major contributing cause of a claimed condition or worsening of an underlying disease. Aetna Casualty Co. v. Aschbacher, supra. Citing Aschbacher, the court has reversed our prior decision and remanded for reconsideration.

Because claimant's low back condition involved repetitive trauma from eight years of work as an offbearer, and her condition 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 her 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 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) aff'd mem Boyer v. Multnomah County School District No. 1, 111 Or App 666 (1992).

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

Here, the record contains numerous medical opinions which address causation of claimant's low back condition.

Following a 1979 accepted industrial injury, claimant was diagnosed with a "back strain with possible mild degenerative arthritis of the lumbosacral junction."

On October 1, 1981, Dr. Endicott, M.D., claimant's treating physician, treated her following an onset of back pain. Dr. Endicott subsequently reported that claimant's low back pain was an aggravation of her disc disease.

Claimant continued to experience low back pain although she was able to remain at her job. In November 1987, claimant lost feeling from her low back down to her legs. After November 1987, claimant's pain continued to worsen.

In January 1988, Dr. Endicott treated claimant for back pain and numbness in her legs. He reported that claimant's condition was a continuation of her disc syndrome due to the 1979 and 1981 work-related incidents. In February 1988, Dr. Endicott reported that claimant's lumbar CT scan showed moderate focal bulging of the disc centrally at L4-5, in addition to narrowing and hypertrophic changes.

Dr. Endicott referred claimant to Dr. Haines, who examined her for complaints of severe back pain. Dr. Haines noted that claimant's job involved a great deal of pulling and tugging on panels. He reported that, in November 1987, claimant experienced an increase in discomfort in her back, in addition to problems with her feet and legs. Dr. Haines noted that claimant's CT scan showed evidence of a "very moderate disc bulge" at L4-5. Dr. Haines diagnosed peripheral neuropathy, and he recommended further evaluation by Dr. Throop.

Dr. Throop, neurologist, examined claimant upon referral from Dr. Haines. Dr. Throop diagnosed cauda equina syndrome with diffuse compression at either L5 or S1, with no sign of underlying neuropathy. In April 1988, Dr. Throop reported that claimant's heavy work activity would "aggravate and, indeed, cause the very lower back difficulty such as the patient is complaining of." He concluded that such work activities "would be a major cause of her low back condition."

On May 6, 1988, claimant was examined by Drs. Dinneen and Brooks of the Western Medical Consultants. The Consultants noted disc bulges at L4-5 and L5-S1 with decreased intervertebral space at L5-S1. The Consultants diagnosed low

back sprain superimposed on existing degenerative disc disease, with possible spinal canal narrowing. Drs. Dinneen and Brooks opined that there appeared to be at least a minimal disability as a result of claimant's many years of working at the mill.

On June 9, 1988, Dr. Endicott concluded that claimant's work activities were the major cause of her low back condition. He opined that the 1981 injury was a material contributing cause of claimant's current problems, with continued lifting, turning, etc., "causing further difficulties on a preexisting condition."

On June 23, 1988, Dr. Melgard, M.D., examined claimant upon referral from Dr. Endicott. Melgard was unsure whether claimant had a protruded disc. However, if she did, Melgard would "be able to give a little bit more credence to her history, dating back to November 1987, of the pulling, bending, and twisting in her job as an offbearer/grader bringing about the disc protrusion at that time." Dr. Melgard scheduled a myelogram for claimant and reported that, if claimant had a disc, he thought that it was more likely to have originated as a result of work activities in November 1987.

Following a June 27 myelogram, Dr. Melgard reported that claimant had a protruded disc at L4-5. He believed claimant's condition was "undoubtedly due to her injury of November 1987," which he had delineated in his initial report.

We conclude that the record, as a whole, establishes that claimant's work activities as an offbearer were the major cause of the onset or worsening of her low back condition, resulting in disability and the need for treatment. With the exception of Dr. Haines, (who declined to make a final recommendation or disposition and who referred claimant to Dr. Throop), all of the medical opinions in the record relate claimant's low back condition to her work activity.

We agree with the insurer that the record contains numerous diagnoses of claimant's low back condition. However, as stated in our prior order, we do not agree that the physicians' inability to arrive at a single diagnosis is fatal in a case in which the medical evidence nonetheless establishes that work caused claimant's condition. See Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988).

Finally, with the exception of the opinion of Dr. Endicott (whom we found to be not persuasive in our prior order), we do not agree with the insurer that the medical opinions in this case are not persuasive. As explained above, we do not discount the doctors' opinions on the basis that they demonstrate a variety of diagnoses.

The insurer specifically argues that Dr. Melgard's opinion is not persuasive as he is the only physician to diagnose a protruded disc. However, as noted by claimant, a disc bulge, lesion or protrusion at L4-5 has been noted by several other physicians beginning in February 1988. See Ex. 20, 24, 28, 31, 39 40. Therefore, we do not find Dr. Melgard's opinion to be inconsistent with the medical evidence in the record.

The insurer also argues that Dr. Melgard's opinion should be discounted as he reports a November 1987 "injury" that is not supported elsewhere in the record. We disagree. We find that Dr. Melgard initially reported that claimant's November 1987 activities of pulling, bending and twisting could have "brought about" a protruded disc. We note that a subsequent myelogram did demonstrate such a disc problem, which Dr. Melgard related to claimant's work. Therefore, although Dr. Melgard may have referred to an "injury" in November 1987, we are convinced that he is, in fact, describing claimant's work

activities with the employer at that time, which brought about her condition. Moreover, we find his description to be consistent with a work-related occupational disease and we note that his opinion has not been rebutted.

Under the circumstances, we continue to conclude that claimant has established a compensable occupational disease claim for her low back condition. Accordingly, as supplemented herein, we republish our September 26, 1990 order in its entirety.

IT IS SO ORDERED.

June 9, 1992 Cite as 44 Van Natta 1125 (1992)

In the Matter of the Compensation of
RICHARD A. MISSERES, Claimant
WCB Case No. 90-18208
ORDER ON REVIEW
Joelson, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney
Norman Kelley, Assistant Attorney General

Reviewed by Board Members Brazeau and Moller.

Claimant, pro se, requests review of Referee Emerson's order that upheld the SAIF Corporation's denial (on behalf of the alleged noncomplying employer) of claimant's low back injury claim. On review, claimant contends that he was not a casual worker under ORS 656.027(3) and that his claim is compensable. In addition, claimant has submitted written statements and affidavits from individuals who did not testify at the hearing. Based on this information, he seeks remand for the taking of additional evidence. ORS 656.295(5).

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

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be 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. Olson, 37 Van Natta 1054, 1055 (1986), aff'd mem, 80 Or App 152 (1986).

Here, claimant was represented by an attorney at the hearing. At that time, claimant asserted that he was a subject worker of Terry Tramel when he injured his low back. The parties further agreed to the dismissal of Tramel's landlord, Charles Redmon, as a party to the proceeding.

Following the hearing, the Referee found that claimant's work for Tramel was casual. See ORS 656.027(3). After considering the testimony of several witnesses (including claimant, claimant's wife, Tramel, and Redmon), the Referee was not persuaded that claimant and Tramel had a contract for hire other than for a single day's work (the day claimant was injured) for $5 per hour.

Claimant has submitted documents, written statements, and affidavits from two individuals (Danny Yannone and Marlene Silversong). These materials suggest that Yannone was formerly employed by Redmon on a "non-casual" basis and that claimant was hired by Tramel on behalf of Redmon to replace Yannone. Claimant

asserts that this information was not available at the time of hearing because claimant was not aware of what evidence would be presented until the hearing. Under such circumstances, claimant seeks remand for the introduction of this new evidence.

We deny the motion to remand. To begin, claimant was present at the hearing and was represented by an attorney. At the conclusion of the proceeding which included the presentation of all of the witnesses' testimony, claimant did not seek a continuance to introduce additional evidence. In other words, after the testimony had been taken and the hearing concluded, claimant was certainly aware of what evidence had been presented. Yet, he raised no objection to the closure of the record. Thus, we are not persuaded that the evidence he now seeks to be admitted was unobtainable at the time of hearing with due diligence. In any event, we do not consider the present record (without the inclusion of the post-hearing statements from Yannone and Silversong) improperly, incompletely, or insufficiently developed to determine the issue of whether claimant was a subject worker for Tramel when he suffered his June 26, 1990 low back injury.

It is regrettable if claimant disagreed with the actions taken on his behalf by his attorney. Nevertheless, such circumstances do not provide sufficient grounds to justify remand.

In conclusion, after conducting our review of the record, we are not persuaded that claimant had a contract for hire with Tramel for more than one day's work. Consequently, we find that claimant was a casual worker and, as such, was not a subject worker. See ORS 656.027(3). Accordingly, we agree with the Referee's decision to uphold SAIF's denial.

ORDER

The Referee's order dated December 27, 1991 is affirmed.

June 9, 1992 Cite as 44 Van Natta 1126 (1992)

In the Matter of the Compensation of
CLYDE READ, Claimant
Own Motion No. 66-0213M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted a March 3, 1992 claim for medical benefits relating to claimant's September 20, 1957 compensable face, shoulder, ribs, back, heel and leg injuries. Claimant was awarded permanent total disability benefits in 1959. SAIF recommends reopening this claim under our own motion to provide reimbursement for the current bills for prescriptions. In addition, SAIF recommends that claimant's claim remain open to privde office visits and prescriptions related to claimant's compensable injury for a period of six months

Inasmuch as claimant sustained a compensable injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. William A. Newell, 35 Van Natta 629 (1983). However, 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).

Claimant received multiple injuries in 1957. Claimant has had continued symptoms in those areas of his body every since. Dr. Kopp rotates claimant between Orudis and other anti-inflammatory medications and prescribes Tylenol for

claimant's pain. Thus, we find that the requested medical services are reasonable and necessary for the compensable injury which has rendered claimant permanently and totally disabled. Accordingly, claimant's claim is reopened to provide the above medical services. See OAR 438-12-037(1)(c).

In the past, the Board has authorized Tylenol, Motrin, Dyozide, Maalox, Voltaren and Dolobid. However, the is nothing in the record from claimant's treating physician that prescribes any of the above medication for the next six months or a year. There is also nothing in the file to indicate that claimant requires office visits on a routine basis, i.e.; once a month, every three or four months, etc.

Thus, we deny reopening for a six month period of time unless we receive the required evidence that claimant will continue to need these services in the future. Therefore, by this order, the claim is again closed.

SAIF also requests the Board to authorize reimbursement from the Reopened Claims Reserve pursuant to ORS 656.625. The Court of Appeals has held that the Board lacks the authority to grant or deny reimbursement from the Reserve. See SAIF v. Holmstrom, 113 Or App 242 (1992). Accordingly, we are unable to grant SAIF's request.

IT IS SO ORDERED.

June 9, 1992 Cite as 44 Van Natta 1127 (1992)

In the Matter of the Compensation of
PAMELA L. STALLSWORTH, Claimant
WCB Case No. 91-04293
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of Referee Mongrain's order that set aside its denial of claimant's aggravation claim for her current left arm condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact. We do not adopt the Referee's Ultimate Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's compensable injury was a material contributing cause of her worsened left elbow condition. We disagree.

In order to establish a compensable aggravation of her left elbow condition, claimant must prove, by medical evidence supported by objective findings, a worsened condition resulting from the compensable condition. ORS 656.273(1) and (3); Perry v. SAIF, 307 Or 654 (1989). A compensable worsening is generally established by proof that the compensable injury is a material contributing cause of the worsened condition. Robert E. Leatherman, 43 Van Natta 1677 (1991). To prove a worsening of a scheduled body part, claimant must show that she is more disabled, i.e., that she has sustained an increased loss of use or function of that body part, either temporarily or permanently, since the last arrangement

of compensation. International Paper Co. v. Turner, 304 Or 354 (1987), on rem 91 Or App 91 (1988).

A February 24, 1989 Determination Order found claimant to be medically stationary on August 23, 1988. No permanent disability was awarded.

In May 1989, claimant returned to her treating doctor, Dr. Chamberlain, and reported increasing pain into the left arm and complaints of numbness in the hand. Claimant also reported that she was having difficulty holding onto things. Dr. Chamberlain diagnosed continuing lateral epicondylitis, left elbow.

From August through December 1990, claimant continued to return to Dr. Chamberlain for treatment of left arm and elbow pain. On December 21, 1990, Dr. Chamberlain requested authorization, on claimant's behalf, for a repeat Bosworth Procedure, left elbow.

In March 1991, Dr. Chamberlain reported that he was "not exactly sure" what constituted the major contributing cause of claimant's current complaints. He reported that, with regard to a material worsening, the only documentation he had was an increase in pain in the elbow area and feelings of diminished use.

In March 1991, Dr. Dickerman, M.D., performed an independent medical examination and diagnosed status-post left lateral epicondylar release, related, medically stationary, and probable peripheral entrapment syndromes, unrelated. Dr. Dickerman opined that claimant's activity of performing chores at her farm was most likely responsible for any symptoms that she might have. He did not believe that claimant's condition had worsened.

In May 1991, Dr. Chamberlain reported that he had reexamined claimant on April 17, 1991 and an x-ray taken at that time showed calcific densities about the lateral epicondylar area of the elbow. He believed that the x-ray shed "some new light on the patient's continued elbow complaints."

In a July 2, 1991 "check-the-box" letter, Dr. Chamberlain reported that claimant had sustained a worsening of her left elbow condition sufficient that he recommended surgical intervention. Dr. Chamberlain also answered "yes" to the question of whether claimant's original elbow claim of January 17, 1987, which resulted in the surgery of May 1987, was the major contributing cause of her worsened left elbow condition.

On July 9, 1991, Dr. Dickerman reported that he had not reviewed the x-rays which demonstrated the calcific densities in the area of claimant's elbow. However, he concluded that it was unusual to have calcifications in an area of previous scar tissue. Dr. Dickerman reported that claimant's off-work activity would most likely be the reason for calcific tendonitis to occur.

Under the circumstances, we conclude that claimant has failed to establish that her compensable injury is a material contributing cause of a worsened left elbow condition. In March 1991, Dr. Chamberlain was unable to determine the cause of claimant's left elbow problems. Additionally, although Dr. Chamberlain found new evidence of calcific densities in the elbow area, he did not initially relate such findings to claimant's compensable injury. Moreover, considering Dr. Chamberlain's initial inability to cite the cause of claimant's elbow condition and his new findings of calcific densities, we do not find that his subsequent, conclusory "check-the-box" opinion is persuasive medical evidence of the causation of claimant's worsened condition.

Finally, we find no other medical evidence to support claimant's aggravation claim, as Dr. Dickerman has opined that claimant's condition has not

worsened and any symptoms that she may have are unrelated to her compensable injury. We, therefore, reverse the Referee on the issue of aggravation.

ORDER

The Referee's order dated August 29, 1991 is reversed. The insurer's aggravation denial is reinstated and upheld. The Referee's attorney fee award of $2,000 is also reversed.

June 9, 1992 Cite as 44 Van Natta 1129 (1992)

In the Matter of the Compensation of
WAYNE WOOD, Claimant
WCB Case No. 90-20320
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Kevin Mannix, P.C. Defense Attorneys

Reviewed by Board Members Moller and Brazeau.

Claimant requests review of Referee McWilliams' order that: (1) upheld the insurer's denial of his claim for a low back injury; and (2) declined to award a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found that because claimant requested a hearing after May 1, 1990 and the hearing was convened after July 1, 1990, the matter is analyzed under the 1990 amendments to the Workers' Compensation Law. See Or Laws 1990 (Special Session), ch. 2, 54(2); Ida M. Walker, 43 Van Natta 1402 (1991). We agree that the new law applies to this case.

Here, the Referee concluded that the insurer failed to prove fraud, misrepresentation or other illegal activity in support of its back-up denial. Although claimant contends, on review, that Bauman v. SAIF, 295 Or 788 (1983), has been effectively overruled, we have recently concluded that the rule was only overturned in part by amended ORS 656.262(6). See Anthony G. Ford, 44 Van Natta 240 (1992).

In Ford, we found that the recently amended version of ORS 656.262(6) expressly permits back-up denials:

> "[I]f the insurer or self-insured employer accepts a claim in good faith but later obtains evidence that the claim is not compensable or evidence that the paying agent is not responsible for the claim, the insurer or self-insured employer, at any time up to two years from the date of claim acceptance, may revoke the claim acceptance and issue a formal notice of claim denial."

Thus, we concluded that an insurer may now issue a back-up denial at any time up to two years from the date of claim acceptance. Finally, we determined

that, within that two-year period, an insurer need not prove fraud, misrepresentation or other illegal activity in support of its back-up denial. Ford, supra.

In the present case, although the insurer was not required to prove fraud or misrepresentation to support its denial, it proceeded to defend its denial on those grounds at hearing and on review. Under the circumstances, we agree with the Referee that the insurer has failed to prove fraud or misrepresentation on the part of claimant. We, therefore, adopt her Conclusions of Law and Opinion on that issue.

We now turn to the merits of claimant's injury claim. We have above found that an insurer has two years from the date of claim acceptance to revoke such acceptance and issue a formal notice of denial. However, if a claimant requests a hearing from such a denial, an insurer must prove by clear and convincing evidence that the claim is not compensable. ORS 656.262(6). Therefore, the insurer can prevail if it proves by clear and convincing evidence that claimant did not experience a compensable low back injury. To be clear and convincing, the evidence must be free from confusion, fully intelligible and distinct. Riley Hill General Contractor v. Tandy Corporation, 303 Or 390 (1987).

On review, claimant contends that his claim is compensable under either an injury or occupational disease theory. However, we find that this matter is properly analyzed as an injury claim. Here, both an incident in December 1989 and the April 1990 incident involved work-related activity that unexpectedly resulted in the onset of pain. See Valtinson v. SAIF, 56 Or App 184 (1982); Ex. 16-1, 30-1, 32-1.

We find that, although the exact date of claimant's incident in December 1989 has not been established, the record contains medical evidence supported by objective findings that claimant suffered an accidental injury which arose out of and in the course of his employment that was a material contributing cause of disability or need for treatment. ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991); Suzanne Robertson, 43 Van Natta 1505 (1991).

At hearing, claimant testified that in December 1989, near the time when he injured his abdomen at work, he also injured his back in a separate incident while attempting to move a large load of lumber. Claimant testified that his back popped loudly and he informed his supervisor about the incident, although he decided not to fill out an accident report because he had no pain following the initial "shot of pain" felt immediately afterward.

Moreover, the record indicates that although claimant did not report the incident for some time, he did eventually report a December incident to several physicians. Ex. 14-1, 16-1, 32-1. A co-worker of claimant's also testified that he remembered two incidents at work when claimant hurt his back while pushing loads of lumber. Finally, objective findings existed, in that a March 27, 1990 CT scan indicated a slightly protruding disc at L5-S1.

Although we agree with the Referee that claimant did not file a back injury claim at the time of the December incident and several months passed before back pain was reported to his treating doctor, we note that the burden of proof in this regard is upon the insurer, rather than claimant. Further, the insurer's standard of proof is "clear and convincing evidence." The Referee found claimant to be an unreliable historian rather than a noncredible witness. Under the circumstances, we conclude that the insurer has failed to prove, by clear and convincing evidence, that claimant's low back injury of December 1989 is not compensable.

Alternatively, we analyze claimant's injury claim as related to the April

23, 1990 incident. The record demonstrates that claimant's disc herniation at L5-S1 was diagnosed before the work-related incident in April 1990. Although we are not convinced that claimant's prior disc herniation condition was not work-related, we would find the claim to be compensable even if the disc herniation could be considered a preexisting condition.

Under ORS 656.007(a)(B), where a claimant has a preexisting condition which combines with a compensable injury to cause or prolong disability or need for treatment, the claimant must establish that the compensable injury is the major contributing cause of the disability or need for medical services.

Here, we would alternatively find that claimant has established a compensable injury on April 23, 1990. On that day, claimant lifted a pallet at work and felt a pull in his low back with radiating pain into his left leg. He reported the incident that day and received treatment the same day from Dr. Herscher. On May 24, 1990, a lumbar myelography showed amputation of the left S1 nerve root, with mild ventral defects at L3-4 and L4-5. The May 25, 1990 surgery performed by Dr. Franks revealed a "very significant bulging disc". Finally, Dr. Franks attributed claimant's condition to the April 23, 1990 incident, and the claim was initially accepted by the insurer. Under the circumstances, we conclude that claimant has estabilished a compensable industrial injury occurring April 23, 1990.

Although we find that there was a compensable injurious incident on April 23, 1990, under ORS 656.005(7)(a)(B), we also must determine whether the compensable April 23 injury is the major contributing cause of claimant's disability or need for medical services. Bahman M. Nazari, 43 Van Natta 2368 (1991).

On February 13, 1991, claimant's treating doctor, Dr. Franks, M.D., reported that the April 23, 1990 injury was the "final crowning blow" of a disc that had already been shown to be abnormal by a March 27, 1990 CT scan. Dr. Franks opined that the April 1990 incident at work was the "major causal event" that caused the radicular loss of function for which claimant required emergency surgery. In arriving at his opinion, Dr. Franks considered both claimant's work activity and an off-work boating incident.

Under the circumstances, we rely upon the medical report of Dr. Franks, claimant's treating physician, and find that the compensable injury of April 23, 1990 is the major contributing cause of claimant's disability and need for treatment. We, therefore, reverse the Referee on the issue of compensability.

Penalties and attorney fees

We adopt the Referee's Conclusions and Opinion on the issue of penalties and attorney fees for an allegedly unreasonable denial.

Claimant is entitled to an attorney fee for services at hearing and on review concerning the issue of compensability. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services at hearing and on Board review concerning the compensability issue is $3,500, 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), the complexity of the issue and the value of the interest concerned.

ORDER

The Referee's order dated May 15, 1991 is reversed in part and affirmed in part. The insurer's denial of claimant's low back injury claim is set aside and

the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed fee of $3,500, to be paid by the insurer. The remainder of the Referee's order is affirmed.

June 11, 1992 Cite as 44 Van Natta 1132 (1992)

In the Matter of the Compensation of
JULIA F. AMELL, Claimant
WCB Case Nos. 90-17431 & 90-18765
ORDER ON REVIEW
Rick W. Roll, Claimant Attorney
Stoel, et al., Defense Attorneys
Alan Ludwick (Saif), Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Liberty Northwest Insurance Corporation requests review of that portion of Referee Holtan's order that: (1) set aside its denial of claimant's "new injury" claim for her low back condition; and (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee decided this matter under the Workers' Compensation Act, as amended in 1990. We agree that the new law applies and we too analyze this matter under the Act as amended, effective July 1, 1990.

The Referee concluded that Section 49(1) (codified in ORS 656.308) applied to the case and he found that claimant had sustained a "new compensable injury" while working for the subsequent employer (Liberty's insured).

Here, we agree with the Referee that SAIF has established that claimant sustained a new compensable injury on May 22, 1990, during her employment with Liberty's insured. We, therefore, adopt the Referee's "Opinion" on the issue of claimant's new compensable injury. See Ricardo Vasquez, 43 Van Natta 1678 (1991).

On review, Liberty contends that the Referee erred by not applying ORS 656.005(7)(a)(B) to this matter. Specifically, Liberty contends that claimant's injury with SAIF and her degenerative disc disease constitute preexisting conditions, requiring application of the statute. We agree in part.

We have recently rejected the argument that a prior compensable injury constitutes a preexisting disease or condition under ORS 656.005(7)(a)(B). See Rosalie S. Drews, 44 Van Natta 36 (1992). We have held that to include a "compensable injury" within the "preexisting condition" language of ORS 656.005(7)(a)(B) would contravene the intent of ORS 656.308 to provide compensation for a worker who sustains a "new compensable injury." See John L. Law, 44 Van Natta 1091 (1992). Accordingly, we disagree with Liberty's contention that claimant's prior compensable injury with SAIF's insured should be considered as a preexisting condition.

Although we do not consider claimant's prior compensable injury under ORS 656.005(7)(a)(B), we conclude that the statute is applicable in a situation in which a claimant's noncompensable preexisting condition combines with the "new compensable injury." In Law, supra, we concluded that, under such circumstances, a carrier's liability may be limited by ORS 656.005(7)(a)(B). Therefore, although we have agreed with the Referee that responsibility shifts to Liberty, we review the record to determine whether Liberty's liability for claimant's condition is limited by the statute.

Under ORS 656.005(7)(a)(B), where a claimant has a preexisting condition which combines with a compensable injury to cause or prolong disability or need for treatment, the claimant must establish that the compensable injury is the major contributing cause of the disability or need for medical services. Here, claimant's treating physician, Dr. Poulson, has opined that claimant's preexisting degenerative disc disease has combined with her May 1990 injury. Inasmuch as that preexisting condition is noncompensable, we apply ORS 656.005(7)(a)(B) to determine whether claimant's current disability or need for medical services is compensable.

In other words, claimant must, under ORS 656.005(7)(a)(B), prove by a preponderance of the evidence that the compensable May 1990 injury is the major contributing cause of her disability or need for medical services. See e.g. Bahman M. Nazari, 43 Van Natta 2368 (1991). Here, we find that the causation of claimant's resulting low back condition is of sufficient medical complexity that we cannot decide it without expert opinion. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

On December 12, 1990, Dr. Poulson, M.D., claimant's treating physician, reported that claimant had sustained a new injury in May 1990. He also reported that it was probable that claimant's May 1990 incident remained the major contributing cause of her disability.

On December 20, 1990, Dr. Buttler, D.C., claimant's former treating chiropractor, reported that her May 1990 injury had combined with her preexisting condition to worsen and prolong her impairment and disability. However, Dr. Buttler opined that claimant's May 1990 incident remained the major contributing cause of her disability and need for treatment.

In a deposition taken March 28, 1990, Dr. Poulson testified that he would be unable to apportion the amount of contribution claimant's two industrial accidents had upon her current condition. Additionally, Dr. Poulson agreed that claimant's degenerative process could have predisposed her to a disc herniation. However, Dr. Poulson opined that, in claimant's case, there was a "clear history" of an injury that occurred at work while claimant was sweeping. Dr. Poulson also testified that the major cause of a change in claimant's condition was the incident that occurred on May 22, 1990.

We rely upon the opinions of claimant's treating physician and her former treating chiropractor, who have had the opportunity to examine and treat claimant over an extended period of time. Accordingly, we conclude that the compensable May 22, 1990 injury is the major contributing cause of claimant's disability and need for treatment. Under the circumstances, Liberty's liability for claimant's condition is not limited pursuant to ORS 656.005(7)(a)(B).

In this case, Liberty denied compensability. Moreover, no .307 order issued. Thus, claimant's right to compensation was at risk at hearing. Both compensability and responsibility were decided in the Referee's order. Therefore, by virtue of the Board's de novo review authority, compensability remained at risk on review as well. Destael v. Nicolai Co., 80 Or App 596 (1986). See

Dilworth v. Weyerhaeuser Co., 95 Or App 85 (1989). Because Liberty initiated review and claimant's compensation was not reduced or disallowed, claimant is entitled to an assessed fee under ORS 656.382(2). See Joel D. Turpin, 41 Van Natta 1736 (1989). Because Liberty sought Board review, Liberty is responsible for the assessed attorney fee for claimant's counsel's services on Board review. Cigna Insurance Companies v. Crawford & Co., 104 Or App 329 (1990).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $500 is a reasonable assessed fee for claimant's counsel's efforts on review. In reaching this conclusion, we have particularly considered the time devoted to the 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 July 17, 1991 is affirmed. For services on Board review, claimant's counsel is awarded a reasonable fee of $500, payable by Liberty Northwest Insurance Corporation.

June 11, 1992 Cite as 44 Van Natta 1134 (1992)

In the Matter of the Compensation of
ELEANOR G. CASTRIGNANO, Claimant
WCB Case Nos. 90-19933, 90-11127 & 90-16291
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Schwabe, et al., Defense Attorneys
Roberts, et al., Defense Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Moller and Brazeau.

Kemper Insurance Co. requests review of those portions of Referee Bethlahmy's order that: (1) set aside its denial of claimant's occupational disease claim for a left hand and arm condition; (2) upheld Travelers Insurance Company's denial of claimant's occupational disease claim for the same condition; and (3) upheld Maryland Casualty Company's denial of claimant's occupational disease claim for the same condition. On review, the issue is responsibility. We affirm.

PRELIMINARY MATTER

At hearing, the parties stipulated that the employer was insured by Travelers in 1985. On review, counsel for Travelers has advised the Board that coverage by Travelers extended to March 27, 1989. That advisement was accepted without objection from the other parties. We therefore correct the stipulation to reflect the correct dates of coverage by Travelers.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found claimant's occupational disease claim compensable and assigned responsibility for the claim to Kemper under the last injurious exposure rule. On review, Kemper only contests the Referee's conclusion regarding

responsibility. First, Kemper asserts that responsibility should be determined under ORS 656.308(1) rather than the last injurious exposure rule. Specifically, Kemper contends that, by enacting ORS 656.308(1), the legislature intended to initially assign responsibility for an occupational disease to the carrier at risk when the disease first produces disabling symptoms and that responsibility is not shifted unless there is proof that subsequent work exposure was the major contributing cause of the disease. We disagree.

ORS 656.308(1) provides:

> "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."

We recently held that ORS 656.308(1) applies only to the shifting of responsibility in those cases in which the claimant sustains a compensable injury while working for one employer, followed by an increase in disability during employment with a subsequent employer. Fred A. Nutter, 44 Van Natta 854 (1992). The statute is not applicable where there is no accepted condition and a determination must be made concerning the assignment of initial liability between successive employers. See id. In such cases, as it did before the 1990 amendments, the last injurious exposure rule continues to operate to allocate responsibility. See id.

ORS 656.308(1) was added to the Oregon's Workers' Compensation Act in 1990 as part of Senate Bill 1197. However, by enacting ORS 656.308(1), we find no legislative intent to modify the application of the last injurious exposure rule to allocate liability for a single claim among successive employers or carriers. Rather, we conclude that the legislature intended only to modify the law regarding whether responsibility for a claimant's increased disability following an accepted injury is shifted to a subsequent employer. That conclusion is supported, first, by the language of ORS 656.308(1). The statute provides that when "a worker sustains a compensable injury, the responsible employer shall remain responsible * * * unless the worker sustains a new compensable injury involving the same condition." Facially, the statute refers only to those workers who have first sustained a compensable injury and then sustain further disability involving the same condition.

This interpretation is supported by legislative history. Testimony and floor debate regarding Senate Bill 1197 discussed the new statute only in the context of a worker who had sustained a compensable injury with one employer and who was seeking compensation for increased disability while working for a subsequent employer. See Minutes, Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 3, Side A at 130 (Ross Dwinell explained: "[ORS 656.308(1)] talks about the responsibility issue. * * * [I]f the worker comes with a pre-existing injury, a compensable injury -- what we're saying here is that if the worker sustain a new compensable injury then the new employer is responsible for that worsening."); Id., May 4, 1990, Tape 18, Side A at 329 (Representative Mannix stated: "[ORS 656.308(1)] says 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."); Statement of Representative Mannix, House Special Session, May 7, 1990 ("[W]hen a worker has an industrial injury the responsibility for that injury remains with the first employer; and, another employer can take on that worker without worrying about * * * a previous

injury unless the worker has an actual new compensable injury with a new employer. Then there will be a new claim.")

Therefore, we find no evidence in the legislative record indicating an intent to modify the law regarding responsibility of a single claim in cases of successive employers or carriers. Consequently, there continues to be an absence of a standard in the statutes for the allocation of responsibility in such cases. Moreover, there is no evidence of intent, or even discussion, by the legislature to modify the last injurious exposure rule. In view of the fact that the rule was adopted by the Supreme Court as early as 1980, see Inkley v. Forest Fiber Products Co., 288 Or 337 (1980), we find this further proof that the legislature had no intent to alter the rule's application in such cases. Accordingly, pursuant to the last injurious exposure rule, we proceed to address responsibility of claimant's occupational disease.

Under the last injurious exposure rule, if a worker proves that an occupational disease was caused by work conditions that existed where more than one carrier is on the risk, the potentially causal employer at the time disability occurs is assigned liability for the disease. Bracke v. Baza'r, supra, 293 Or at 248. If the claimant is not in potentially causal employment when disability occurs, the last such employer is liable. Id. The onset of disability is the date upon which the claimant first becomes disabled as a result of the compensable condition or, if the claimant does not become disabled, the date he first seeks medical treatment for the condition. Progress Quarries v. Vaandering, 80 Or App 160, 162 (1986).

Here, there was evidence that claimant's work activities under each carrier contributed to her occupational disease of the left hand and arm. (Exs. 71-3). The record also demonstrates that, on February 23, 1990, claimant sought treatment for her left hand and arm symptoms and that her treating chiropractor released claimant from work for 10 to 15 days. (Exs. 53, 55). February 23, 1990, therefore, qualifies as the onset of disability.

Kemper argues, however, that February 23, 1990 should not be considered the onset of disability because the record proves that claimant first complained of left hand pain in October 1988 and essentially was unable to work in December 1989. Kemper contends that claimant should be determined to have been disabled in December 1989, when Maryland Casualty was on the risk.

Claimant testified that, by December 1989, she "was basically a nonproductive employee compared to what" she had been. (Tr. 19). She further testified that, although her left arm pain was "bad," she did not schedule an appointment for examination of her left hand and arm until February 1990 because a co-worker was about to go on maternity leave. (Id.) According to claimant's testimony, during that time, she periodically "just couldn't use" her arm because it would "lock up" suddenly and become "useless." (Id. at 20).

Whether or not claimant's testimony demonstrates that she was disabled as of December 1989, we conclude that such evidence, by itself, is insufficient to prove the onset of disability. Given the complexity of claimant's left hand and arm condition, it would be only a matter of speculation whether claimant was disabled at that time. We therefore find that resolution of claimant's possible disability during December 1989 requires expert medical opinion evidence. See Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Given the absence of any such evidence in the record, we conclude that there is no proof that the date of disability properly should be determined as December 1989. Instead, we rely on medical evidence showing that claimant first sought treatment and was released from work on February 23, 1990 to find that the date of disability is February 23, 1990. Because Kemper was the carrier on the risk on that date, we

conclude that, for purposes of the last injurious exposure rule, liability for claimant's condition should be allocated to Kemper.

Kemper does not argue that claimant's prior employment exposure during Maryland Casualty's or the Traveler's period of coverage was the sole cause of claimant's disability or that it was impossibile for claimant's employment exposure during Kemper's period of coverage to have caused claimant's disability. Moreover, the medical evidence is to the contrary. Therefore, we find no basis to transfer responsibility from Kemper to Maryland Casualty or the Traveler's. See FMC Corporation v. Liberty Mutual Ins. Co., 70 Or App 370 (1984, clarified 73 Or App 223 (1985).

Finally, because claimant right to compensation was at issue and thus at risk at hearing, claimant is entitled to a carrier-paid fee for services rendered on review pursuant to ORS 656.382(2). See Riley E. Lott, Jr., 43 Van Natta 209, 212 (1991). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is $800, to be paid by Kemper. 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 to claimant of the interest involved.

ORDER

The Referee's order dated July 12, 1991 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $800, to be paid by Kemper.

June 11, 1992 Cite as 44 Van Natta 1137 (1992)

In the Matter of the Compensation of
PAMELA S. CHENEY, Claimant
WCB Case Nos. 91-02238, 90-19808 & 90-21704
ORDER ON REVIEW
Allen T. Murphy, Jr., Claimant Attorney
Kathryn Wilske (Saif), Defense Attorney

Reviewed by Board Members Hooton and Brazeau.

The SAIF Corporation, on behalf of the noncomplying employer, requests review of those portions of Referee Knapp's order that set aside its denials of claimant's right foot pain (Ex. 7) and wrenched knee and back strain (Ex. 6) claims. On review, the issue is compensability. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact except that the Referee's second ultimate finding of fact is modified as follows.

Claimants right ankle pain and low back strain arose out of and in the course of her employment.

CONCLUSIONS OF LAW AND OPINION

Credibility

SAIF first contends that the Referee erred in finding claimant credible. It notes that the evidence suggests that claimant committed both fraud and theft prior to or concurrent with the events giving rise to her workers' compensation

claims and that the Referee's credibility finding must therefore be reversed. We disagree.

Allegations of fraud and theft must be supported by evidence showing intentional misconduct. It is not necessarily clear that the evidence presented in this case rises to that level. In addition, that evidence does not necessarily determine our findings on credibility. The evidence is weighed together with other evidence, including claimant's demeanor at the time of hearing. In weighing all the evidence, including the fact that claimant's description of the incidents giving rise to her injuries was confirmed by fellow employees, and that those employees observed physical signs of injury or behavior consistent with injury, the referee concluded that claimant was a credible witness. On the present record, we are not convinced that there is a persuasive reason to reverse that finding.

Compensability

SAIF challenges the referee's determination of compensability for claimant's right ankle pain and low back injury, including a diagnosed low back strain and herniated lumbar discs at multiple levels including L3-S1 (Ex. 6A). We affirm the finding of compensability for right ankle pain and low back strain and modify on the finding of compensability for claimant's multiple herniated discs.

Right Ankle

Claimant's fall of December 1989 was witnessed, both audibly and visually. The effects of that fall, which included swelling of the right ankle, were immediately observed by claimant's co-workers. The following day, she was seen by Dr. Bernier, who also observed swelling. Under these circumstances the question of causation is not a complex medical question requiring expert testimony to support compensability. See Uris v. Comp. Dept., 247 Or 420 (1967). In addition, the swelling observed by claimant's co-workers and by Dr. Bernier provides objective evidence of injury sufficient to meet the requirements of ORS 656.005(7)(a).

Low Back Strain

In like fashion, claimant's fall of July 1990 was also witnessed and produced immediate complaints of pain and pain behaviors associated with low back discomfort. With increasing symptoms, claimant took herself to an emergency room in September 1990 where examination demonstrated evidence which supported claimant's continuing claim of low back pain. Under these circumstances, we find the evidence to be sufficient to support the compensability of the low back strain which was subsequently diagnosed by Dr. Berselli and denied by SAIF. See Uris v. Comp. Dept., supra.

Herniated Discs

We do not accept that the compensability of claimant's herniated discs may be established without expert medical testimony. See Uris v. Comp. Dept., supra. This is a complex medical question requiring expert testimony. The referee erred in his conclusion that sufficient evidence of causation can be derived from speculation regarding the intention of the treating surgeon on requesting authorization for surgery from a workers' compensation carrier. This determination, however, has little effect on the present claim.

SAIF denied only right ankle pain and low back strain. It has failed to accept or deny the claim for herniated discs at multiple levels. Claimant

requested her hearing from the denials formally entered by SAIF and did not amend her request for hearing to include a de facto denial of herniated discs. Though there is some evidence in the transcript that claimant's attorney may have intended to do so, the Referee expressly sought clarification which confirmed that claimant opposed the denials issued by SAIF on October 15, and December 3, 1990. SAIF raised no issues and did not seek to extend any of the denials to cover conditions not expressly included.

In Johnson v. Spectra Physics, 303 Or 49 (1987), the Supreme Court held that "[i]f an insurer specifically accepts in writing only one of several conditions or injuries encompassed by a single claim, the insurer has not 'specifically' or 'officially' accepted the other conditions allegedly related to the accepted part of the claim." 303 Or @ 56. There is no compelling reason not to apply the same analysis to insurer denials. Here, SAIF has failed to process the claim for herniated discs. Further, claimant has not requested a hearing from SAIF's de facto denial of that condition.

Therefore, the Referee was not invested with jurisdiction to consider the compensability of the herniated discs. That portion of his order which addressed that condition is vacated. SAIF continues to have an obligation to process that claim pursuant to ORS 656.262, and claimant may choose to await that processing, or request a hearing on SAIF's de facto denial. In the meantime, the obligation to pay interim compensation and to comply with all other claims processing requirements continues to run.

Inasmuch as we are vacating the portion of the Referee's order that found claimant's herniated discs to be compensable, we also modify the Referee's assessed attorney fee award. After considering the factors in OAR 438-15-010(4) and applying them to this case, we find a reasonable fee for claimant's attorney's services at hearing in prevailing against SAIF's denials of the right ankle, knee and low back strain conditions is $1,400, payable by SAIF. See ORS 656.386(1). In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the hearing record), the complexity of the issues, the value of the interest involved, and the risk that the attorney's efforts may go uncompensated.

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. 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 attorney's services on review concerning the compensability of the right ankle, knee and low back strain conditions is $360, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 23, 1991 is affirmed in part, vacated in part, and modified in part. That portion of the order which found that claimant's herniated discs are compensable is vacated. The Referee's attorney fee award is modified to $1,400, payable by the SAIF Corporation. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded a reasonable assessed fee of $360, payable by the SAIF Corporation.

In the Matter of the Compensation of
STEPHEN L. DOKEY, Claimant
WCB Case No. 90-01839
ORDER ON REVIEW
Victor Calzaretta, Claimant Attorney
Carol Taaffe (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Bethlahmy's order that: (1) found that claimant's claim had not been prematurely closed; and (2) awarded 20 percent (64 degrees) unscheduled permanent disability for a urinary incontinence condition, whereas a Determination Order had awarded no disability in addition to claimant's prior award of 55 percent (176 degrees) unscheduled permanent disability for a low back condition. In his brief, claimant argues that he is entitled to an award of scheduled permanent disability for loss of use or function of his legs. On review, the issues are premature closure, and if the claim was not prematurely closed, extent of permanent disability. We reverse.

FINDINGS OF FACT

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

We do not adopt the next-to-last full sentence on page 2.

On October 5, 1988, Dr. Melgard performed a two-level disc excision at L4-5 and L5-S1.

FINDING OF ULTIMATE FACT

On January 18, 1990, when claimant's claim was closed, there was a reasonable expectation of improvement in claimant's condition from medical treatment or the passage of time.

CONCLUSIONS OF LAW AND OPINION

The Referee decided that the Evaluation Section properly determined claimant to be medically stationary as of September 13, 1989 and at the January 18, 1990 claim closure, based on the Orthopaedic Consultants' September 13, 1989 report. Claimant contends that the opinions of Dr. Melgard, treating surgeon, and Dr. Knox, treating neurologist, establish that claimant was not medically stationary when his claim was closed. We agree.

It is claimant's burden to prove that his claim was prematurely closed. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the January 18, 1990 Determination Order considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980). We generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 or App 810 (1983). In this case, we find no such reasons.

Dr. Knox, claimant's treating physician since February 1988, referred claimant to Dr. Melgard concerning claimant's compensable low back condition. On October 5, 1988, Dr. Melgard performed a two-level disc excision at L4-5 and L5-S1. On March 13, 1989, Melgard predicted that it would be "18 months before we will see how much return [claimant] will get [from his surgery]." (Ex. 5A). Melgard also reported "pretty good progress" at that time and planned to reexamine claimant in six months, noting that Dr. Knox would follow claimant in the meantime. (Id.) On September 12, 1989, Melgard opined, "I think we will just have to watch him and see how he does. He isn't ready to go back to driving truck as yet." (Ex. 6).

On September 13, 1989, the Orthopaedic Consultants examined claimant and opined that neurological findings were not inconsistent with claimant's symptoms. (Ex. 8). In an October 30, 1989 letter, Dr. Donahoo, of the Orthopaedic Consultants, stated that he considered claimant to be medically stationary "at this time." (Ex. 8-1). In a May 4, 1990 letter, Donahoo stated that he meant to say that claimant was medically stationary as of the September examination. (Ex. 16).

Following claimant's October 1988 low back surgery, Dr. Knox examined claimant periodically and performed numerous neurological tests. Knox did not predict that claimant's condition would or would not improve. (See Ex. 17). However, when asked whether he agreed with the Orthopaedic Consultants' September 13, 1989 report, Knox checked-the-box indicating that he did not concur with the Consultants. Knox explained briefly that he found the independent examiners' findings and conclusion to be "at variance with numerous neurological examinations." (Ex. 10).

As we have noted, claimant's treating surgeon, Dr. Melgard, predicted, in April, 1989, that 18 months' time would be necessary to observe claimant's progress following his surgery. Only 10 months had passed when the claim was closed. Moreover, on September 12, 1989, the day before the Consultants' "closing examination," Melgard opined that claimant was not yet ready to return to truck driving. In our view, the latter comments indicate that Melgard expected claimant's back condition to continue improving, as previously predicted. Considering Melgard's advantageous position as treating surgeon, particularly his "first-hand exposure to and knowledge of claimant's condition," we give his opinion great weight. See Argonaut Insurance Company v. Mageske, 93 Or App 698, 702 (1988). Under these circumstances, we also find Melgard's stated expectations to be reasonable. Therefore, the claim was prematurely closed.

Because we have found that the claim was prematurely closed, we do not reach the issue of the extent of claimant's permanent disability.

ORDER

The Referee's order dated September 25, 1991 is reversed. The claim closure order is set aside as premature. The claim is remanded to the SAIF Corporation for further processing according to law. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

In the Matter of the Compensation of
JERRY G. FOSTER, Claimant
WCB Case No. 90-19749 & 91-01052
ORDER ON REVIEW
Phillip Garrow, Claimant Attorney
Michael O. Whitty (Saif), Defense Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

The SAIF Corporation requests review of Referee Peterson's order that: (1) set aside its responsibility denial for claimant's current low back condition; and (2) upheld Liberty Northwest's responsibility denial for the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of the second sentence of the last paragraph.

CONCLUSIONS OF LAW AND OPINION

The question presented is which of two successive carriers, SAIF or Liberty, is responsible for claimant's current low back condition. SAIF acknowledges that claimant sustained a compensable low back injury in October 1989 while working for its insured. It contends, however, that claimant suffered a new injury in July 1990 while working for Liberty's insured and that, consequently, all compensable medical services and disability involving claimant's low back condition should be processed as a new injury claim by Liberty. We agree.

ORS 656.308 provides, in part:

> "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."

Thus, in order to shift responsibility, either claimant or SAIF must establish that claimant suffered a new, independently compensable injury while working with Liberty's insured. See Ricardo Vasquez, 43 Van Natta 1678 (1991). A new compensable injury is established with proof that claimant's subsequent work exposure was a material contributing cause of disability or need for treatment. Rosalie S. Drews, 44 Van Natta 36 (1992). We find that the causation of claimant's current low back condition is of sufficient medical complexity that we cannot decide it without expert opinion. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Two expert opinions on medical causation were introduced in this matter. Dr. Campbell, claimant's treating chiropractor since July 1990, opined that claimant's October 1989 injury had resolved and that claimant had sustained a new injury with Liberty's insured. Dr. Fitzpatrick, who treated claimant on one occasion in June 1991, expressed the opinion that the October 1989 injury with SAIF's insured remained the major contributing cause of claimant's current low back problems.

The Referee discredited the opinion of Campbell because claimant testified that his 1989 injury never resolved and that he continued to suffer low back

symptoms. We note that claimant testified that, after January 1990, his back remained somewhat "tight." Nonetheless, such minor symptoms do not, in our view, invalidate Campbell's opinion that claimant's 1989 back injury had resolved, especially given claimant's other testimony that, after January 1990, he had no pain in his low back, leg, hip or right buttock, and that he had sought no additional treatment until after his July 1990 injury with Liberty's insured. We find his medical opinion sufficient to establish that claimant sustained a new compensable injury with Liberty's insured.

In reaching our decision, we are not persuaded by Fitzpatrick's opinion. While he opined that the major contributing cause of claimant's current low back condition was the 1989 injury, he did not address the question at issue here, i.e., whether claimant's subsequent work exposure with Liberty's insured was a material contributing cause of disability or need for treatment. Rosalie S. Drews, supra. Moreover, as noted by SAIF, he did not examine claimant until June 13, 1991, almost a year after claimant was medically stationary from his injury, and did not have the benefit of examining claimant contemporaneously to the injury. Accordingly, we give his opinion little weight. Somers v. SAIF, 77 Or App 259 (1986).

In short, we conclude that SAIF has carried its burden of establishing that claimant experienced a new compensable injury while working for Liberty's insured. Accordingly, Liberty is responsible for claimant's current low back condition.

ORDER

The Referee's order dated September 26, 1991 is reversed. The SAIF Corporation's responsibility denial for claimant's current low back condition is reinstated and upheld. The Liberty Northwest Insurance Corporation's responsibility denial for the same condition is set aside, and the claim is remanded for further processing. The Referee's $2,500 assessed attorney fee shall be paid by Liberty, rather than SAIF.

June 11, 1992 Cite as 44 Van Natta 1143 (1992)

In the Matter of the Compensation of
ANNA L. HARRIES, Claimant
WCB Case No. 91-08398
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Kinsley.

The SAIF Corporation requests review of that portion of Referee Peterson's order which directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree. On review, the issue is the rate of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. The January 30, 1990 Notice of Closure awarded a specific dollar amount which corresponded to a rate of $145 per degree. The Notice of Closure also declared claimant medically stationary as of August 14, 1989. Claimant did not stipulate to any amount or rate of scheduled permanent disability in the September 13, 1990 Stipulation.

CONCLUSIONS OF LAW AND OPINION

The Referee ordered SAIF to pay claimant's scheduled permanent disability award at the rate of $305 per degree. Because only a portion of claimant's total award should be paid at the rate of $305, we modify.

In Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), we held that the Oregon Laws 1990, Chapter 2, section 7 amendment to ORS 656.214(2), which increased the value per degree of scheduled permanent disability to $305, applied to all awards of scheduled disability made on or after May 7, 1990, regardless of the date of injury.

Here, claimant was awarded 4 percent scheduled disability by a Notice of Closure on January 30, 1990. Because that award was made before May 7, 1990, it must be paid at the rate of $145 per degree, in accordance with former ORS 656.214(2). See David D. Kerr, 43 Van Natta 2781 (1991). However, because a prior referee approved an additional 5 percent scheduled permanent disability by the September 13, 1990 Stipulation and this was after May 7, 1990, and because claimant did not stipulate to any amount or rate of scheduled permanent disability, that increased award must be paid at the rate of $305 per degree. Alan G. Herron, supra; David D. Kerr, supra; Henry K. Schwane, 44 Van Natta 679 (1992).

ORDER

The Referee's order dated October 14, 1991 is modified. The SAIF Corporation shall pay claimant 4 percent (7.68 degrees) scheduled permanent disability, as awarded by Notice of Closure on January 30, 1990, at the rate of $145 per degree, and pay 5 percent (9.6 degrees) scheduled permanent disability, as awarded by Stipulation on September 13, 1990, at the rate of $305 per degree. Claimant's attorney fee shall be adjusted accordingly.

June 11, 1992 Cite as 44 Van Natta 1144 (1992)

In the Matter of the Compensation of
ERNESTO MAGANA, Claimant
WCB Case No. 88-10463
ORDER ON REMAND
Ronald A. Fontana, Claimant Attorney
Schwabe, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Magana v. Wilbanks International, 112 Or App 134 (1991). The court reversed our prior order in Ernesto Magana, 43 Van Natta 272 (1991), that upheld an occupational disease denial of a kidney condition. In affirming and adopting a Referee's order upholding the denial, we further stated that "[b]ecause claimant has not eliminated all other explanations, we conclude that claimant has failed to establish a compensable occupational disease claim." Citing ORS 656.802(1)(a), and SAIF v. Scott, 111 Or App 99, 101 (1992), the court reasoned that claimant must establish that his work exposure to chemicals was the major contributing cause of his time loss or need for medical services. Concluding that conflicting inferences arose from our order regarding the issue of causation, the court has remanded for reconsideration.

After conducting our reconsideration of this case, we adhere to the reasoning and conclusions contained in our prior order with the following supplementation and modification.

As held by the court, claimant need not eliminate all other possible explanations of causation to establish the compensability of his occupational disease claim. Magana v. Wilbanks International, supra, at page 136. Instead, he must prove that his work exposure to chemicals was the major contributing cause of his disability and/or need for medical services. Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); SAIF v. Scott, supra.

In light of the court's holding, we do not republish that portion of our decision which reasoned that claimant's occupational disease claim was not compensable because he had not eliminated all other explanations for the cause of his condition. Notwithstanding this alteration of our prior reasoning, we remain unpersuaded by the medical evidence that claimant's work exposure to chemicals was the major contributing cause of his kidney condition. Inasmuch as claimant must satisfy such a standard of proof to establish the compensability of his occupational disease claim, we continue to agree with the Referee that the self-insured employer's denial must be upheld.

Accordingly, on reconsideration, as supplemented and modified herein, we affirm the Referee's order dated February 1, 1990.

IT IS SO ORDERED.

June 11, 1992 Cite as 44 Van Natta 1145 (1992)

In the Matter of the Compensation of
LARRY K. MELTON, Claimant
And, In the Matter of the Complying Status of
FOWLER LOGGING, Employer
WCB Case Nos. 91-00617, 90-19904 & 90-22604
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney
Phillips, et al., Attorneys

Reviewed by Board Members Brazeau and Moller.

Claimant requests review of that portion of Referee Neal's order that upheld the SAIF Corporation's denial, on behalf of the noncomplying employer, of claimant's low back injury claim. SAIF cross-requests review of those portions of the order that awarded additional interim compensation and a penalty for an allegedly unreasonable refusal to pay compensation. On review, the issues are compensability, interim compensation, and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction. Claimant worked on July 16 and July 17, 1990. (Ex. 24-4).

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt that portion of the Referee's order pertaining to compensability of claimant's low back injury claim.

Interim Compensation

SAIF paid claimant interim compensation from January 24, 1991 through February 20, 1991, the date of claim denial. The Referee found that claimant

was entitled to additional interim time loss benefits from November 19, 1990, the date claimant's treating physician authorized time loss, through January 23, 1991.

"Interim compensation" is temporary disability payments made between the employer's notice of the injury and the acceptance or denial of the claim. Bono v. SAIF, 298 Or 405, 407 n. 1 (1984). A claimant's entitlement to interim compensation is triggered by the carrier's notice or knowledge of the claim. See ORS 656.262(4)(a); Stone v. SAIF, 57 Or App 808, 812 (1982). When the employer is noncomplying, the first payment must be made within 14 days of the claim's referral to SAIF by the director. ORS 656.054(1); Joseph E. Dabacon, 43 Van Natta 1962, 1963 (1991).

Although a claimant is entitled to interim compensation whether or not his or her claim eventually is proved compensable, there is no duty to pay such compensation if the worker has not left work pursuant to ORS 656.210(3). See Bono v. SAIF, supra, 298 Or at 408, 410. Furthermore, a claimant who is absent from work for reasons unrelated to the injury is not entitled to interim compensation. Nix v. SAIF, 80 Or App 656, 659 (1986).

Here, because claimant worked for a noncomplying employer, the director referred his claim to SAIF for processing on November 30, 1990. SAIF investigated whether claimant was absent from work due to an injury by inquiring of Dr. Herbert, claimant's former treating physician, and Dr. Nash, claimant's current treating physician, whether time loss had been authorized. (Ex. 31-1). SAIF was advised by both offices that no time loss was indicated. (Id. at 1-2). It was not until January 24, 1991 that SAIF was advised by Dr. Nash that claimant "has been unable to be productively employed since my initial examination of November 19, 1990." (Ex. 21-2).

From the aforementioned evidence, we conclude that SAIF's obligation to pay claimant interim compensation did not arise until it received Dr. Nash's report. Furthermore, although Dr. Nash authorized time loss retroactively to November 19, 1990, we conclude that SAIF properly paid claimant interim compensation from January 24, 1991 until claim denial on February 20, 1991.

In determining the time for payment of compensation, the statutes and the administrative rules emphasize notice to the carrier. For instance, ORS 656.262(4)(a) provides that the "first installment of compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim." OAR 436-60-150(4) provides that timely payment of temporary disability benefits means payment no later than the 14th day after the employer's "notice or knowledge of the claim if temporary disability is immediate," or "notice or knowledge of temporary disability related to but subsequent to the injury."

Because notice or knowledge by the carrier is the trigger for payment of compensation, a claimant's entitlement to interim compensation begins on that date even if claimant can prove that he left work due to his injury prior to the date of claim notice. See e.g., Spivey v. SAIF, 79 Or App 568, 570-71 (1986); Sandra L. Berkey, 41 Van Natta 944 (1989).

Given the above analysis, we conclude that the carrier's notice of claimant's inability to work due to an injury, rather than the date of disability, triggers claimant's entitlement to interim compensation. Here, SAIF received such notice on January 24, 1991, when it received Dr. Nash's report. We therefore find that SAIF properly paid claimant interim compensation for the period of January 24, 1991 through February 20, 1991.

In light of this conclusion, we further hold that SAIF's claim processing was not unreasonable. Consequently, we reverse that portion of the order which assessed a penalty against SAIF for failing to pay interim compensation prior to January 24, 1991.

ORDER

The Referee's order dated May 22, 1991 is affirmed in part and reversed in part. That portion of the order requiring the SAIF Corporation to pay claimant additional interim compensation for the period of November 19, 1990 through January 23, 1991, plus a penalty of 25 percent of the additional interim compensation award, is reversed. The remainder of the order is affirmed.

June 11, 1992 Cite as 44 Van Natta 1147 (1992)

In the Matter of the Compensation of
GERALD D. SPENCER, Claimant
Own Motion No. 66-0226M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our February 19, 1992 Own Motion Order on Reconsideration in the above-captioned case. In order to allow sufficient time to consider the motion for reconsideration, we abated our prior order on March 17, 1992.

Claimant submits new evidence consisting of a letter dated March 11, 1992 from Dr. Conner, M.D. which states that claimant's hospitalization on December 5, 1990 was due to a cellulitis in the area of the anesthetic part of the right leg injured in the accident of 1963. Dr. Conner opines that the scarring and compromise of blood supply plus the anesthesia in this area made the infection possible that eventually required the hospitalization. Therefore we find that claimant's hospitalization of December 5, 1990 was due to a cellulitis condition related to his 1963 injury.

Accordingly, the medical treatment and hospitalization for treatment of chronic cellulitis are reasonable and necessary and curative for the compensable 1963 injury. Therefore, we conclude that claimant's claim should be reopened to provide those medical services. See OAR 438-12-037(1)(a) Accordingly, claimant's claim is reopened for the provision of medical services and supplies related to his cellulitis condition of the right leg and related services.

In addition, we determined in our prior February 19, 1992 order that claimant had not voluntarily removed himself from the work force. Therefore, SAIF is authorized to begin the payment of temporary total disability compensation beginning December 5, 1990, the date he was hospitalized. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-12-055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by SAIF directly to claimant's attorney. See OAR 438-15-010(4); 438-15-080.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRIAN TICHENOR (Deceased), Claimant
WCB Case No. 89-21502
ORDER ON REVIEW
Allen T. Murphy, Jr., Claimant Attorney
C. Douglas Oliver (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

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

FINDINGS OF FACT

Claimant, who is now deceased, worked as a lithographer from 1948 until retiring in 1976. (Ex. 9B-3). He began working for SAIF's insured in 1953. (Ex. 23A-1). He was hired as a journeyman stripper and worked in that position until 1973. After that date, he worked in quality control until retiring. (Ex. 33-10, 11).

As a journeyman stripper, claimant positioned film negatives in preparation for platemaking. (Id. at 10). This process did not involve direct contact with chemicals. (Tr. 44). Platemaking involved coating with a light-sensitive solution. The plate and film negatives were then exposed to high-intensity light and developed under water. (Id.) Prior to 1960, the solution was manually wiped on the plates. Thereafter, the plates arrived pre-coated. (Id. at 11). While working in quality control, claimant examined the finished plates for errors. (Id.)

In March 1989, claimant was treated for shortness of breath and coughing. (Ex. 5-1). He was admitted into the hospital on April 12, 1989. A bronchoscopy was performed, confirming adenocarcinoma of the lung. (Ex. 22). After being discharged, claimant was again admitted into the hospital on April 29, 1989. (Ex. 13). On May 4, 1989, he died from respiratory arrest secondary to adenocarcinoma of the lung. (Ex. 22). No autopsy was performed.

Claimant's hobbies included painting with acrylic watercolors. (Ex. 23A-2).

CONCLUSIONS OF LAW AND OPINION

Claimant's widow seeks benefits for her husband's death due to lung cancer. See former ORS 656.204. Because she asserts that claimant developed lung cancer from exposure to chromates in his job as a lithographer, she must prove a claim for occupational disease under former ORS 656.802(1)(a). The Referee found that claimant's lung cancer was caused by exposure to chromates while he worked as a lithographer for SAIF's insured. SAIF asserts that claimant failed to prove the nature and intensity of exposure to chromate while employed at its insured. SAIF also argues that there is a failure of proof regarding medical causation. For the following reasons, we agree with SAIF.

The record contains persuasive evidence that exposure to chromates can cause lung cancer. See e.g. Ex. 32. The record contains no persuasive evidence, however, concerning the exact nature of claimant's employment conditions while working as a lithographer. Only one medical report, that of Dr. Browning, addresses claimant's specific work conditions. The remaining reports linking lithography work to the development of lung cancer are general in nature and do not specifically relate to claimant's employment. We therefore do not find them

persuasive with regard to whether claimant's employment conditions were the major contributing cause of his lung cancer. See Sherman v. Western Employers Insurance, 87 Or App 602, 606 (1987).

Before his death, claimant stated to Dr. Browning that he "made plates daily for 10 years" and that the chemical used to coat the plates was a dichromate emulsion. (Ex. 23A-1). Claimant further told Browning that the chemicals came into contact with his hands, despite his wearing gloves, and that he developed a rash in the 1960's due to "chrome poisoning." (Id.)

The remaining evidence regarding claimant's employment conditions is provided by the testimony of Warren Deal, one of the founders of SAIF's insured, and Lloyd Teeters, who began working for the employer in 1961. Deal testified that he hired claimant in 1953 and supervised the plant until retiring in 1985. (Ex. 33-8, 9-10). He explained that before claimant was hired, claimant told Deal that he had experienced eczema in his prior job and that he wanted to work only as a stripper and not as a platemaker. (Id. 22). Deal indicated that claimant never worked as a platemaker for the present employer and that claimant never complained of problems with eczema while working there. (Id. at 23-24). Deal did not know whether the inks used by claimant contained chromium. (Id. at 8).

Lloyd Teeters testified that in 1961, claimant was working as a stripper. (Tr. 43). He also testified that during the 1950's, it was common for strippers to perform several functions, including platemaking or camera work. Teeters had no personal knowledge, however, of claimant's actual job duties prior to 1961. (Id. at 47).

Teeters also testified that bichromate acids or chromate acids were used by the present employer until sometime during the 1960's. (Id. at 41). Teeters knew that a man who worked with the press equipment experienced reactions on his skin whenever he came into contact with the chemicals. (Id. at 42). Teeters did not know whether claimant had ever suffered from such reactions. (Id.)

From the above evidence, we are not persuaded that claimant worked as a platemaker for the present employer, that he was exposed to chromates, or that the employer used chromates in its inks. The only evidence in that regard is contained in Dr. Browning's report. Lloyd Teeters' testimony, however, does not support that report; Teeters did not work for the employer until 1961 and, therefore, has no personal knowledge of claimant's activities, or the chemicals used there, before that time. Warren Deal's testimony directly conflicts with Browning's report; he has stated that claimant worked only as a stripper and did no platemaking. Browning's report contains only a recitation of claimant's statements to her. Those statements are not corroborated and, in some instances, are refuted by other testimony. We, therefore, conclude that claimant has failed to prove that he was exposed to chromates while working as a lithographer for the present employer. Legal causation has not been established.

Further, we conclude that medical causation has not been established. The physicians in this case agree that chromium has been shown to cause cancer only in the lungs. Thus, if claimant's cancer originated elsewhere in his body and then traveled to his lung, it is unlikely that chromium exposure caused his lung cancer. See e.g. Exs. 27-1, 43. Here, a pathologist, Dr. Scott, examined a biopsy sample taken from claimant's lung. Scott found that although "the histologic features are entirely consistent with a pulmonary primary, the possibility of a metastatic lesion, particularly of renal origin, cannot be excluded with this histologic appearance." (Ex. 8).

Dr. Edwards, a professor of medicine at OHSU, also studied claimant's

medical reports. Edwards concluded that "it is most likely that this cancer originated elsewhere [than in the lung] with the most likely site being the kidney[.]" (Ex. 27-2). Edwards based this conclusion on the histologic appearance noted by Dr. Scott and the observation by Dr. Reich, who performed the bronchoscopy, of "multiple tumors." Edwards explained that these tumors "are particularly common in cancers originating in the kidneys" but is "not characteristic of cancers actually originating in the bronchi of the lung." Edwards further noted that the presence of blood in claimant's urine is "one of the presenting signs of renal (kidney) cancer." (Id.)

Dr. Houghton, a pathologist, examined claimant's biopsy report. Houghton found that the "lung might be the primary site of the tumor, but I would guess that it is not." (Ex. 30). He based this conclusion on the growth pattern of the cancer and the lack of mucin production, both of which are "common in other kinds of cancer, including kidney cancer, a possibility which is attractive to me in light of his renal mass." (Id.) Dr. Whitehead, claimant's treating physician, later reported that no evidence of a renal mass had been found. (Ex. 42).

Dr. Kalez, a surgeon who examined claimant's urinalyses, found that the presence of hemoglobin "frequently occurs in the kidney area, and when one sees this particular finding, it is my feeling it would be quite reasonable to assume one should explore this further." (Ex. 31).

Dr. Reich stated that claimant "might have a primary carcinoma of the kidney presenting as metastases to the lung, [but] I am not inclined to agree with that view. The tumor at the spur [where the biopsy sample was taken] was clearly bronchial in origin." (Ex. 34-1). Reich reported that the location of claimant's tumor "would be an exquisitely rare site for extrathoracic tumor to present as metastases." (Id.) Reich also stated, in reference to blood found in claimant's urine, that the small number of blood cells did not exclude the possibility of kidney cancer, but that he was satisified that claimant "had a primary lung cancer[.]" (Id.)

Finally, Dr. Jansen, an occupational medicine specialist, reviewed the reports of Drs. Edwards and Houghton. Jansen concluded that "it is impossible to state where the malignancy developed, because an autopsy has not been performed." (Ex. 43-1).

The only strong medical evidence suggesting that claimant's cancer originated in the lung is provided by Dr. Reich. On the whole, we find that Reich's opinion is outweighed by, or at least in equipoise with, the other medical opinions. Both Drs. Edwards and Houghton provide persuasive and well-reasoned opinions that claimant's cancer was not of bronchial origin. Although Dr. Houghton mistakenly assumed that a renal mass had been found in claimant's kidney, he further based his opinion on the growth pattern of claimant's tumor and the lack of mucin production. Drs. Kalez and Jansen also suggest that claimant's cancer did not originate in the lung.

Having found the medical record insufficient to prove that the claimant's cancer originated in his lung, we also find a failure of proof regarding whether the cancer resulted from exposure to chemicals on the job.

ORDER

The Referee's order dated April 15, 1991 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's attorney fee award to claimant's counsel is reversed.

In the Matter of the Compensation of
KENNETH M. WAGNER, Claimant
WCB Case No. 91-03498
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Westerband, Brazeau and Gunn.

The insurer requests review of Referee Schultz's order which set aside its denial of claimant's aggravation claim for a herniated disc. On review, the issues are compensability and aggravation. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's September 25, 1987 compensable injury was the material and major contributing cause of of his current herniated disc at L5-S1. Therefore, the Referee concluded that claimant had established a compensable aggravation of his original industrial injury and set aside the insurer's denial. We disagree.

The threshold issue is whether claimant's current herniated disc condition is compensable. If it is, we then determine whether claimant has established a compensable worsening under ORS 656.273. See Thomas L. Fitzpatrick, 44 Van Natta 877 (1992); Lareta C. Creasey, 43 Van Natta 1735 (1991).

In Julie K. Gasperino, 43 Van Natta 1151 (1991), we held that the 1990 amendments do not affect the standard of compensability for conditions which result directly from the industrial accident. However, conditions which arise as a consequence of compensable injuries sustained in the accident are "consequential conditions" subject to proof by the major contributing cause standard. ORS 656.005(7)(a)(A).

Here, claimant argues that his herniated disc at L5-S1 arose directly (although belatedly) from the industrial accident and that he need only prove that the injury is a material contributing cause of his current condition.

We conclude that there has been a failure of proof under either the major or the less burdensome material contributing cause standards. Claimant's initial diagnosis after the 1987 industrial accident was severe lumbar sprain/strain with a suspicion of a herniated lumbar disc. (Ex. 2A-2). A December 12, 1987 CT scan, however, revealed found no disc herniation and that diagnosis was ruled out. (Ex. 4-1). Subsequent MRI's revealed preexisting degenerative disc disease. (Exs. 11-1, 12-5, 14).

On December 15, 1990, claimant was at home sitting on his couch sharpening a chainsaw. He set a chainsaw file down on the table and stood up. Before he was able to stand erect, he experienced sudden and severe pain in the same area of the back that had bothered him chronically since 1987. The pain, however, was of a magnitude much greater than he had ever before experienced. A CT scan was performed which revealed a disc herniation at L5-S1. (Ex. 16A). Whether this disc herniation is related (in material or major part) to the 1987 industrial accident is a complex medical question.

We generally defer to the opinion of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 65 Or App 810 (1983). We find that there are substantial reasons not to defer to claimant's treating physician in the present case.

Dr. Davidhizar, claimant's treating osteopath, reported that:

> "[Claimant's] diagnosis is herniated L5-S1 herniated disk with minor bulges at 3-4, and 4-5. Since he was complaining of the same symptoms, previous to his flareup in December [1990], I would have to conclude that this was a worsening of his previous injury." (Ex. 24).

Dr. Davidhizar further concluded that: "[claimant's] original injury is the major contribution to his present back pain and disability. * * * He also now has a ruptured disc. I am not sure if his ruptured disc was documented in the past." (Ex. 25).

We conclude that Dr. Davidhizar's opinion is conclusory, given the complex history of claimant's back conditions. Furthermore, it does not appear that Dr. Davidhizar was entirely aware of claimant's medical history. After the 1987 compensable injury, claimant did not have a herniated disc. He was diagnosed as having a herniated disc only after the December 1990 incident at his home. Dr. Davidhizar's opinion does not address this substantial change in claimant's condition, the role of the incident at claimant's home, or the effect of claimant's degenerative disease conditions. Furthermore, Davidhizar does not explain why he believes that the existence of claimant's chronic low back symptoms since 1987 supports his conclusion that the disc herniation was caused, in major part, by the 1987 injury. We do not find Davidhizar's opinion persuasive.

Claimant was examined by independent medical examiners, Dr. Rich, neurologist, and Dr. Logan, orthopedic surgeon, on June 17, 1991. (Ex. 26). Drs. Rich and Logan reported that:

> "We believe that [claimant's] current symptomatology and need for treatment is relative to a new injury, i.e., low back strain and disc herniation at L5-S1, produced by bending and twisting while arising from a seated position at home."
>
> "* * *
>
> "It would seem by longitudinal history that the patient had preexisting degenerative disc disease at multiple levels in the lumbar spine. He strained his back in late September, 1987, without subsequent imaging evidence of disc herniation at any level. He subsequently had waxing and waning symptomatology of backache consistent with his imaging demonstrated degenerative disc disease."
>
> "Subsequently a new injury occurred in December, 1990, at which time the disc at the L5-S1 level apparently herniated. We do not believe that the current disc herniation is necessarily related in any significant way to the original strain of September, 1987." (Ex. 26-6).

Although in view of claimant's permanent disability award, we take exception to that portion of Drs. Rich's and Logan's opinion which found that the 1987 sprain injury had completely resolved, on balance, we find their analysis to be more cogent than Dr. Davidhizar's; they appear more aware of the complexities of claimant's medical history. With the exception noted above, we find

their opinion to be well-reasoned and thoroughly explained. We, therefore, find it persuasive. Somers v. SAIF, 77 Or App 259 (1986). Accordingly, we conclude that claimant has failed to establish that his current herniated disc condition is related, even in a material way, to his 1987 industrial accident and injury.

Aggravation

Since claimant has failed to establish that his herniated disc condition is materially related to his compensable injury, it necessarily follows that he has not established a worsening due to his compensable injury.

ORDER

The Referee's order dated June 27, 1991, as reconsidered July 16, 1991, is reversed. The insurer's denial is reinstated and upheld. Claimant's attorney's assessed attorney fee of $2,000 is also reversed.

Board Member Gunn dissenting.

I would affirm and adopt the Referee's Opinion and Order. I disagree with my respected colleagues for the following reasons.

Claimant's treating doctor provides sufficient medical evidence to sustain claimant's burden of proof. Further, claimant's incident at home does not establish an injury. Finally, to adopt the majority's conclusion requires accepting medical opinions which are fundamentally flawed.

The majority concludes that a herniated disc was not diagnosed until after the 1990 incident at home. This is incorrect. At the time of the 1987 injury, two doctors diagnosed disc herniation. (See Exs. 2A, p.2; 4A). The herniated disc was not discovered until December of 1990.

The majority disregards Dr. Davidhizar's opinion and fails to grant the normal deference this body gives to a treating doctor. Weiland v. SAIF, 65 Or App 810 (1983). The majority declines to adopt the treating doctor's opinion because he failed to tell the majority why the 1987 CT scan did not reveal any disc abnormalities. I note, however, that this same CT scan also failed to reveal any degenerative disc disease (Ex. 4-1), which also was diagnosed later in subsequent imaging examinations. Significantly, the fact that claimant's herniated disc, like the degenerative disc disease, did not appear until a subsequent imaging examination is not unusual, but merely a reminder that reliance on technology (medical or otherwise) to answer all our questions is foolhardy.

The difficulty in determining causation from the medical evidence has been seen in other cases. Addressing this issue in Volk v. Birdseye Division, 16 Or App 349, 356 (1974), the court quoted Mr. Chief Justice Weintraub concurring in Dwyer v. Ford Motor Co., 36 N J 487, 178 A2d 161, 176 (1962). Mr. Chief Justice Weintraub stated that:

> "* * * When the possibility of causal connection is accepted, we cannot deny relief in all cases simply because science is unable decisively to dissipate the blur between possibility and probability. In such circumstances judges must do the best they can, with the hope their decisions square with the truth, and with a willingness to consider in succeeding cases whatever contribution scientific advances may offer."

Chief Justice Weintraub then added:

> "This rough basis for decision is not a happy one. A process which leads to an all-or-nothing result in so murky an area is not truly just either to the individual litigants or to the larger interests in the industrial scene. * * * "

Also see Clayton v Compensation Department, 253 Or 397, 405 (1969).

With Mr. Chief Justice Weintraub's remarks in mind, I would boldly add that Board members, like judges, also must "hope their decisions square with the truth" in light of less than perfect medical technology. Accordingly, where medical science fails to provide dispositive help, we must look to the record as a whole, with a strong foothold in logic when faced with the evidence presented.

The majority is troubled that the treating doctor did not address "the role of the incident at claimant's home." Perhaps the good doctor like myself did not consider the mundane act of standing erect as sufficient to cause an injury or qualify as an incident. Also see Tamara E. Thompson, 44 Van Natta 337, 338 (1992) (Doctor's opinion not discounted merely because he did not discuss the role that certain off-work factors could have played in causing claimant's condition where the doctor was aware of such factors and thus, had the opportunity to consider them when arriving at his opinion).

Further, inasmuch as the Board and courts have always been hesitant to infer compensable causation from chronological sequence,[1] in the present case, I find no logical reason that noncompensable causation should be inferred between a commonplace act of standing from a sitting position and claimant's herniated disc condition. See Allie v. SAIF, 79 Or App 284, 288 (1986); Bradshaw v. SAIF, 69 Or App 587 (1984); Edwards v. SAIF, 30 OR App 21 (1977) rev den 279 Or 301 (1977).

Lastly, the majority is concerned over the treating doctor's failure to address what role, if any, claimant's degenerative disc disease played in the 1990 disability. This matter and the former, seems to be an attempt to require claimant to prove a negative.

Claimant's burden is to prove that he has a worsened condition resulting from the original injury established by medical evidence supported by objective findings. ORS 656.273. Claimant's treating doctor's report meets that evidentiary requirement. The majority's conclusion, however, has effected a more arduous burden of proof by requiring claimant to prove that the "incident" at home and the disc disease are not the cause of claimant's disability and need for medical services.

To reach the same conclusion of the majority requires adopting the opinions of Drs. Rich and Logan. As the majority notes, Drs. Logan and Rich postulate that claimant's 1987 sprain injury had completely resolved. This is at odds with claimant's permanent disability award and the extensive medical history which notes continuing problems since the 1987 injury. I cannot both ignore the treating doctor and then rely upon medical opinions which are predicated on a fallacy.

Accordingly, being bound to draw from the evidence all inferences favorable to claimant and being authorized to draw inferences from circumstantial evidence, I respectfully dissent.

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[1] Post hoc ergo propter hoc ("after this hence for this") is a classic legal fable.

In the Matter of the Compensation of
GIDEON T. JACKSON, Claimant
Own Motion No. 92-0211M
OWN MOTION ORDER
Doblie, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability benefits for a worsening of his compensable pelvis and low back injury. Claimant's aggravation rights expired on January 23, 1984. SAIF opposes authorization of temporary disability compensation on the ground that claimant has withdrawn from the work force.

We may authorize, on our own motion, the payment of temporary disability compensation 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). In such cases, we may authorize the payment of compensation from the time the worker is actually hospitalized or undergoes outpatient surgery. Id.

In order to qualify for the payment of temporary disability compensation, claimant must have been in the work force at the time of the worsening. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Cutright v. Weyerhaeuser Company, 229 Or 290 (1985).

SAIF submits that claimant will not lose any income as a result of the surgery and therefore contends that claimant has withdrawn from the work force. We disagree. Whether or not claimant loses any income as a result of the surgery is not relevant to entitlement to temporary disability benefits, but rather to the amount of temporary disability benefits available. Claimant does not have to establish actual loss of wages to be entitled to benefits, but rather, must prove that because of a worsening, he was less able to work to such an extent that he was temporarily incapacitated from regularly performing work and was otherwise willing to seek work. International Paper Company v. Hubbard, 313 Or 244 (1992).

Here, claimant is self-employed, but when he is able, he is also a skilled heavy equipment operator. Dr. Momberg reports that claimant is self-employed "so that he can better manage the pain that he has in his back and still continue, Here he is asking for whatever help that might be had." Therefore, we find, as claimant is self-employed, he has not removed himself from the work force.

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning, the date he was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-12-055.

SAIF also requests the Board to authorize reimbursement from the Reopened Claims Reserve pursuant to ORS 656.625. The Court of Appeals has held that the Board lacks the authority to grant or deny reimbursement from the Reserve. See SAIF v. Holmstrom, 113 Or App 242 (1992). Accordingly, we are unable to grant SAIF's request.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by SAIF directly to claimant's attorney. See OAR 438-15-010(4); 438-15-080.

IT IS SO ORDERED.

In the Matter of the Compensation of
LISA MILES, Claimant
WCB Case No. 91-07672
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Neal's order that dismissed her request for hearing on the ground that claimant had abandoned her request for hearing. In her appellant's brief, claimant's counsel requests that the matter be held in abeyance for a designated period of time "pending notification from claimant." On review, the issue is the propriety of the dismissal. We affirm.

FINDINGS OF FACT

Claimant requested a hearing on June 27, 1991 from the insurer's May 10, 1991 denial. A hearing was set for September 16, 1991.

Claimant did not appear at hearing, however her counsel did appear. Claimant's counsel had not been able to contact her and did not have her current address. Notice of hearing that had been sent to claimant had been returned to the Board and then to claimant's counsel.

At hearing, claimant's attorney moved to reset the hearing on the basis that he was going to withdraw as counsel. Claimant's counsel was not willing to proceed on the merits and he moved for postponement of the hearing.

The insurer moved for dismissal and the Referee granted the motion to dismiss the hearing request on the ground that claimant had abandoned her request for hearing by not remaining in contact with her attorney or the Board.

After the Referee's order issued, claimant's counsel requested Board review, contending that his client had not received a Notice of Hearing.

CONCLUSIONS OF LAW AND OPINION

OAR 438-06-071 provides that:

> "(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."

OAR 438-06-081 provides, in relevant part:

> "A scheduled hearing shall not be postponed except by order of a referee upon a finding of extraordinary circumstances beyond the control of the party or parties requesting postponement."

In the present case, we first address whether the Referee properly denied the motion to postpone the hearing. If the Referee correctly denied postponement, we then determine whether the Referee properly dismissed claimant's hearing request on the ground of abandonment.

At the outset, we find that the record is sufficiently developed to determine whether a postponement was justified. Here, claimant's counsel appeared at

hearing and stated that claimant had not contacted his office and all correspondence to claimant from her attorney and the Hearings Division had been returned unanswered.

We have previously held that, in a case in which a claimant knows that a request for hearing has been made but fails to maintain contact with the Hearings Division and his attorney, his contention that he did not receive notice of the hearing date does not establish extraordinary circumstances beyond his control, sufficient to justify postponement. See Jose Arisqueta-Martinez, 42 Van Natta 2072 (1990). Here, claimant was the party requesting a hearing. As in Arisqueta-Martinez, claimant did not maintain contact with the Board or her attorney. Under the circumstances, we find that the Referee properly denied claimant's motion to postpone.

Finally, although we do not find evidence that, at the time of hearing, claimant's conduct resulted in an unjustified delay in the hearing of more than 60 days, we nonetheless affirm the Referee's dismissal. OAR 438-06-071 also provides that a request for hearing may be dismissed if a referee finds that the party that requested the hearing has abandoned the request for hearing.

Here, the Referee found, and we agree, that claimant's failure to remain in contact with either her attorney or the Hearings Division constituted abandonment of her request for hearing. We, therefore, find that the Referee properly dismissed claimant's request for hearing pursuant to OAR 438-06-071.

ORDER

The Referee's order dated September 17, 1991 is affirmed.

June 16, 1992 Cite as 44 Van Natta 1157 (1992)

In the Matter of the Compensation of
JOHN L. LAW, Claimant
WCB Case Nos. 91-00219 & 90-20445
ORDER OF ABATEMENT
Aller & Morrison, Claimant Attorneys
Gail M. Gage (Saif), Defense Attorney
Scheminske & Lyons, Defense Attorneys

The SAIF Corporation requests reconsideration of that portion of our June 4, 1992 Order on Review which awarded claimant a $1,500 insurer-paid attorney fee under ORS 656.386(1) to be paid by SAIF (the insurer who was not found responsible for the claim), when SAIF conceded the compensability portion of its denial prior to hearing. Contending that the statutory provision which we relied on in awarding the attorney fee is not applicable to this situation, SAIF asks that we withdraw the $1,500 award.

In order to consider SAIF's motion, we withdraw our June 4, 1992 order in its entirety. Should claimant and Cigna Insurance wish to respond to SAIF's motion, they should do so within 14 days from the date of this order. Thereafter, we shall take SAIF's motion under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
ANN M. DOLBERG, Claimant
WCB Case No. 90-13097
ORDER ON REVIEW
Daniel Snyder, Claimant Attorney
H. T. Anderson (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

The SAIF Corporation requests review of those portions of Referee Hoguet's order that: (1) directed it to pay a medical bill for claimant's hand therapy; (2) assessed a penalty for its failure to pay the medical bill; (3) directed it to pay interim compensation for the period from August 28, 1990 through September 27, 1990; and (4) assessed a penalty for its failure to pay the interim compensation. On review, the issues are medical services, interim compensation, and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "FINDINGS OF FACT," with the following correction. Claimant began hand therapy on August 15, 1990, not September 5, 1990 as the Referee found.

CONCLUSIONS OF LAW AND OPINION

Medical Services

The Referee ordered SAIF to pay the hand therapy bill on the basis that SAIF offered no reason for refusing to pay the bill. On review, SAIF argues that the hand therapy was noncompensable palliative treatment and that it was not compensable as treatment for a worsened condition.

We agree with the Referee. The record shows that SAIF paid a portion of the hand therapy bill in October 1990. (Ex. 35). Therefore, SAIF had notice of the bill by that time. Yet, SAIF neither paid nor denied payment of the bill by the time of hearing in March 1991. In her amended hearing request, claimant raised non-payment of the bill as an issue at hearing. SAIF did not respond to that issue and, at hearing, SAIF did not raise any defense or reason for not paying the bill. After the Referee issued his order, SAIF filed a motion for reconsideration raising, for the first time, the argument that the hand therapy was noncompensable palliative treatment.

We have previously held that an insurer may not deny a claim on one basis, proceed to hearing on that basis and then, during closing arguments, raise a new basis for denial. See Jefferson S. Case, 44 Van Natta 1007 (1992); Ricardo Aguas, 41 Van Natta 2783 (1990), aff'd 109 Or App 220 (1991); Edward A. Rankin, 41 Van Natta 1926, on recon 41 Van Natta 2133 (1989). Correspondingly, an insurer may not remain silent regarding its nonpayment of a medical bill, proceed to hearing and then, after the issuance of a referee's order, raise a basis for not paying the bills.

Additionally, there is medical evidence in the record relating claimant's need for hand therapy to her compensable right hand condition. Dr. Layman, attending hand surgeon, explained that the hand therapy was needed to increase function and decrease symptoms due to the compensable condition. (Exs. 27, 29).

Accordingly, we conclude that, because SAIF did not raise a defense at hearing to non-payment of the hand therapy bill, it is now precluded from raising a defense and must pay the bill. We also agree that the Referee's assessment of a penalty for non-payment of the bill is appropriate.

Interim Compensation

The Referee found that SAIF conceded it owed claimant interim compensation for the period from August 27, 1990 through September 27, 1990. On review, SAIF argues that it made no such concession and that claimant is not entitled to interim compensation because it did not receive notice of claimant's medically verified inability to work due to a worsening of the compensable injury. We agree.

There is no indication in the record that SAIF conceded that claimant is entitled to interim compensation. Therefore, we do not find that such a concession was made. Proceeding to the merits, an insurer's duty to pay interim compensation under ORS 656.273(6) is not triggered until the insurer receives medical verification of an inability to work due to a worsening of a compensable injury. Silsby v. SAIF, 39 Or App 555, 563 (1979).

Here, claimant relies on Dr. Layman's handwritten note dated August 28, 1990, that claimant is "unable to do rapid repetitive wrist or finger movement with right hand until further written notice." (Ex. 24). However, the note is not sufficient, because it did not indicate that claimant is unable to work and that her inability is due to a worsening of her compensable condition. Therefore, we do not find that the note triggered SAIF's obligation to pay interim compensation.

Inasmuch as SAIF did not receive medical verification of claimant's inability to work due to a worsening of the compensable injury before September 29, 1990 (see Ex. 27), we reverse the Referee's award of interim compensation. We also reverse the Referee's assessment of a penalty based on the award of interim compensation.

Attorney Fee on Review

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review concerning the medical service 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 attorney's services on review concerning the medical services issue is $400, to be paid by the SAIF Corporation. 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 April 15, 1991, is affirmed in part and reversed in part. Those portions of the order that awarded claimant interim compensation for the period from August 28, 1990 through September 27, 1990, and assessed a penalty based on that compensation, are reversed. The remainder of the Referee's order is affirmed. For services on review concerning the medical services issue, claimant is awarded an assessed attorney fee of $400, payable by the SAIF Corporation.

In the Matter of the Compensation of
RICHARD A. FRIEND, Claimant
WCB Case No. 91-04181
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Hooton and Brazeau.

The insurer requests review of that portion of Referee Peterson's order that increased claimant's unscheduled permanent disability award from 31 percent (99.2 degrees), as awarded by an Order on Reconsideration, to 92 percent (294.4 degrees). Claimant cross-requests review of that portion of the order that declined to grant permanent total disability. On review, the issue is extent of unscheduled permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

The Referee concluded that claimant had failed to prove that he is permanently and totally disabled. We agree.

To prove entitlement to permanent total disability, claimant must establish that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206; Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Because claimant retains some physical capacity, the question is whether claimant has established permanent and total disability under the "odd lot" doctrine, under which a disabled worker may remain capable of performing work of some kind, but still be foreclosed from obtaining gainful employment due to a combination of medical and nonmedical disabilities. Welch v. Banister Pipeline, 70 Or App 699 (1984). Claimant also must establish that he is willing to seek regular gainful employment and has made reasonable efforts to obtain such work, unless such efforts would be futile. SAIF v. Stephen, 308 Or 41 (1989).

Claimant contends that his age of 56 years, his limited education, lack of transferable skills and physical disabilities currently preclude him from gainful employment. He relies on the opinion of Ms. Betty Nelson, a rehabilitation consultant, who believes that claimant requires training to reenter the job market in a suitable occupation. Nelson's statement, however, was made with reference to a report prepared by another rehabilitation counselor, Ms. Kathy Wallace, who concluded that her labor market research efforts "failed to yield any suitable occupation where [claimant] could be reemployed at a wage as close as possible to his wage earned at the time of injury." (Ex. 10D). That conclusion does not establish that claimant is precluded from gainful employment for purposes of determining permanent and total disability. As explained by the court in Tee v. Albertsons, Inc., 107 Or App 638 (1991), "gainful" employment as used in ORS 656.206, is not measured in terms of a claimant's level of earnings. The court held that a claimant who is capable of regularly performing any service for which there exists a hypothetically normal labor market can be "gainfully" employed, even if the employment may not pay as well as the claimant's preinjury occupation.

Here, despite her conclusion that claimant would be unable to return to work at a wage equal to his wage at the time of injury without retraining, Wallace found claimant currently employable at several entry level positions identified in the labor market. Likewise, Mr. Michael Viegas, claimant's current rehabilitation counselor, testified at hearing that, while claimant probably needs training to obtain employment at a wage equal to his preinjury occupation, claimant is currently employable at other occupations. Based on that evidence, as well as our review of the record as a whole, we agree with the Referee's conclusion that claimant is not entitled to an award of permanent total disability.

Unscheduled Permanent Disability

The Referee awarded claimant benefits for 92 percent unscheduled permanent partial disability. After our review of the record, we agree and adopt his conclusions and reasoning with the following supplementation.

The Referee concluded that claimant was entitled to a formal education value of 1, because he did not graduate from high school. Former OAR 436-35-300(3). The insurer contends that, contrary to the Referee's finding, claimant did graduate from high school and even completed two years of college. Accordingly, it argues that the appropriate value for claimant's formal education is 0. We disagree. At hearing, claimant testified that he did not graduate from high school and persuasively explained prior discrepancies. Moreover, his rehabilitation counselor reported that his academic achievement scores were consistent with someone who had dropped out of high school and had no college education. On this record, we agree with the Referee's finding that claimant did not graduate from high school and, therefore, is entitled to a formal education value of 1.

The insurer also argues that the Referee erred in awarding claimant benefits for the partial removal of posterior elements of the C4, 5, 6 and 7 discs. Relying on the December 28, 1989 surgery report, the insurer contends that no posterior elements were removed and that claimant's fascia was simply incised on the left and the musculature was elevated so that the spinous process and lamina of the cervical spine could be visualized. We do not fault the insurer's interpretation of the operative report. However, Dr. Mason, who performed the procedure, rated claimant as having such an impairment in a later report. Under those circumstances, we defer to the treating surgeon's conclusions regarding the surgical report and procedure, and affirm the Referee's award.

Attorney Fee on Review

Because the insurer initiated the request for review regarding the extent of claimant's unscheduled permanent partial disability and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an assessed 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 attorney's services on review is $800, 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 July 22, 1991 is affirmed. For services on Board review, claimant's attorney is awarded a reasonable fee of $800, to be paid by the insurer.

In the Matter of the Compensation of
ARLENE M. MASON, Claimant
WCB Case Nos. 91-02032, 90-12679 & 90-14269
ORDER ON REVIEW
Coughlin, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

Scott Wetzel Services (Scott Wetzel) requests review of Referee Tenenbaum's order that: (1) set aside its denial of claimant's occupational disease claim for her right carpal tunnel condition; and (2) upheld Lumbermen's Underwriting Alliance (Lumbermen's) denial of claimant's claim for the same condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of the last sentence in that section.

CONCLUSIONS OF LAW AND OPINION

Claimant filed her requests for hearing after May 1, 1990 and the hearing convened on April 16, 1991. Consequently, we analyze this matter under the Workers' Compensation Law as amended effective July 1, 1990. See Ida M. Walker, 43 Van Natta 1402 (1991).

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

Compensability

On review, Scott Wetzel argues that claimant's right carpal tunnel condition is not compensable because claimant did not miss work as a result of her condition and she never sought treatment specifically for her right carpal tunnel syndrome.

The Referee found, and we agree, that claimant first sought treatment for right wrist pain from Dr. Nelson, D.O., in March 1990. Dr. Nelson referred claimant to Dr. Hendricks, M.D., in April 1990. Dr. Hendricks found decreased grip strength on the right and decreased awareness to pinprick on the right hand. Based upon claimant's test results, Dr. Hendricks diagnosed right carpal tunnel syndrome "most likely related to work activity." He subsequently recommended a wrist splint and/or injection into the carpal tunnel.

On May 17, 1990, Dr. Flanagan, M.D., performed an independent medical exam and diagnosed overuse syndrome of the right upper extremity which resulted in (among other things) "early signs of right carpal tunnel syndrome including mildly abnormal nerve conduction studies." Dr. Flanagan concurred with Dr. Hendricks and opined that claimant's work was a significant contributing factor.

Finally, in October 1990, Dr. Alanko, M.D., reported that claimant had carpal tunnel entrapment in addition to her shoulder problems. He believed that both problems were "due to her employment."

We conclude that claimant has established that work is the major contributing cause of her right carpal tunnel condition. Moreover, although Scott Wetzel argues that the opinion of claimant's chiropractor, Dr. Nelson, should be discounted because he diagnosed bilateral carpal tunnel, we note that Dr. Nelson referred claimant to Dr. Hendricks for such testing. Additionally, we find Dr. Hendricks' opinion to be thorough and well-reasoned. Accordingly, we find that the persuasive medical evidence in the record establishes that work is the major cause of claimant's carpal tunnel condition.

Responsibility

At the outset, we agree with the Referee that section 49 of SB 1197, codified at ORS 656.308, does not apply in this case, as claimant does not have an accepted right wrist claim. See Fred A. Nutter, 44 Van Natta 854 (1992) (Application of ORS 656.308(1) assumes that there is a compensable injury and that the initially responsible insurer is seeking to shift further liability to another insurer/employer). Consequently, the Referee correctly applied the law in effect prior to the 1990 amendments.

Here, claimant first experienced right wrist problems while Lumbermen's was on the risk. She again experienced wrist problems after Scott Wetzel went on the risk in September 1989. Moreover, claimant's work while Lumbermen's and Scott Wetzel were on the risk involved jobs requiring repetitive hand and wrist activity and constitutes the type of employment situation in which any of the work exposures could have caused disability. See Linda L. Wise, 42 Van Natta 115 (1990).

Accordingly, because claimant has established that her employment caused the occupational disease, responsibility is initially assigned to the last employment which at the time of the onset of disability could have contributed to the occupational disease. In the absence of disability, responsibility is assigned to the employer/insurer on the risk at the time of the first medical treatment for the occupational disease. See Medford Corp. v. Smith, 110 Or App 486 (1992).

Here, the parties agree, and the record establishes, that claimant did not miss work due to her right carpal tunnel condition. Accordingly, we must determine which carrier was on the risk at the time claimant sought medical treatment for her right wrist.

Scott Wetzel argues that, although claimant never treated specifically for right wrist pain, she did complain to her doctors about wrist pain during the time she was treating for her back and neck condition. Therefore, Scott Wetzel contends that claimant first sought treatment while Lumbermen's was on the risk. We disagree.

There is no persuasive evidence that claimant sought or specifically received medical treatment for her right carpal tunnel syndrome condition before she sought treatment from Dr. Nelson in March 1990. We agree with the Referee's conclusion that responsibility is initially assigned to Scott Wetzel, as it was the carrier on the risk at the time claimant first sought treatment.

Finally, we find that responsibility does not shift to Lumbermen's, as Scott Wetzel has failed to establish that claimant's work while Lumbermen's was on the risk was the sole cause of her need for treatment. Moreover, Scott Wetzel has not established that, during its coverage, it was not possible for claimant's work to have caused her right carpal tunnel condition. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370 (1984) clarified 73 Or App 223 (1985). Accordingly, responsibility remains with Scott Wetzel.

Attorney fees

Scott Wetzel requested Board review and contested compensability and responsibility. Claimant's counsel participated on Board review submitting an appellate brief. Inasmuch as claimant's compensation has not been reduced or disallowed, we conclude that claimant's attorney is entitled to a fee for services on Board review under ORS 656.382(2), payable by Scott Wetzel.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $700 is a reasonable assessed fee for claimant's counsel's effort on review. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues presented and the value of the interest involved.

ORDER

The Referee's order dated August 5, 1991 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $700, payable by Scott Wetzel.

In the Matter of the Compensation of
DORIS S. KLAGER, Claimant
WCB Case No. 90-08318
ORDER DENYING RECONSIDERATION
Goldberg & Mechanic, Claimant Attorneys
Schwabe, et al., Defense Attorneys

On May 19, 1992, the Board issued an Order on Review which: (1) set aside a Determination Order as premature and remanded the claim to the self-insured employer for further processing according to law; (2) awarded temporary total disability from December 22, 1989 to February 12, 1990; (3) assessed a penalty equal to 25 percent of the temporary total disability due between December 22, 1989 and February 12, 1990 (to be shared equally by claimant and her attorney); (4) awarded claimant's attorney an out-of-compensation fee equal to 25 percent of the increased compensation created by the Board's order, not to exceed $3,800; and (5) awarded claimant's attorney a carrier-paid fee of $1,500 for services at hearing and on review pertaining to the employer's contention at hearing and on review that claimant was medically stationary on November 10, 1989.

The Board has received a letter from a claims examiner for the employer's claims administrator. The letter seeks "clarification" of the Board's May 19, 1992 order. Inasmuch as the claims administrator is a corporation and since the submission has not been submitted by a member of the Oregon State Bar, the request is not properly before us. See OAR 438-06-100(1). Consequently, we decline to reconsider the Board's May 19, 1992 order.

Nevertheless, had we responded to the request for clarification, we would have disagreed with the suggestion that claimant's $1,500 carrier-paid attorney fee award be reduced. In doing so, we would further note that the penalty assessed in the Board's May 19, 1992 order (to be shared equally between claimant and her attorney) is in lieu of, rather than in addition to, the penalty assessed by the Referee's order. Finally, since the Determination Order has been set aside and the claim remanded for further processing in accordance with law, we would disagree with the observation that the Board's order did not result in increased compensation.

Accordingly, the request for "clarification" is denied. The parties' rights of appeal shall continue to run unabated from the date of our May 19, 1992 order.

IT IS SO ORDERED.

June 19, 1992 Cite as 44 Van Natta 1165 (1992)

In the Matter of the Compensation of
DAGOVERTO R. BENAVIDEZ, Claimant
WCB Case No. 90-19282
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Westerband and Moller.

Claimant requests review of Referee Otto's order which: (1) upheld the self-insured employer's aggravation denial; and (2) upheld the employer's denial of an occupational disease claim for his spondylolysis condition. On review, the issues are aggravation and compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Aggravation

The Referee found that claimant's work activities in 1989 and 1990 caused the symptoms of his compensable 1987 low back strain to wax and wane but they did not cause a worsening of the underlying condition. Therefore, the Referee concluded that claimant had failed to establish a compensable aggravation. We agree with the Referee's ultimate conclusion; however, we apply the following analysis.

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement or award of compensation. ORS 656.273(1). To prove a compensable worsening of his unscheduled low back strain 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 worsening must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

It is also claimant's burden to prove that he has sustained a worsening of his compensable 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 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, supra; see also International Paper Co. v. Turner, 91 Or App 91, rev den 307 Or 101 (1988).

Claimant's back strain condition was closed by Determination Order on June 3, 1988, and an October 18, 1988 Stipulation increased his unscheduled permanent disability award to 27 percent. As a result of increased low back pain,

claimant returned to his treating physician, Dr. Gambee, orthopedic surgeon in June 1990. In December 1990, Dr. Gambee reported that claimant's low back strain had been "persisting with intermittent exacerbations and remissions." (Ex. 18-3). In February 1991, Dr. Gambee opined that claimant had "decompensated as a result of his work activities and become [sic] symptomatic as a result of his work." (Ex. 27). Drs. Gripekoven and Neufeld, independent medical examiners, opined that claimant had experienced a symptomatic flareup of his back symptoms in June 1990, attributed to his underlying condition associated with increased physical activity. (Exs. 17; 22; 25).

Under the circumstances, we are persuaded that claimant has established a symptomatic worsening of his back strain condition. We also find that this is supported by objective findings in the reports of Dr. Gambee. See Suzanne Robertson, 43 Van Natta 1505 (1991); Jacqualyn L. Hetrick, 43 Van Natta 2357 (1991) ("objective findings" may be determined by a physician's evaluation of the worker's description of the pain he is experiencing). Accordingly, we conclude that claimant has established a symptomatic worsening of his compensable back strain condition.

Although claimant has established a worsening of his condition, he must also establish that this worsening has resulted in diminished earning capacity. Smith v. SAIF, supra. Here, Dr. Gambee took claimant off work from June 20, 1990 to July 16, 1990. Therefore, we conclude that claimant has established a worsening of his condition resulting in diminished earning capacity. However, because claimant has previously been awarded unscheduled permanent disability, he must also show that the worsening of his condition resulting in diminished earning capacity is more than a waxing and waning of symptoms contemplated by the previous permanent disability award. ORS 656.273(8).

Here, claimant's last award of compensation was the October 1988 Stipulation which increased his unscheduled permanent disability award to 27 percent. The Stipulation did not recite that it was in anticipation of future waxing and waning. However, on May 5, 1988, Dr. Gambee reported that claimant "has a fairly common developmental defect in the lumbar spine, which tends to produce an unstable situation, and recurrent episode of back pain." (Ex. 9-2). Further, as early as 1987, Dr. Gambee predicted that claimant's symptoms would wax and wane with increased physical activity. (Ex. 5-6).

Under the circumstances, we find that claimant has failed to establish that his worsening is more than a waxing and waning of symptoms contemplated by the previous permanent disability award. Accordingly, we agree with the Referee that claimant has failed to establish a compensable aggravation.

Occupational Disease

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

Claimant bears the burden of proving by a preponderance of the evidence that his work exposure in the form of a series of traumatic events or occurrences was the major contributing cause of a worsening of his preexisting spondylolysis condition resulting in his disability or need for medical treatment. ORS 656.802(1)(c) and (2). Here, Dr. Gambee reported that:

> "I disagree . . . that the major contributing cause of his current problem and need for treatment is the spondylolysis. The spondylolysis made him vulnerable to a back sprain. The back sprain was the thing that I was trying to treat. The spondylolysis simply made him easy to sprain. It did not cause this need for treatment,

but rather caused his back sprain. The latter was the thing I was treating . . ." (Ex. 27).

Accordingly, we agree with the Referee that claimant has not met his burden of proving that work activities were the major contributing cause of a worsening of his preexisting spondylolysis condition resulting in his need for medical treatment or disability.

ORDER

The Referee's order dated May 3, 1991 is affirmed.

June 19, 1992 Cite as 44 Van Natta 1167 (1992)

In the Matter of the Compensation of
MICHAEL A. FERDINAND, Claimant
WCB Case Nos. 91-09632 & 91-17972
ORDER DENYING MOTION TO DISMISS
Merrill Schneider, Claimant Attorney
Sally A. Cooper, Defense Attorney

Claimant has moved for an order dismissing the insurer's request for Board review, contending that the insurer has not timely filed a request for review in accordance with statutory requirements. The motion to dismiss is denied.

FINDINGS OF FACT

On March 6, 1992, Referee Mills issued an Opinion and Order. The order contained a statement explaining the rights of the parties under ORS 656.289(3) and 656.295. On March 11, 1992, the insurer requested abatement and reconsideration of the Referee's order. Specifically, the insurer sought clarification of the amount of an out-of-compensation attorney fee granted by the Referee's order, which was set forth in the "Order" portion of the Referee's opinion as $450.

On March 31, 1992, the Referee issued an Amended Opinion and Order, which modified the out-of-compensation attorney fee award from $450 to $420. The March 31, 1992 order contained a statement explaining the rights of the parties under ORS 656.289(3) and 656.295.

On April 3, 1992, the insurer mailed by certified mail a request for review to the Board. The request stated that the insurer was seeking Board review of "Referee John Mark Mill's [sic] order dated March 6, 1992." The request, which carried the correct WCB case number, also indicated that copies of the request had been provided to all parties to the proceeding before the Referee.

On April 9, 1992, the Board mailed a computer-generated letter to the parties acknowledging the request for review.

On April 30, 1992, claimant mailed by certified mail a request for Board review of the Referee's March 31, 1992 order. On May 11, 1992, claimant's "cross-request" for review was acknowledged by the Board.

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 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). The necessary function of notice statutes is to inform the parties of the issues in sufficient time to prepare for an adjudication. Nollen v. SAIF, 23 Or App 420, 423 (1975) rev den (1976).

The time within which to appeal an order continues to run unless the order 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, claimant asserts that, although the insurer requested review of the Referee's March 6, 1992 order, the insurer failed to request review of the Referee's March 31, 1992 amended order. Under such circumstances, claimant contends that "[t]he appeal should be dismissed." We disagree.

The insurer's April 3, 1992 request did state that it was seeking review of the Referee's "March 6, 1992" order. Nevertheless, since the Referee's March 6, 1992 order had been expressly amended by the March 31, 1992 order in response to the insurer's motion for reconsideration, we conclude that the insurer's intentions were obvious. It was seeking Board review of the March 6, 1992 order, as modified by the March 31, 1992 amended order. Inasmuch as the insurer's request was mailed within 30 days of the issuance of the Referee's March 31, 1992 Amended Opinion and Order, we conclude that we have jurisdiction to consider this matter. See ORS 656.289(3); Farmers Insurance Group v. SAIF, supra; Rudolph A. Beeman, 43 Van Natta 55 (1991); Mary C. Chard, 39 Van Natta 786 (1987).

Accordingly, the motion to dismiss is denied. As a result of claimant's motion, the following revised briefing schedule will be implemented. Claimant's respondent's/cross-appellant's brief shall be due 21 days from the date of this order. The insurer's reply/cross-respondent's brief will be due 14 days from the date of mailing of claimant's respondent's/cross-appellant's brief. Claimant's cross-reply brief will be due 14 days from the date of mailing of the insurer's reply/cross-respondent's brief. Thereafter, this case shall be docketed for review.

IT IS SO ORDERED.

In the Matter of the Compensation of
RALPH E. FRITZ, Claimant
WCB Case No. 90-21853
ORDER ON REVIEW (REMANDING)
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Michael V. Johnson's amended order of dismissal. On review, the issue is whether the Hearings Division has jurisdiction over claimant's request for hearing. We conclude that we have jurisdiction to address claimant's procedural entitlement to temporary disability, penalties and attorney fees, and remand to the Referee for further proceedings concerning

those issues. Consequently, we affirm in part, vacate in part, and remand in part.

FINDINGS OF FACT

On November 11, 1990, the insurer accepted claimant's claim for lumbosacral strain, classifying it as a nondisabling injury. (Ex. 8). On that same date, the insurer also issued to claimant a notice of claim closure and indicated that no time loss or medical compensation had been paid. (Ex. 9).

On December 10, 1990, the Hearings Division received claimant's request for hearing. Claimant identified temporary partial disability, temporary total disability, penalties and attorney fees, and entitlement to compensation as those issues to be litigated at hearing.

After convening a hearing on February 28, 1991, the Referee issued an order dismissing the request for hearing based on lack of jurisdiction. The Referee subsequently granted claimant's request for reconsideration. After considering the parties' additional arguments, the Referee issued an amended order of dismissal, again finding that he lacked jurisdiction to consider the request for hearing. The Referee admitted written exhibits into the record at hearing but took no oral testimony.

CONCLUSIONS OF LAW AND OPINION

At hearing, the Referee interpreted claimant's request for hearing as raising a challenge to the insurer's Notice of Closure. He concluded that the Hearings Division lacked jurisdiction over this issue. We agree with, and adopt, his analysis concerning jurisdiction over the Notice of Closure. However, although claimant does not contest the Referee's basic premise that the Hearings Division lacks jurisdiction to hear a direct challenge to a Notice of Closure, claimant nevertheless contends that his request for hearing raised his entitlement to interim compensation as an issue and that the Hearings Division has jurisdiction over this issue of procedural entitlement to temporary disability.

We agree that claimant's specification of issues can reasonably be interpreted as raising the issue of interim compensation. See Liberty Northwest Ins. Corp. v. Alonzo, 105 Or App 458 (1991). Moreover, the issue of interim compensation was clearly noted in claimant's May 15, 1991 letter to the Referee. Accordingly, we next address the jurisdiction of the Hearings Division to consider this issue.

We recently considered our jurisdiction to address procedural entitlement to temporary disability in our order on reconsideration in Steven V. Bischoff, 44 Van Natta 255, on recon 44 Van Natta 433 (1992). In that case, the claimant's accepted injury was classified as nondisabling. The claimant requested a hearing; the Referee concluded that the injury had become disabling. On review, we applied ORS 656.277(1), which requires the carrier to report a worker's claim that a nondisabling injury is disabling to the Director for determination pursuant to ORS 656.268. Id. at 255. Therefore, because the Evaluation Section had not issued a determination pursuant to ORS 656.268(11), we concluded that we lacked jurisdiction to address the matter. Id. at 256.

On reconsideration, however, we found that the actual issue presented was claimant's procedural entitlement to temporary disability benefits. Id. at 434. Because that issue was not within the disabling/nondisabling status issue, over which the Director had jurisdiction, or the substantive entitlement issue, which would be determined at claim closure, we found that we had jurisdiction to

address it under ORS 656.283(1). See id. We find that the same reasoning applies to this case. Therefore, the issues of interim compensation and penalties and attorney fees are properly before us.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Given the lack of oral testimony, we find that the record is incompletely and insufficiently developed with regard to the issues of interim compensation and penalties and attorney fees. See Charles A. Butler, 44 Van Natta 994, 996 (1992). We therefore find it appropriate to remand this matter to the Referee for further proceedings consistent with this order.

Accordingly, we affirm the Referee's amended order of dismissal insofar as it pertained to a lack of jurisdiction regarding the notice of closure. However, because we find that Referee Michael V. Johnson had jurisdiction to consider claimant's contention regarding procedural entitlement to temporary disability and penalties and attorney fees, we remand this case to the Referee for further proceedings to determine claimant's entitlement, if any, to interim compensation as well as penalties and attorney fees for the insurer's allegedly unreasonable conduct. Following those proceedings, the Referee shall issue a final appealable order concerning those matters.

ORDER

The Referee's amended order dated June 5, 1991 is affirmed in part and vacated in part. The order is affirmed to the extent that it dismissed claimant's request for hearing regarding any objections to the notice of closure. We vacate the order to the extent that the Referee concluded that he was without jurisdiction to consider claimant's entitlement to procedural temporary disability and penalties and attorney fees. Consideration of those issues is remanded to Referee Michael V. Johnson for further proceedings consistent with this order.

June 19, 1992 Cite as 44 Van Natta 1170 (1992)

In the Matter of the Compensation of
JOHN M. McMILLEN, Claimant
WCB Case Nos. 91-02068 & 91-14973
ORDER ON REVIEW (REMANDING)
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Thye's order which: (1) held that the Hearings Division lacked original jurisdiction to consider claimant's contention that his claim was prematurely closed by a Determination Order; (2) found that claimant was not entitled to temporary disability prior to March 25, 1991; and (3) declined to assess penalties and attorney fees for allegedly unreasonable claim processing. Noting that the Referee "inadvertently excluded" an exhibit from the record, the parties jointly seek remand for the introduction of the omitted exhibit (Ex. 34). We grant the motion for remand.

Should we determine that a case has been improperly, incompletely, or otherwise insufficiently developed, we may remand to the Referee for further evidence taking, correction, or other necessary action. ORS 656.295(5).

Here, the parties have jointly moved for remand for the admission of Exhibit 34, which is apparently a March 1991 medical report from Dr. Hansen,

claimant's treating physician. This report was timely submitted by claimant's attorney in advance of hearing. At the hearing, the Referee stated that the parties had agreed which exhibits were relevant and that the insurer's counsel would be submitting those exhibits and an exhibit list following the hearing. Thereafter, the employer's counsel submitted exhibits and an exhibit list which omitted Exhibit 34. In issuing his order, the Referee likewise omitted Exhibit 34 from inclusion in the record.

In seeking remand for the admission and consideration of Exhibit 34, the parties agree that the exhibit was "inadvertently excluded" from evidence. We interpret such a statement to mean that the parties stipulated at hearing that the exhibits which the insurer's counsel would be providing to the Referee following the hearing would include Exhibit 34 and that the insurer's counsel unintentionally omitted the exhibit from the materials and exhibit list submitted to the Referee for admission into the record.

Considering the aforementioned circumstances, we find that this case has been improperly, incompletely, or otherwise insufficiently developed, and conclude that remand is an appropriate action. ORS 656.295(5). Accordingly, this matter is remanded to Referee Thye for further proceedings. These proceedings may be conducted in any manner that the Referee concludes will achieve substantial justice and ensure a complete and accurate record. The limited purpose of the proceedings is to obtain a copy of Exhibit 34 and admit the exhibit into the record. No additional exhibits or testimony shall be admitted. Thereafter, the Referee shall issue a final, appealable order on reconsideration.

ORDER

The Referee's order dated March 31, 1992 is vacated. This case is remanded to Referee Thye for further proceedings consistent with this order.

June 19, 1992 Cite as 44 Van Natta 1171 (1992)

In the Matter of the Compensation of
HEATH A. NICKEL, Claimant
WCB Case No. 91-07230
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Thomas Ewing (Saif), Defense Attorney

Reviewed by Board Members Moller and Westerband.

The SAIF Corporation requests review of Referee Mills' order which set aside its denial of claimant's left ankle injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, but with the following modifications and supplementation.

At one point while claimant was "messing around" with his co-worker, Alan Braguy, Alan was on claimant's back, with claimant holding Alan's neck and head and one leg. (Tr. 19, 28-29). It was at this point that co-worker Ron Maxwell observed the wrestling. Alan said that claimant was moving around in circles, while he (Alan) tried to get off his back. Then claimant fell, and Alan fell at the same time. (Tr. 29).

The employer did not condone wrestling on the premises, nor was he aware that claimant had engaged in wrestling prior to the incident in which he injured his ankle. (Tr. 38; see also Tr. 21, 25, 32).

FINDINGS OF ULTIMATE FACT

In lieu of the Referee's finding, we find that claimant was not injured during the course and scope of his employment.

CONCLUSIONS OF LAW AND OPINION

The Referee held that the court's reasoning in Brown v. Liberty Northwest Ins. Co., 105 Or App 92 (1990) should guide the outcome in this case. However, unlike the Brown case, the Referee here found that horseplay in general was commonplace during work, and that it was more acquiesced in than prohibited. Based on these findings, he concluded that claimant's injury occurred during the course and scope of his employment. We disagree.

In this case, claimant fell and injured his left ankle as a result of wrestling with a co-worker. Claimant was performing his work duties when he walked to another area of the building where he worked, encountered his co-worker Alan Braguy, and engaged him in a brief period of wrestling. The activity was done in "good fun," without anger. Claimant had engaged in similar "horsing around" with co-workers previously in this job. (Tr. 10-11). The activity ended when claimant fell, injuring his ankle. (Tr. 28-29; cf. Tr. 13-15).

ORS 656.005(7)(a) defines a "compensable injury" as an accidental injury arising out of and in the course of employment. In order to establish that his injury arose "out of and in the course of employment," claimant must prove that his injury is sufficiently work-related to be compensable under the unitary work-connection test. See Rogers v. SAIF, 289 Or 633 (1980); Mellis v. McEwen, Hanna, Gisvold, 74 Or 572, 575, rev den 300 Or 249 (1985).

In Brown v. Liberty Northwest Ins. Co., supra, the court made it clear that injuries arising from horseplay are not automatically work-related, and that "claimant must show a causal link between the occurrence of the injury and a risk connected with his or her employment." 105 Or App at 96, 95. In Brown, the court affirmed the Board's finding that claimant's injury, incurred when he jumped over a pile of lumber while "horsing around" with a co-worker, was not compensable. See Robert R. Brown, 42 Van Natta 862, 863 (1990), aff'd Brown v. Liberty Northwest Ins. Co., supra.

The Court of Appeals has identified 7 factors to consider in evaluating whether an activity at the time of injury is work-related: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employee; (3) whether the activity was an ordinary risk of, and incidental to, the employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed by or acquiesced in by the employer; and (7) whether the employee was on a personal mission of his own. Mellis, supra at 574. While all 7 factors are considered, no one factor is dispositive. Id.

In the instant case, we find that claimant's wrestling activity did not benefit the employer, who is engaged in the business of repairing and painting cars and needs to protect freshly painted cars from dust, dirt and scratching. (Tr. 36-37). Claimant asserts that the shop was a "fun" place to work, and that having a relaxed work place and happy work force is a benefit to the employer. However, we have previously held that the benefit must go beyond improved

employee morale, in order to constitute a benefit to the employer. Steve M. Chambers, 42 Van Natta 2600, 2601 (1990).

Wrestling activity was not contemplated as part of claimant's job duties, and we find that it was not an ordinary risk of claimant's employment in an auto painting shop. Claimant points out that there were air hoses on the floor in the area where he was injured, and argues that because he "could have" tripped over one even if there had been no horseplay, tripping over an air hose is an ordinary risk of his employment. We find claimant's argument irrelevant in this case, since the evidence fails to establish that claimant tripped over an air hose; claimant simply does not know how he fell. (Tr. 17).

We find that the employer neither condoned nor acquiesced in wrestling at work, and claimant himself described the activity as "messing around." (Tr. 13). The employer stated that he would have given a stern warning to any worker he caught wrestling. (Tr. 38). Although the employer had no specific, written company policy regarding horseplay, claimant's co-workers knew that wrestling on the employer's premises was prohibited. (Tr. 21, 32, 35). Claimant had been previously reprimanded for horseplay involving throwing tapeballs. Claimant acknowledged that he previously paid for a broken car mirror, caused by his throwing a "tapeball" in the shop, and that his employer told him to discontinue the activity.

While the injury occurred at the employer's work site and claimant was paid for his work, these factors are not sufficient to make the injury compensable. Robert R. Brown, supra, aff'd Brown v. Liberty Northwest Ins. Co., supra.

Under these circumstances, we conclude that there is no causal relationship between claimant's injury and a risk connected with his employment. See Robert R. Brown, supra. Accordingly, claimant's injury did not arise out of nor was it in the course of his employment. ORS 656.005(7)(a).

ORDER

The Referee's order dated September 26, 1991 is reversed. The Referee's award of a $1,750 assessed attorney fee is reversed. The SAIF Corporation's May 7, 1991 denial is reinstated and upheld.

June 19, 1992 Cite as 44 Van Natta 1173 (1992)

In the Matter of the Compensation of
ALETHA R. SAMPERI, Claimant
WCB Case No. 91-09848
ORDER ON REVIEW
Parks & Ratliff, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee Mongrain's order which directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree. On review, the issue is rate of scheduled permanent disability. We affirm.

FINDINGS OF FACT

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

Pursuant to a November 1, 1991 stipulated settlement, the parties agreed to submit the issue of the proper rate of claimant's scheduled permanent disability award to a Referee.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that no exhibits were received into evidence by the Referee. However, because the February 27, 1991 Determination Order and the November 1, 1991 stipulated settlement agreement are included in the record and the parties and the Referee refer to these documents, we conclude that the Referee intended to admit --and implicitly did admit-- both as evidence in this case. See Nellie M. Ledbetter, 43 Van Natta 570, 571 (1991). Therefore, we consider the February 27, 1991 Determination Order and the November 1, 1991 written agreement and proceed with our review. ORS 656.295(5).

The parties' written agreement provides in relevant part:

> "* * * (2) Claimant shall be awarded an additional 5% scheduled disability equal to 7.5 degrees for the right knee, for a total award for the right knee to date of 54 degrees equal to 36%. Said award due per this stipulation is $1,087.50.
>
> "3) The parties are unable to agree regarding the rate per degree that disability is to be paid. The parties stipulate that the referee may issue an Opinion and Order regarding the rate per degree of disability. * * *"

The stipulation plainly states that the parties were "unable to agree regarding the rate per degree to be paid," and that "a referee may issue an Opinion and Order" regarding that rate to resolve the parties' dispute. Considering the plain language of the agreement, we find that the parties intended to submit the rate issue to a Referee. The parties agreement is binding. See Evans v. Rookard, 85 Or App 213, 214 (1987). Therefore, we conclude that the employer may not renege.

Finally, concerning the merits of the rate matter, we adopt the Referee's "Opinion" and "Conclusion of Law." See Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991).

Claimant is entitled to an assessed attorney fee for prevailing over the employer's request for review. 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 attorney's services on review is $1,000, 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 November 20, 1991 is affirmed. For his services on review, claimant's attorney is awarded an attorney fee of $1,000, payable by the self-insured employer.

In the Matter of the Compensation of
CARL SMITH, Claimant
WCB Case No. 91-05815
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The self-insured employer requests review of that portion of Referee Baker's order that directed it to pay claimant's scheduled permanent partial disability award at the rate of $305 per degree. Claimant cross-requests review of that portion of the order that set aside an order on reconsideration on the basis that it was invalid under ORS 656.268. Claimant also alleges that he is entitled to: (1) a 5 percent award for a chronic condition limiting repetitive use of his right hand; and (2) penalties under ORS 656.268(4)(g) and (e) and an assessed attorney fee under ORS 656.382(1). The employer also asserts that, if the Board finds that it has jurisdiction to address claimant's cross-request for review concerning an order on reconsideration, we should remand to the Referee the matters of extent of disability and penalties.

On review, the issues are jurisdiction, remand, extent of scheduled disability, rate of scheduled disability, and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

A notice of closure awarded claimant 5 percent scheduled permanent partial disability for a right arm injury. As required by ORS 656.268(4)(e), claimant requested reconsideration of the notice of closure. In that request, claimant contended that he was entitled to ratings for a chronic condition limiting repetitive use of his right hand and loss of grip strength in his right hand. (Ex. 13-1). On reconsideration, the WCD Appellate Unit agreed that claimant was entitled to an award for loss of grip strength but found no evidence to support an award for a chronic condition limiting repetitive use. (Ex. 18-1). The notice of closure was amended to provide for an award of 22 percent scheduled permanent disability. (Id).

The employer requested a hearing, contending that the award provided by the order on reconsideration was excessive. At hearing, claimant continued to assert an entitlement to 5 percent for a chronic condition. The Referee concluded that the order on reconsideration was invalid because no medical arbiter had been appointed under ORS 656.268(7). The Referee, therefore, found that the reconsideration process had not been completed and that "[t]he Hearings Division has no authority [to consider the request for hearing concerning the order on reconsideration] until after reconsideration is completed in accordance with the law." (O & O at 2).

As we have previously held, we lack jurisdiction to consider a request for hearing concerning objections to a notice of closure or determination order before the reconsideration process established by ORS 656.268(5) through (7) is completed. See Lorna D. Hilderbrand, 43 Van Natta 2721, 2722 (1991). Moreover, we also have recently held that an order on reconsideration is invalid, and we

therefore lack jurisdiction to consider a request for hearing concerning the order on reconsideration, if the basis for objection to the notice of closure or determination order is disagreement with the impairment findings used in rating the worker's disability, and the department fails to appoint a medical arbiter and submit the arbiter's findings for reconsideration. See ORS 656.268(7); Olga I. Soto, 44 Van Natta 697, 700 (1992).

However, since the Referee issued his order we have found that, in determining the validity of an order on reconsideration, we distinguish between a party who objects to the actual findings of impairment by the attending physician, and a party who objects to the application or interpretation of the attending physician's impairment findings to determine the award of scheduled permanent disability. See Doris C. Carter, 44 Van Natta 769, 770 (1992). For instance, in Olga I. Soto, 44 Van Natta 697, where we concluded that we lacked jurisdiction to consider the claimant's request for hearing of an order of reconsideration, the claimant clearly objected to the impairment findings of her attending physician, indicating such on her request for reconsideration. However, in Doris C. Carter, 44 Van Natta 770, where we concluded that the order on reconsideration was valid, the claimant indicated on her request for reconsideration, at hearing, and on review, that she did not disagree with the findings of her attending physician but objected to the extent of disability awarded by the Evaluation Section, which was based on the physician's impairment findings.

Here, we find that claimant objects to the application of the attending physician's findings of impairment rather than the actual findings themselves. Claimant's request for reconsideration alleges that, based on findings by his attending physician, he is entitled to ratings for a chronic condition and loss of grip strength. Although the request for reconsideration does not specifically state whether or not he disagrees with the impairment findings, the request clearly relies on the physician's findings in asserting entitlement to an increased scheduled permanent disability award. Under these circumstances, we conclude that the order on reconsideration is valid despite the absence of a medical arbiter and that we have jurisdiction to consider claimant's cross-request for review.

Extent of scheduled disability

In the event we find that we have jurisdiction to address the Order on Reconsideration, the employer asserts that we should remand to the Referee the issue of the extent of claimant's scheduled permanent disability. We remand only if a case has been improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5). Here, the Referee admitted both written and oral evidence at hearing. We find that the record concerning the extent of scheduled disability is fully developed, and therefore, proceed to address the issue. But see Charles R. Butler, 44 Van Natta 994 (1992) (where Referee did not permit testimony and Board held Order on Reconsideration valid, case remanded for the taking of testimony).

The order on reconsideration found that the medical evidence proved a 35 percent loss of grip strength, which, under former OAR 436-35-110(3)(d), entitled claimant to an 18 percent scheduled disability award. (Ex. 18-1). That award, combined with the 5 percent award for lost range of motion, provided a total award of 22 percent scheduled permanent disability. (Id).

At hearing, the employer asserted that the 22 percent award provided by the order on reconsideration was excessive. We agree. The medical evidence does demonstrate that, as of August 1990, the grip strength of claimant's injured hand was 150, compared to 230 on the uninjured hand. (Ex. 9-1). In October 1990, claimant's treating physician stated that "grip strength differences

were related to [claimant's] wrist dislocation injury[.]" (Ex. 11) (emphasis supplied). However, the physician also stated that, as of that date, the injured hand "is somewhat stronger than" the uninjured hand. (Id). Furthermore, the report stated that "grip strength testing is somewhat subjective" and that those test results obtained on that date may have been due to "tendinitis associated with [claimant's] heavy work." (Id). We find that the medical evidence fails to establish both that claimant experienced lost grip strength in his injured hand and that, any such lost grip strength was due to his compensable injury.

Claimant alleges that he is entitled to an additional 5 percent scheduled disability award for a chronic condition limiting repetitive use of his right hand. See former OAR 436-35-010(7). We agree with the order on reconsideration that there is no evidence that claimant suffers from such a condition.

We therefore conclude that claimant failed to prove a loss of grip strength and a chronic condition limiting repetitive use of his right hand. Consequently, we reduce the scheduled permanent disability award provided by the order on reconsideration from 22 percent to the 5 percent awarded by the notice of closure.

Rate of scheduled disability

The employer asserts that claimant's scheduled disability should award be paid at the rate of $145 per degree. We affirm and adopt that portion of the Referee's order directing it to pay the award at $305 per degree. See Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991).

Penalties and attorney fees

Finally, claimant argues that he is entitled to penalties under ORS 656.268(4)(g) and 656.268(4)(f) and an attorney fee award under ORS 656.382.

ORS 656.268(4)(g) provides that if, upon reconsideration of a claim closed by an insurer or self-insured employer, the department orders an increase of 25 percent or more in permanent disability and that award is at least 20 percent, "a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant." Here, the department on reconsideration increased claimant's scheduled disability award from 5 percent to 22 percent; the award therefore was increased by more than 25 percent and is greater than 20 percent. However, as explained above, we have determined that claimant is entitled to 5 percent scheduled permanent disability. Consequently, claimant is not entitled to a penalty under ORS 656.268(4)(g).

ORS 656.268(4)(f) provides:

> "If an insurer or self-insured employer has closed a claim or refused to close a claim pursuant to [ORS 656.268], if the correctness of that notice of closure or refusal to close is at issue in a hearing on the claim and if a finding is made at the hearing that the notice of closure or refusal to close was not reasonable, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant."

Again, having found that the notice of closure properly awarded 5 percent scheduled disability, we find that it was reasonable and, therefore, claimant is not entitled to a penalty under ORS 656.268(4)(f). For the same reason, we also

reject claimant's argument that he is entitled to an assessed attorney fee under ORS 656.382(1) "for the employer's unreasonable claims processing in its failure to award scheduled disability for the loss of grip strength and in the Department's increasing the award to more than 20 percent[.]"

Claimant's attorney is entitled to an assessed attorney fee, however, for prevailing against the employer's request for review concerning the proper rate of scheduled disability. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee is $300, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to this issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated October 25, 1991 is reversed in part and affirmed in part. We reverse that portion of the order finding that the Order on Reconsideration was invalid based on the absence of findings by a medical arbiter. In lieu of the 22 percent (33 degrees) scheduled permanent disability awarded by the Order on Reconsideration, the 5 percent (7.5 degrees) awarded by the Notice of Closure is reinstated and affirmed. The remainder of the order is affirmed. For services on Board review concerning the rate of scheduled permanent disability issue, claimant's attorney is awarded $300, to be paid by the self-insured employer.

In the Matter of the Compensation of
GARY STEVENS, Claimant
WCB Case No. 90-19329
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Kinsley.

Claimant requests review of Referee McWilliams' order that: (1) upheld the SAIF Corporation's denial of claimant's injury for a low back condition; and (2) declined to assess a penalty and attorney fee for SAIF's allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

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

Claimant's work activities for the employer on September 13 and 14, 1990, were a material contributing cause of his subsequent disability and need for medical treatment.

CONCLUSIONS OF LAW AND OPINION

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Inasmuch as claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990, we agree that the 1990 Act applies here.

We agree with and adopt the Referee's finding that claimant was a credible witness based on his demeanor and the substance of his testimony. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

Compensability

Analyzing claimant's claim as an injury claim, the Referee found that claimant had not sustained his burden of proving that work activities for the employer were the major contributing cause of his disability or need for treatment. Citing ORS 656.005(7)(a)(B), the Referee concluded that claimant had failed to establish a compensable injury claim. We disagree with the Referee's reasoning and conclusion.

As amended by the 1990 Legislature, ORS 656.005(7)(a) provides, in pertinent part:

> "(A) 'compensable injury' is an accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death; 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, subject to the following limitations:
>
> "* * * *
>
> "(B) If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment."

In amending that statute, the legislature did not change the elements necessary to establish an initial compensable injury. As in the past, an injury is compensable if it arises out of and in the course of employment and results in disability or the need for medical services. Accordingly, an injured worker establishes a compensable injury claim if he proves that the accident was a material contributing cause of his disability or need for treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991).

By adding subsection (B), however, the legislature limited the compensation to which a worker may be entitled in a compensable injury claim. Under that provision, a worker who suffers a compensable injury, yet who also suffers from a preexisting condition or disease that combines with the injury to cause or prolong disability, will be compensated for disability and treatment only insofar as the compensable injury is the major contributing cause of particular periods of disability or need for particular treatment. See Bahman M. Nazari, 43 Van Natta 2368 (1991).

On this record, we first conclude that claimant has established a compensable injury. Claimant testified that he developed sharp pain in the right hip after operating the employer's tractor on uneven and rocky terrain on September 13 and 14, 1990. (Tr. 8-10). By chart note dated September 18, 1990, Dr. Hansen, attending physician, reported that claimant sought treatment for right hip discomfort with some radiation down the leg, which developed while operating the tractor; his diagnosis was a muscle strain. (Ex. 4). By report dated January 30, 1991, Dr. Woolpert, examining orthopedic surgeon, opined that "[t]he cause of this [low back condition] historically from comments of the [claimant] would be that of work activity if no other injury or other activity can be documented that could cause a change in the disc status." (Ex. 12-4).

The insurer argues, and the Referee agreed, that Dr. Woolpert's report is unpersuasive because he did not have a complete history of claimant's off-work activities. We disagree. At or about the time of his injury, claimant was self-employed in demolition and hauling wood shavings and sawdust. On September 20, 1990, claimant had a significant increase in back pain while moving straw products with a pitchfork off the job. He saw Dr. Hansen, who diagnosed a lumbar strain. (Ex. 4-1). Yet, none of the doctors, including Dr. Hansen, identified any of the aforementioned off-work activities as a potential cause of claimant's condition. (See Ex. 12-4). Accordingly, we do not find that claimant's off-work activities were a contributing factor in claimant's condition.

Based on this record, we find that claimant's work activities on September 13 and 14, 1990, were a material contributing cause of his subsequent disability and need for treatment. Accordingly, claimant has established a compensable injury claim. See Mark N. Wiedle, supra.

Finally, although claimant had preexisting bulging of the L4-5 disc and underwent lumbar laminectomy in January 1988 for a herniated disc at L5-S1 on the left, (see Exs. 3, 4), we do not find that the preexisting condition combined with the compensable injury to cause or prolong disability or the need for treatment. Claimant credibly testified that he had no back symptoms when he began working for the employer in August 1990. (Tr. 6). Additionally, none of the doctors identified the preexisting condition as a cause of the current condition. For these reasons, claimant need not establish that his compensable injury was the major contributing cause of his disability or need for treatment. See ORS 656.005(7)(a)(B); Bahman M. Nazari, supra.

Penalty and Attorney Fee

In determining the reasonableness of a denial, the question is whether the insurer had a legitimate doubt as to its liability at the time of its denial. If the insurer based its denial upon a legitimate doubt, the denial is not unreasonable. Brown v. Argonaut Co., 93 Or App 588 (1988). The insurer's "reasonableness" and "legitimate doubt" must be evaluated in light of the information available to it at the time of the denial. Id.

The Referee found that, at the time of the insurer's October 4, 1990 denial, it did not possess any evidence which controverted claimant's injury claim. In doing so, she noted that claimant's 801 form revealed the existence of a prior injury to his back. However, she concluded that whereas claimant filed his claim on October 3, 1990 and the insurer issued its denial the next day, there was no evidence that the insurer had received the 801 at the time it issued its denial. She, therefore, found that the insurer lacked sufficient information to create a legitimate doubt regarding its liability.

It is claimant's burden to prove that the insurer's denial was unreasonable. Lisa L. Ross, 40 Van Natta 1962, 1964 (1988); Harris v. SAIF, 292 Or 683 (1982). We conclude that claimant has failed to meet his burden. First, we note, as did the Referee, that claimant's claim form referred to a prior injury to his back. We further note, as did the Referee, that the insurer's denial issued after the claimant's claim was filed, albeit one day after. This would suggest that the insurer had knowledge of claimant's claim and, thus, his prior injury at the time it issued its denial; it is unlikely that a denial would issue before the insurer received a claim. Unlike the Referee, however, we conclude that where there is no evidence as to whether or not the insurer received claimant's claim before issuing its denial, the lack of evidence is to be construed against claimant, for it is he who has the burden of proof. On this record, claimant has failed to prove that the insurer's denial had no legitimate

basis. Accordingly, we may not assess either a penalty or penalty-related attorney fee. See ORS 656.262(10)(a), 656.382(1).

Attorney Fee

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $2,800, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (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 March 1, 1991, as reconsidered April 5, 1991, is reversed in part and affirmed in part. The SAIF Corporation's October 4, 1990 denial is set aside, and the claim is remanded to SAIF for processing according to law. The remainder of the order is affirmed. For services at hearing and on review, claimant's attorney is awarded an assessed attorney fee of $2,800, to be paid by the SAIF Corporation.

June 19, 1992 Cite as 44 Van Natta 1181 (1992)

In the Matter of the Compensation of
CURTIS W. STINSON, Claimant
WCB Case No. 89-16397
ORDER ON RECONSIDERATION
Whitehead & Klosterman, Claimant Attorneys
David O. Horne, Defense Attorney

Claimant requests reconsideration of our May 22, 1992 order on review finding that claimant was barred by claim preclusion from litigating the proper rate of temporary total disability paid by the insurer pursuant to 1984 and 1988 Determination Orders. Our order further found, however, that claimant was not barred from litigating the proper rate of his permanent total disability benefits awarded in a former proceeding. Our order affirmed and adopted that portion of the Referee's order determining that claimant was entitled to a higher rate of permanent total disability.

Claimant requests that we amend our order "to include a provision which allows for an approved fee for claimant's attorney, out of the increased permanent total disability awarded by the Opinion and Order and now by the Order on Review." Although claimant recognizes that the Referee awarded a fee of 25 percent, not to exceed $1,050, claimant asks the Board to "award and approve [an] attorney's fee to claimant's attorney at the rate of 25%, up to the maximum allowable before the Workers' Compensation Board."

We do not entirely understand claimant's request. Our order affirmed that portion of the Referee's order providing for a fee of 25 percent of the increased compensation, not to exceed $1,050. Claimant appears to be asking us to either award him a second approved fee from the increased compensation or increase the limit of $1,050 set by the Referee. We have no authority to take either action. The Referee properly awarded an approved fee on the basis that his order increased claimant's temporary total and permanent total disability benefits. See ORS 656.386(2); OAR 438-15-040(2); OAR 438-15-045. However, the

administrative rules limit the award of such a fee to those occasions when the Referee awards additional compensation. There is no rule providing for an additional fee on Board Review. OAR 438-15-040(2), 438-15-045.

Under ORS 656.382(2), however, an assessed fee is awarded to the claimant's attorney if a request for review is initiated by the carrier and the Board finds that "the compensation awarded to a claimant should not be disallowed or reduced[.]" Here, the insurer requested review and we did not reduce the increased temporary total disability benefits awarded by the Referee. Claimant's attorney therefore is entitled to an assessed fee for prevailing against the insurer's request for review regarding claimant's entitlement to an increased rate of his temporary total disability.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee 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.

We withdraw our May 22, 1992 order. After conducting our reconsideration, we adhere to our prior conclusions and supplement our order with the findings contained in this order on reconsideration. Accordingly, claimant's request for reconsideration is granted. As supplemented herein, we republish our May 22, 1992 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
EVERETT L. WEEMS, Claimant
WCB Case No. TP-91026
THIRD PARTY ORDER
Linda J. Rudnick, Claimant Attorney
Tooze, et al, Defense Attorneys
Roberts, et al., Defense Attorneys

Claimant and the third party (Metropolitan Disposal Corporation hereafter "MDC") have petitioned the Board for resolution of a dispute concerning a proposed settlement of a third party action. See ORS 656.587. Should we approve the settlement, claimant also seeks resolution of a "just and proper" distribution of settlement proceeds. See ORS 656.593(3).

AIAC, as paying agency, objects to the proposed $250,000 third party settlement for claimant's compensable injury. Noting that claimant's wife has also received a $330,000 settlement offer for her loss of consortium cause of action (which is not lienable under the third party statutes), AIAC contends that claimant has engaged in "gamesmanship" concerning the allocation of settlement proceeds in an effort to minimize the paying agency's recovery of its $264,989.11 lien. Under such circumstances, AIAC requests that we consider the entire settlement less 10 percent for claimant's wife's claim to be subject to its lien; i.e., $580,000 - $58,000 = $522,000.

We disapprove the $250,000 settlement between claimant and MDC.

FINDINGS OF FACT

Claimant, a janitor, sustained a compensable left leg injury while operating an industrial-sized garbage compactor on his employer's loading dock. The incident which resulted in claimant's injury began when the compactor's ram mechanism did not engage while claimant was loading trash into the machine. Overriding a safety switch, claimant attempted to correct the problem while the compactor was still running. Shortly after this action was taken, two large clamping bolts tore loose from the compactor causing the compactor to move. This movement crushed claimant's left leg between the compactor and the loading dock.

As a result of this injury, claimant's left leg was amputated at the mid-thigh level. To date, AIAC has incurred $161,913.17 in actual claim costs. These costs consist of $112,276.17 in medical expenses and $49,637 in temporary and permanent disability benefits. AIAC also projects future medical costs of $103,075.94. Thus, AIAC asserts a total lien of $264,989.11.

Claimant has been fitted with a prosthesis. He has returned to work with his employer.

Claimant engaged legal representation to pursue a cause of action for negligence and product liability against MDC, the owner of the trash compactor. Claimant asserted that MDC knew or should have known that the bolt clamping mechanism was inadequate or failing.

Claimant's wife also filed a cause of action for loss of consortium. As a result of her husband's injury, she claimed that her marriage of some 25 years had been dramatically effected. Specifically, she alleged that she now bore a much greater responsibility for the household chores, while continuing to fulfill her full-time duties as a nursing home administrator. In addition, claimant's wife has been subject to frequent and severe emotional outbursts from her husband. She has not sought medical care for this increased stress.

In response to claimant's complaint, MDC moved for dismissal of the product liability claim on the grounds that the statute of limitations had expired. The claim was subsequently dismissed.

During the discovery process concerning claimant's negligence claim, it was disclosed that MDC intended to call Dr. Olleman as an expert witness. Olleman intended to testify that there was no reasonable way for MDC to have known that the bolts would become loose when the safety switch was intentionally overridden. Moreover, Olleman also was unaware of any reasonable inspection which could have detected a bolting failure under such circumstances. Finally, Olleman was prepared to testify that claimant's intentional overriding of the safety switch was the cause of the accident.

Based on such an opinion, MDC asserted affirmative defenses to claimant's cause of action. Specifically, MDC asserted that claimant's injury was caused by his intentional misuse of the compactor in overriding the safety switch. In addition, MDC claimed that claimant's employer was also liable for his injuries because the compactor had been located in a work area which was contrary to several Oregon safety codes. (OAR 437-02-242(2)(a)(G), and (d)(D)).

In advance of trial concerning claimant and his wife's claims, a settlement conference was held in the chambers of Judge LaMar, Multnomah County Circuit Court. Prior to the conference, claimant was seeking $825,000 in settlement. At the August 1990 settlement conference, MDC offered a $475,000 settlement. In addition, MDC suggested that AIAC reduce its lien (then $208,000) by

50 percent. In the course of this conference, claimant's attorney, MDC's counsel, and Judge LaMar noted that there was a significant chance for a defense verdict or, at a minimum, a reduced judgment due to contributory negligence. After considering the proposal, AIAC was unwilling to reduce its lien.

In August 1991, in response to their recent telephone conversation, AIAC's attorney sent MDC's counsel a letter. (Ex. 6-9). It was AIAC's understanding that MDC had proposed two alternatives. One, AIAC could accept a 50 percent reduction of its approximately $208,000 lien. If that was unacceptable, claimant would settle his claim for $250,000 and claimant's wife would settle her claim for $225,000. Contending that the suggested allocation of proceeds to claimant's wife was "blatant gamesmanship and an obvious effort to divert money from the statutorily prescribed distribution method mandated by ORS Chapter 656," AIAC's attorney announced that AIAC would not approve the proposed settlement.

Thereafter, AIAC's counsel received a letter from MDC's counsel. (Ex. 6-11). MDC's position was that claimant's and his wife's claims had been separately negotiated. Consequently, MDC had "never allocated the settlement among the two parties." Nevertheless, MDC reiterated that unless AIAC reduced its current lien by 50 percent, MDC "would allocate the settlement among the two parties, and settle them separately" in a manner in which claimant would receive $250,000. MDC noted that such a distribution would result in AIAC receiving less than 50 percent of its current lien. (Approximately $95,000).

MDC also disagreed with AIAC's characterization of the proposal as "blatant gamesmanship," explaining that the parties were reaching "reasonable settlement[s]" of claimant's and his wife's separate claims. Inasmuch as claimant's wife's claim was not lienable, MDC asserted that AIAC had no interest in her settlement. Finally, because AIAC was not contending that claimant's $250,000 settlement was unreasonable, MDC suggested that AIAC grant its approval.

AIAC refused to provide its approval of the proposed $250,000 settlement for claimant's claim. (Ex. 6-19). In announcing its position, AIAC noted that it had contacted several plaintiff's and defense attorneys, who had described a $225,000 settlement for claimant's wife's loss of consortium claim as "beyond laughable." Asserting that it was prepared to submit these attorneys' affidavits in support of its position, AIAC remained steadfast in its contention that the proposed $250,000 settlement was neither just nor reasonable.

Thereafter, claimant and MDC petitioned the Board for resolution of the parties' dispute. Specifically, claimant and MDC sought approval of the $250,000 settlement and distribution of the proceeds in a just and proper manner. Claimant and MDC further noted that claimant's wife's loss of consortium claim had been settled for $330,000.

All of the parties have submitted affidavits from attorneys and claim examiners presenting their opinion concerning the proposed settlements. The affidavits from claimant and MDC state that, in light of the significant liability question, a $250,000 settlement is "extremely reasonable and fair." Affidavits from attorneys in support of AIAC's position, state that claimant's wife's loss of consortium settlement is "grotesquely out-of-proportion as to be far outside the maximum possible range of reasonableness" and is "inconsistent with anything seen in Oregon in 30 years." These attorneys further conclude that the value for loss of consortium claims usually does not exceed 10 percent of the value of the underlying injury claim.

Finally, claimant and MDC submitted an affidavit from Judge Lamar, the Circuit Court judge who oversaw the settlement conference. In Judge Lamar's

opinion, the $250,000 settlement of claimant's claim and the $330,000 settlement of claimant's wife's loss of consortium claim were very reasonable. The affidavit explains that Judge Lamar considered 3 factors in reaching this conclusion: (1) there was a likelihood of a defense verdict, which reduced the monetary value of claimant's claim; (2) if one assumes MDC's liability, claimant's wife's loss of consortium claim had substantial value; and (3) she was aware that if the settlement were approved by the Board, the paying agent would recover $95,000 (less than 50 percent) of its $210,000 workers' compensation lien, which she believes "would be fair, if not generous, considering the potential for a defense verdict and the degree of fault of the claimant himself, which would reduce damages if he were to prevail. I believe the workers' compensation carrier's recovery fairly reflects these factors."

CONCLUSIONS OF LAW

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

A paying agency's failure to recover full reimbursement for its entire lien is not determinative as to whether a third party settlement is reasonable. Jill R. Atchley, 43 Van Natta 1282, 1283 (1991); John C. Lappen, 43 Van Natta 63 (1991). Generally, we will approve settlements negotiated between a claimant/plaintiff and a third party defendant, unless the settlement appears to be grossly unreasonable. Jill R. Atchley, supra; Kathryn I. Looney, 39 Van Natta 1400 (1987).

Since a claimant's wife is not entitled to payment for loss of consortium under the workers' compensation laws, she is not a beneficiary for purposes of ORS 656.587. SAIF v. Cowart, 65 Or App 733, 737, n 3 (1983). Therefore, a paying agency has no statutory right to approve or disapprove of a settlement for loss of consortium. Id.

Here, AIAC contends that the entire $580,000 in settlement proceeds (less 10 percent for a "reasonable" loss of consortium claim) should be subject to its lien. Relying on its counsel's affidavit, as well as affidavits from practicing attorneys, AIAC asserts that: (1) funds were allocated between claimant's and his wife's claims in a manner specifically designed to reduce AIAC's share of claimant's third party settlement proceeds; and (2) a $330,000 settlement for claimant's wife's loss of consortium claim is grossly disportionate to claimant's $250,000 injury settlement.

Based on these assertions, AIAC argues that claimant and MDC have engaged in "gamesmanship" in an effort to shield a portion of the settlement from AIAC's statutory lien. In support of this argument, AIAC cites Scarino v. SAIF, 91 Or App 350 (1988). In Scarino, the court held that a deceased worker's adult children's shares of the decedent's wrongful death settlement (as allotted by the worker's surviving spouse as personal representative for the estate) were not subject to SAIF's lien as a paying agency. In reaching its conclusion, the court noted that its decision was "not an invitation to gamemanship, nor is there any basis for believing that gamesmanship occurred here." Scarino v. SAIF, supra, at page 355, n. 2.

We applied the Scarino rationale in Neil C. Duclos, 43 Van Natta 28 (1991). In Duclos, a paying agency objected to a proposed distribution of a deceased worker's wrongful death settlement proceeds in a manner in which the decedent's surviving spouse (a workers' compensation beneficiary) and adult daughter (whose was not a workers' compensation beneficiary) would receive equal

shares of the recovery. Noting that there was no basis for believing that any "gamesmanship" had occurred in designing the proposed allocation of settlement proceeds, we found no grounds to disturb the proposed distribution.

In the present case, however, petitioners contend and we find that the holdings in Scarino and Duclos are not controlling. Those decisions involved wrongful death actions concerning deceased workers. Thus, regardless of whether the particular recipient of the settlement proceeds was also a workers' compensation beneficiary, all of the settlement funds arose from the deceased worker's cause of action for a compensable injury. Since the third party dispute pertained to a "just and proper" distribution of settlement proceeds under ORS 656.593(3), it was imperative for the court and Board to evaluate whether the shares of that wrongful death settlement had been apportioned in an appropriate manner between the heirs of the worker's estate, some of whom were workers' compensation beneficiaries and subject to the paying agency's third party lien.

Here, in contrast, the dispute pertains to a paying agency's failure to approve a proposed compromise of an injured worker's cause of action. See ORS 656.587. Inasmuch as there is no provision for loss of consortium under the workers' compensation law, a settlement of such a claim is not subject to Chapter 656. SAIF v. Cowart, supra. Consequently, as the law now stands, paying agency approval of a settlement concerning a loss of consortium cause of action is not required and, what is more, this Board is without authority to consider such a dispute. Thus, we agree with petitioners that this Board's authority is strictly limited to a determination of whether claimant's $250,000 settlement for his left leg injury negligence action is reasonable. After conducting our review, we conclude that the settlement appears to be grossly unreasonable.

The question of whether claimant's $250,000 settlement is reasonable cannot be determined by this Board without considering all factors which bear directly on that question. One important factor that petitioners' written materials do not address is the law governing the relationship for liability and damages purposes between the injured party's negligence claim and the claim of his spouse for loss of consortium.

The affidavit of attorney Jonathan M. Hoffman asserts on behalf of AIAC, that under Oregon law, the marital relationship is viewed as an economic unit, and that the contributory or comparative negligence of the injured spouse correspondingly bars or reduces the value of the loss of consortium claim of the non-injured spouse due to the common interests involved in the marital relationship. Mr. Hoffman also asserts that the loss of consortium claim exists as a derivative of the injured spouse's personal injury claim, upon which the consortium claim substantially depends for its legal viability and value. Given the governing law, he asserts that as a practical matter, the injured party's claim is invariably worth in trial and in settlement, substantially more than the spouse's loss of consortium claim. Attorney Ronald E. Bailey concurs in his affidavit with Mr. Hoffman's statements.

Mr. Hoffman's statements are supported by the cases cited in his affidavit. In Ross v. Cuthbert, 239 Or 429, 397 P2d 529 (1964), plaintiff/husband brought an action for personal injuries sustained in a car accident. His wife brought a separate claim for loss of consortium. The husband was found to be contributorily negligent. The trial court denied the wife's demurrer to defendant's affirmative defense of contributory negligence, holding that her husband's contributory negligence operated to bar the wife's claim for loss of consortium. On appeal, the Oregon Supreme Court affirmed the trial court's ruling. The Court found it well-established that a loss of consortium claim was barred where the physically injured spouse was contributorily negligent. Id. at 530-

31. The Court reasoned that the practical economic unity of the husband and wife relationship required barring the loss of consortium claim. Id. at 531-32. Acknowledging that the theory of derivative action and contributory negligence had come under increasing criticism by commentators, the Court noted:

> "Symmetry in the law or, termed otherwise, logical consistency is, of course, highly desirable; but of paramount importance is justice.
>
> "* * * * *
>
> "It is apparent that the logic of testbook writers has not persuaded the court that wives should be permitted to recover from an alleged tort feasor [sic] the entire amount of damages when the husband's contributory negligence was responsible for some of the amount."

Id. at 531. The Court also rejected plaintiff's argument that the Court's prior decision in Wolff v. Du Puis, 233 Or 317, 378 P2d 707 (1963) (involving a question of collateral estoppel) should be extended to allow recovery for loss of consortium regardless of the physically injured spouse's right to recover. The Court said:

> "So long as we retain the notion that contributory negligence is a valid defense to a negligence action, then it is proper to hold that a negligent person's spouse cannot convert the fruits of his negligence into a financial recoupement for the family exchequer." Id. at 352.

In Fox v. Flescher, 274 Or 599, 602, 547 P2d 1392 (1976), the principles of Ross were applied to Oregon's comparative negligence statute, which at the time provided a bar to a plaintiff who was 50 percent at fault. The jury found plaintiff 50 percent at fault, and the trial court entered judgment for defendant on both the personal injury claim and the spouse's loss of consortium claim. The Oregon Supreme Court affirmed the trial court's decision.[1] Furthermore, as Mr. Hoffman's affidavit asserts, several other jurisdictions have applied Oregon "economic unity" analysis in loss of consortium cases and thereby reduced the award by the percentage of the injured plaintiff's degree of fault. See Eggert v. Working, 599 P2d 1389 (Alaska 1979); Lee v. Colorado Dept. of Health, 718 P2d 221 (Colo. 1986).

The cases cited by Mr. Hoffman would not necessarily support a conclusion that the consortium settlement was unreasonably high. Assuming liability, a jury might very well agree with Judge Lamar's assessment that the loss of consortium claim had substantial value and that an award exceeding $330,000 would be appropriate. Thus, for our purposes, we do not question the reasonableness of the $330,000 consortium settlement, as that was a matter within the exclusive province of Judge Lamar as the settlement conference judge. However, the reasonableness of claimant's third party settlement and what constitutes a proper distribution of the proceeds of such a settlement to satisfy the paying agency's lien, are matters within the province of this Board. Our statutory mandate and the policy objectives of Judge Lamar as the Circuit Court settlement conference judge are not necessarily the same. As we have previously held, the primary purpose of the third party provision is to reduce the cost of the workers' compensation system as much as possible. Marvin H. Allen, 41 Van Natta 1323

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[1] The appeal was actually on two evidentiary rulings by the trial court.

(1989), aff'd Allen v. American Hardwoods, 102 Or App 562 rev den 310 Or 547 (1990). Thus, on the reasonableness of claimant's settlement, we will defer to the stated assessment of a settlement conference judge, unless we find substantial reasons not to do so. Here, we find such reasons.

Assuming, as we do here, that the consortium claim was worth $330,000 for settlement purposes, it logically follows given the cases above discussed and the other factors discussed by Mr. Hoffman, that claimant's personal injury claim must be worth substantially more than the $250,000 settlement. This is particularly true when the underlying facts are considered. Claimant suffered the traumatic amputation of his left leg, six inches below the hip. His wife must deal with the adverse effects of claimant's disability on their marital relationship while claimant must deal with the loss of his leg, including the effect of that loss on all aspects of his life, including his marriage. Under the circumstances, claimant's $250,000 settlement appears to be grossly unreasonable.

In conclusion, we find that the proposed $250,000 settlement for claimant's negligence action is unreasonable. Accordingly, we disapprove the settlement. Because the settlement is disapproved, we do not reach the question of what would constitute the just and proper distribution of the settlement proceeds.

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS L. ABEL, Claimant
Own Motion No. 91-0386M
OWN MOTION ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has requested reconsideration of our May 28, 1992 Own Motion Order. Specifically, SAIF contends that we do not have authority to award a penalty-related attorney fee under our Own Motion authority. We disagree.

Pursuant to ORS 656.278(1)(a), the Board may authorize the payment of temporary disability compensation when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or the treatment requiring hospitalization. In conjunction with this provision, ORS 656.382(1) allows the Board to award an assessed attorney fee where a carrier unreasonably resists the payment of compensation.

ORS 656.278 limits the Board's authority to award compensation after claimant's aggravation rights have expired. However, it does not limit the Board's authority, under ORS 656.382(1), to award an assessed attorney fee where a carrier has unreasonably resisted the payment of compensation.

Accordingly, our May 28, 1992 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our former order, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
GILBERT GARCIA, Claimant
WCB Case No. 91-04208
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys

Reviewed by Board Members Brazeau and Kinsley.

The self-insured employer requests review of that portion of Referee Spangler's Order on Reconsideration that directed it to report to the Director claimant's claim that his July 1, 1989 nondisabling injury had become disabling. On review, the issue is claims processing.

We affirm and adopt the order of the Referee, with the following comment.

The employer contends that retroactive application of ORS 656.277 and amended ORS 656.262(6)(c), concerning its duty to report the claim to the Director, leads to an unjust result in this case. Therefore, it argues that the law prior to the 1990 amendments should apply. We disagree.

The Referee correctly concluded that the 1990 amendments to workers' compensation law apply to this case. However, even prior to the 1990 amendments the employer was required to immediately inform the Director that a worker's previously nondisabling injury claim had become disabling. See former ORS 656.262(12); Linda Warner, 43 Van Natta 159 (1991). The employer further contends that claimant did not submit a disabling claim within one year of the

injury. However, Dr. Driver's report of September 23, 1989 reveals that he treated claimant on July 1, 1989, the date of injury, but did not release him for work until July 5, 1989. The fact that the employer may have been able to offset holiday or other pay during that period of disability does not mean that claimant was not disabled and entitled to compensation. See ORS 656.210(3). For these reasons, as well as those stated by the Referee, we are unpersuaded by the employer's argument that its reporting duty was not triggered.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's request for review. 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 attorney's services on review concerning the claims processing issue is $250, to be paid by the self-insured 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 July 31, 1991, as reconsidered August 27, 1991 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $250, payable by the self-insured employer.

June 22, 1992 Cite as 44 Van Natta 1190 (1992)

In the Matter of the Compensation of
KATHERN A. KNIGHTEN, Claimant
WCB Case No. 90-15985
ORDER OF ABATEMENT
Coons, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney
Employers Defense Counsel, Defense Attorneys

On May 22, 1992, we vacated a portion of the Referee's order which addressed the appropriateness of a proposed carpal tunnel surgery, reversed a portion of the Referee's order which held that a Determination Order was premature and affirmed an Order on Reconsideration award of 5 percent (7.5 degrees) scheduled permanent disability for each forearm. On behalf of the parties, the insurer seeks abatement of our order so that we can retain jurisdiction over this matter to consider the parties' proposed settlement.

In light of such circumstances, we withdraw our May 22, 1992 order. Upon receipt of the parties' proposed agreement, we will proceed with our review. The parties are requested to keep us fully apprised of further developments concerning this case.

IT IS SO ORDERED.

In the Matter of the Compensation of
KATHERN A. KNIGHTEN, Claimant
WCB Case No. 91-14319
ORDER OF ABATEMENT
Coons, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney
Employers Defense Counsel, Defense Attorneys

On May 22, 1992, we affirmed a Referee's order that affirmed a Medical Director's order finding that claimant's proposed surgery was not appropriate. On behalf of the parties, the insurer seeks abatement of our order so that we can retain jurisdiction over this matter to consider the parties' proposed settlement.

In light of such circumstances, we withdraw our May 22, 1992 order. Upon receipt of the parties' proposed agreement, we will proceed with our review. The parties are requested to keep us fully apprised of further developments concerning this case.

IT IS SO ORDERED.

In the Matter of the Compensation of
THERESA A. SNYDER, Claimant
WCB Case No. 90-09664
ORDER ON REVIEW
Jim L. Scavera, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Kinsley and Hooton.

Claimant requests review of Referee Holtan's order that upheld the self-insured employer's denial of her recurrent cystocele injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee first concluded that claimant experienced an injurious event while lifting grocery bags at work in February 1990. We agree and adopt his conclusions and reasoning. The Referee then concluded, however, that claimant's recurrent cystocele was not compensable under ORS 656.005(7)(a)(B), because the February 1990 injury was not the major contributing cause of her need for medical treatment. Accordingly, he upheld the employer's denial in its entirety. We agree that the employer's denial should be upheld, but for reasons differing from those of the Referee.

On May 7, 1990, the Governor signed into law Senate Bill 1197, an extensive revision of the workers' compensation statutes. Or Laws 1990 (Special Session), ch. 2. Because claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990, this matter is properly analyzed under those revisions, which generally became operative July 1, 1990. Ida M. Walker, 43 Van Natta 1402 (1991).

In amending ORS 656.005(7)(a), the legislature retained the traditional definition of a compensable injury. Accordingly, as in the past, an injured worker establishes a compensable claim by proving that the work-related injury is a material contributing cause of disability or need for treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991). By adding subsection (B) to the definition, however, the legislature limited the compensation to which a worker may be entitled in a compensable injury claim. Under that provision, a worker who suffers a compensable injury, yet who also suffers from a preexisting condition or disease that combines with the injury to cause or prolong disability, will be compensated for disability and treatment only if the compensable injury is the major contributing cause of particular periods of disability or need for particular treatment. See Bahman M. Nazari, 43 Van Natta 2368 (1991).

On this record, we first conclude that claimant has established a February 1990 event. As stated above, we agree with the Referee's conclusion that, while in the course and scope of her employment, claimant experienced an injurious event while lifting grocery bags at work. We also agree with and adopt the Referee's subsequent conclusion and reasoning that the lifting incident was a material contributing cause of the recurrent cystocele. This is not sufficient, however, to establish that claimant sustained a compensable injury.

Claimant has a preexisting condition which has been described as "pelvic floor relaxation," and as a type of hernia, which has caused a need for medical services, including surgery, with resultant disability. Claimant had completed only a portion of the recommended treatment. Upon her return to work following the injurious event, claimant experienced no medical services or disability which did not flow naturally from the noncompensable preexisting condition and prior surgical repair.

The recurrence of the cystocele did not cause claimant to seek medical treatment. Indeed, claimant sought no treatment whatsoever until her next regularly scheduled post-operative visit on February 19, 1990. That visit was scheduled on January 22, 1990, prior to the injurious work-related event. (Ex. 1-2). Further, the only treatment claimant received for the recurrent cystocele was the second portion of the operative procedure that was previously planned, and, while her treating physician indicates that further hard straining may worsen the situation and make the repair more difficult, he did not indicate that the recurrence itself had produced any effect on the planned treatment. His subsequent work restriction appears to have been based on the preexisting conditon rather than arising from the work-related event. (Ex. 1-2).

After our review of the medical evidence, we are unable to conclude that claimant experienced a compensable injury as defined in ORS 656.005(7)(a). That statute requires that an injurious event produce disability or a need for treatment in order to give rise to a compensable claim. Because claimant's recurrent cystocele required no medical services not already planned or scheduled, and produced no disability or time loss in and of itself, claimant has failed to establish a compensable injury. Consequently, we need not reach the question of a resultant condition or the compensability issues that arise under ORS 656.005(7)(a)(B) and Bahman M. Nazari, supra. Accordingly, we conclude that, although claimant has established the occurrence of an injurious event, her claim is not compensable. The self-insured employer's denial of April 23, 1990, as amended by letter dated May 16, 1990, is therefore upheld.

ORDER

The Referee's order dated April 12, 1991 is affirmed.

In the Matter of the Compensation of
ROBERT L. ADLER, Claimant
Own Motion No. 91-0720M
OWN MOTION ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requested reconsideration of our February 5, 1992 Own Motion Order in which we reopened his claim and awarded his attorney a fee payable out of compensation. Specifically, claimant contended that he is entitled to penalties and attorney fees for the SAIF Corporation's unreasonable resistance to the reopening of his claim. In order to allow sufficient time to consider the motion for reconsideration, we abated our February 5, 1992 order and granted SAIF an opportunity to respond. After receiving SAIF's response, and further considering the matter, we make the following conclusions.

Penalties and attorney fees may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10)(a); ORS 656.882(1). The reasonableness of a carrier's action must be gauged based upon the information available to the carrier at the time of its action. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

SAIF received notice of this claim on October 30, 1991. On October 31, 1991 SAIF issued a letter addressed to claimant at 29652 Jeans Road, Veneta, OR 97487, in which it asked claimant to submit proof of earnings for the last two years to document that he was currently a member of the work force. On November 19, 1991, claimant was examined Dr. Woolpert, at SAIF's request. On November 24, 1991, Dr. Woolpert issued his report to SAIF. In the report, Dr. Woolpert noted that claimant had worked the previous four months as an apartment manager. On December 19, 1991, we received SAIF's Carrier's Own Motion Recommendation. On the form, SAIF recommended denial on the basis that claimant was not in the work force.

Claimant did not reply to SAIF's October 31, 1991 letter until December 30, 1991 at which time claimant, through his attorney, submitted evidence that he was in the work force.

Although claimant did not reply to SAIF's inquiry concerning his work status, we find nothing in the record which gave SAIF reasonable grounds to doubt that claimant was in the work force and to demand that claimant provide proof of earnings. Furthermore, Dr. Woolpert's report clearly indicated that claimant was in the work force at the time of his worsening. Therefore, the only evidence available to SAIF at the time of its recommendation indicated that claimant was in the work force. Under these circumstances, we find that SAIF's action constitutes unreasonable resistance to the payment of compensation.

Although we have found SAIF's action unreasonable, we find no amounts "then due" on which to base a penalty. ORS 656.262(10)(a). When a claim is under own motion jurisdiction, no compensation is due claimant until we issue an order reopening the claim. Thus, because no compensation was due at the time of SAIF's action, a penalty cannot be assessed under ORS 656.262(10)(a). See Frederick D. Oxford, 42 Van Natta 476 (1990). On the other hand, where, as here, we find that a carrier has unreasonably resisted the payment of compensation, we may assess an attorney fee iin the absence of amounts of compensation "then due." See ORS 656.382(1); Nicolasa Martinez, 43 Van Natta 1638 (1991). Accordingly, for SAIF's unreasonable resistance to the payment of compensation, we assess an attorney fee of $500.

Consequently, as supplemented herein, we adhere to and republish our February 5, 1992 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT J. EGYEDI, Claimant
WCB Case No. 91-07642
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of Referee Mills' order that awarded claimant an attorney fee pursuant to ORS 656.386(1) when SAIF accepted claimant's right elbow and shoulder condition prior to hearing. On review, SAIF contends that claimant's attorney was not instrumental in obtaining compensation for claimant without a hearing. Speculating that SAIF's appellant's brief was untimely filed, claimant has moved to strike the brief. On review, the issues are attorney fees and motion to strike.

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

The statute quoted in the last full paragraph on page two of the Referee's order is ORS 656.386(1), rather than ORS 656.382(1).

As a preliminary matter, we note that, on December 24, 1991, claimant requested that SAIF's appellant's brief be stricken as untimely filed. The motion is denied.

SAIF's appellant's brief was due by December 16, 1991. On December 16, 1991, we received SAIF's appellant's brief. Inasmuch as the brief was timely filed, claimant's motion to strike the brief is denied. See OAR 438-05-046(1).

Concerning the attorney fee issue, SAIF argues first that there was no "rejected claim" regarding claimant's right upper extremity, because it denied no such conditions. Second, SAIF argues, assuming claimant filed claims for right upper extremity conditions which were not accepted, it had no duty to process such claims, because there was no unpaid compensation in this case. Therefore, according to SAIF, claimant's counsel could not have been instrumental in "obtaining compensation" for claimant and is not entitled to an assessed fee under ORS 656.386(1). We disagree with SAIF's reasoning.

SAIF received notice of claimant's injury involving his right wrist, elbow and shoulder on May 20 and May 30, 1991. (See Ex. 2). Such notice is sufficient to constitute a "claim." See ORS 656.005(6). Although SAIF paid claimant's medical bills, such payments do not constitute acceptance of the claim or admission of liability. ORS 656.262(9). Upon notice of the injury, SAIF was required to accept or deny the claim within 90 days. ORS 656.262(6). When SAIF did not respond within the statutory time period --except to the claim for a right wrist condition, the remaining claims were deemed "de facto" denied. See Barr v. EBI, 88 Or App 132 (1987). In other words, SAIF effectively denied the compensability of the claimed conditions which it did not accept. Under these

circumstances, the denied claims are a "rejected" case, for purposes of ORS 656.386(1). See Euzella Smith, 44 Van Natta 778 (1992); compare Michael A. Dipolito, 44 Van Natta 981 (1992).

Furthermore, we disagree with SAIF's contention that claimant's attorney failed to obtain compensation for claimant simply because no compensation was due when the right elbow and shoulder claims were accepted. "Compensation" includes all benefits, including medical services, provided for a compensable injury to a subject worker by a carrier pursuant to ORS chapter 656. ORS 656.005(8). Here, as a result of claimant's attorney's efforts, SAIF has rescinded its "de facto" denial of claimant's right elbow and shoulder conditions and accepted those conditions. With such an acceptance, claimant became entitled to all benefits including medical services set forth in ORS Chapter 656 resulting from those conditions. ORS 656.005(8). Since claimant's entitlement to such benefits had not been secured until SAIF's acceptance prior to hearing, we hold that claimant's attorney was "instrumental in obtaining compensation" for claimant without a hearing, as required by ORS 656.386(1). See Euzella Smith, supra; Fidel D. Chavez, 43 Van Natta 2515 (1991).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree with the Referee's conclusion that a reasonable attorney fee for claimant's counsel's efforts concerning SAIF's pre-hearing acceptance of claimant's right arm and shoulder conditions is $750. In making this determination, we note that in the "Opinion" part of the order, the Referee states that $500 was a reasonable attorney fee, but the "Order" portion of the Referee's decision granted $750. In any event, after our review of the record, we hold that a reasonable attorney fee for claimant's counsel's pre-hearing services is $750.

Finally, inasmuch as claimant's right to compensation was not at risk on review, claimant's attorney is not entitled to a fee for his services on review. See Dept. of Justice Inmate Ins. Fund v. Hendershott, 108 Or App 584 (1991).

ORDER

The Referee's order dated September 26, 1991 is affirmed with the following modification. For services concerning SAIF's pre-hearing acceptance of the right arm and shoulder conditions, claimant's attorney is awarded $750, to paid by SAIF. The Referee's "50/50" penalty assessment is affirmed.

June 23, 1992 Cite as 44 Van Natta 1195 (1992)

In the Matter of the Compensation of
ELINOR R. ELLIOTT, Claimant
WCB Case No. 91-06706
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Thomas Sponsler, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Schultz' order that affirmed a Workers' Compensation Division (WCD) Order on Reconsideration award of 13 percent (41.6 degrees) unscheduled permanent disability for a low back condition. The self-insured employer cross-requests review of that portion of the Referee's order that awarded 5 percent (7.5 degrees) scheduled permanent partial disability for claimant's loss of use or function of her left leg, whereas the WCD order had awarded no scheduled permanent disability. On review,

the issue is extent of permanent disability, scheduled and unscheduled. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "Stipulations" and "Findings of Fact," except for his "Ultimate Findings of Fact," with the following supplementation.

Claimant's job-at-injury was within the medium category. Her post-injury work was within the light category.

CONCLUSIONS OF LAW AND OPINION

We adopt the first three paragraphs of the Referee's "Conclusions of Law and Opinion," with the following correction.

The Referee stated that he applied the standards contained in WCD Administrative Order 6-1988. That order's corrected title is WCD Administrative Order 7-1988. See WCD Administrative Order 1-1989.

We also note that the Referee properly applied the standards in effect when the Determination Order issued in this case. See former OAR 436-35-003(1) & (2) (WCD Admin. Order 2-1991) (effective April 1, 1991); former OAR 438-10-010(2) (WCB Admin. Order 4-1991) (temp).

Unscheduled permanent disability

The parties dispute only the values assigned by the Referee for claimant's adaptability and impairment factors.

Adaptability

The Referee assigned an adaptability factor of 1, based on his determination that claimant's jobs at injury and post injury modified work were in the light/medium category. We affirm and adopt the Referee's reasoning and conclusion.

Impairment

Based on Dr. Peterson's June 21, 1990 opinion that claimant's lifting restrictions "should remain in place," (see Ex. 14-3), claimant argues that she is entitled to a 5 percent rating for a chronic condition limiting repetitive use of her low back. We do not agree.

In this regard, we note that claimant's activities have been restricted at various times following her compensable low back injury. Dr. Custis released her to light work with no lifting as of March 12, 1990. (Exs. 4-2, 8A). Dr. Tanabe also released her to "light regular" work on March 13, 1990, without mention of restricted lifting. (Ex. 9). Dr. Balkovich examined claimant on June 21, 1990, concerning her status post-March 1990 breast reconstruction surgery. He opined that claimant should permanently refrain from heavy repetitive activities with her right upper extremity. (Ex. 13). Dr. Peterson examined claimant on June 21, 1990 concerning her low back condition and opined that claimant's lifting restrictions "should remain in place." (Ex. 14-3). Dr. Peterson also noted that claimant was restricted from filing work, due to the reaching and squatting required. (Ex. 14-2). Most recently, Dr. Tanabe released claimant to work 8 hours per day on July 24, 1990, without restrictions. (Ex. 15-2). Claimant was medically stationary on July 24, 1990. Although claimant's lifting was restricted following her back injury and breast surgery, on this evidence we

conclude that she has not proven that she has a permanent injury-related chronic condition limiting repetitive use of her low back. Therefore, she is not entitled to a rating under former OAR 436-35-320(4).

Computation of unscheduled disability

Having determined each value necessary to compute claimant's permanent disability under the standards, we proceed to that calculation. When claimant's age value, 1, is added to her education value, 2 (the sum of 0 for education, 2 for skills and 0 for training) the sum is 3. When that value is multiplied by claimant's adaptability value, 1, the product is 3. When that value is added to claimant's impairment value, 10 (as stipulated), the result is 13 percent unscheduled permanent disability. Consequently, we affirm that portion of the Referee's order which affirmed the Order on Reconsideration award of 13 percent unscheduled permanent disability.

Scheduled permanent disability

The Referee awarded 5 percent scheduled permanent disability for loss of use or function of claimant's left leg due to atrophy. See OAR 436-35-230(5)(b). However, inasmuch as there is no evidence relating any left leg atrophy which claimant may have to her compensable injury, claimant has not proven entitlement to that award. See ORS 656.214(2).

ORDER

The Referee's order dated September 9, 1991 is reversed in part and affirmed in part. That portion of the order that awarded 5 percent scheduled permanent disability is reversed. The remainder of the order is affirmed.

June 23, 1992 Cite as 44 Van Natta 1197 (1992)

In the Matter of the Compensation of
PETER L. GALIANO, Claimant
WCB Case No. 91-07470
ORDER ON REVIEW (REMANDING)
Jim L. Scavera, Claimant Attorney
Steve Cotton (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Nichols' order which: (1) dismissed claimant's request for hearing; (2) set aside an Order on Reconsideration because it was invalidly issued; and (3) found that jurisdiction over this matter remained with the Appellate Unit of the Workers' Compensation Division (WCD). On review, the issue is the validity of the WCD's Order on Reconsideration. We remand.

FINDINGS OF FACT

Claimant filed an occupational disease claim in May 1989. The claim was accepted for left lateral epicondylitis. His claim was closed by Notice of Closure on August 21, 1990 with an award of temporary disability only.

Claimant requested reconsideration of the Notice of Closure. The record does not contain claimant's request for reconsideration. On May 10, 1991, an Order on Reconsideration issued which awarded claimant 2 percent scheduled

permanent partial disability (3.84 degrees) for loss of the left arm. The Director did not appoint a medical arbiter.

CONCLUSIONS OF LAW AND OPINION

Validity of Department's Order

The Referee found that the Order on Reconsideration was not valid on the basis that the Director had not appointed a medical arbiter prior to issuing the order. Therefore, the Referee set aside the Order on Reconsideration, concluded that jurisdiction remained with the Department and dismissed claimant's hearing request. We find that the record, which does not contain claimant's request for reconsideration, is incompletely developed and we remand.

Claimant became medically stationary after July 1, 1990. Therefore, the 1990 amendments to the Workers' Compensation Act apply to this case. See Oregon Laws 1990 (Special Session), 54(3). The Director's rules in effect at the time of the May 10, 1991 Order on Reconsideration are applicable. Former OAR 436-30-003(4) (WCD Admin. Order 7-1990, effective July 1, 1990).

ORS 656.268(7) provides, in part:

> "If the basis for objection to a notice of closure or determination order issued under this section is disagreement with the impairment used in rating of the worker's disability, the director shall refer the claim to a medical arbiter appointed by the director. . . . The findings of the medical arbiter shall be submitted to the department for reconsideration of the determination order or notice of closure. . . ." (Emphasis supplied).

We have recently interpreted this provision to mean that where a party requests reconsideration of a Notice of Closure or Determination Order and the basis for that request is a disagreement with the medical findings for impairment, then the Director is required to submit the matter to a medical arbiter or panel of arbiters prior to issuing an Order on Reconsideration. See Olga I. Soto, 44 Van Natta 697 (1992). However, where a party does not contest the medical findings of impairment, referral to an arbiter or panel of arbiters is not required. Doris C. Carter, 44 Van Natta 769 (1992); Charles R. Butler, 44 Van Natta 994 (1992).

In all of the aforementioned cases, we have relied on the claimant's request for reconsideration to determine the basis for the claimant's disagreement with the Determination Order or Notice of Closure. Here, the record lacks claimant's actual request for reconsideration of the Notice of Closure. Without evidence of the basis for claimant's challenge to the Notice of Closure, we are unable to determine whether or not claimant objected to the attending physician's findings regarding impairment. Consequently, we are unable to determine whether the Director's failure to appoint a medical arbiter renders the Order on Reconsideration invalid.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Based on the absence of claimant's request for reconsideration, we conclude that the record is insufficiently developed.

Accordingly, the Referee's order dated October 2, 1991 is vacated. This matter is remanded to Referee Nichols to open the record to admit evidence concerning claimant's request for reconsideration. The Referee may proceed in any manner that will achieve substantial justice to the parties. ORS 656.283(7).

ORDER

The Referee's order dated October 2, 1991 is vacated. This matter is remanded to Referee Nichols for further proceedings consistent with this order.

June 23, 1992 Cite as 44 Van Natta 1199 (1992)

In the Matter of the Compensation of
STEVE E. MAYWOOD, Claimant
WCB Case No. 91-04511
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of that portion of Referee Knapp's order that authorized the insurer to offset a duplicate payment of $1,800 in unscheduled permanent partial disability benefits. On review, the issue is offset. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. By a Stipulated Order dated February 21, 1989, claimant was awarded an additional 7.5 percent (24 degrees) unscheduled permanent partial disability. (Ex. 33). Claimant's attorney was allowed a fee of 25 percent of this increased award. After deduction of the attorney fees, claimant's share of the award was $1,800. The insurer made two payments of $1,800 to claimant. (Tr. 6, 7, 8).

CONCLUSIONS OF LAW AND OPINION

The Referee authorized an offset which included the $1,800 duplicate payment of permanent partial disability. Claimant argues that ORS 656.268(13) does not allow an offset of this $1,800 in his case because: (1) the overpayment was not prematurely made; and (2) it occurred as the result of a stipulation rather than a Determination Order. We agree that ORS 656.268(13) does not provide for an offset under the facts of this case.

ORS 656.268(13) provides as follows:

> "Any determination or notice of closure made under this section may include necessary adjustments in compensation paid or payable prior to the determination or notice of closure, including disallowance of permanent disability awards and payment of temporary disability payments which are payable but not paid."

This statute deals with adjustments made by Determination Orders as the result of pre-Determination Order overpayments. Therefore, because the insurer's duplicate payment in this case was not made prior to a Determination Order and any adjustment to remedy the overpayment would not be made by a Determination Order, ORS 656.268(13) does not apply. However, ORS 656.268(13) does not provide an exclusive means for recoupment of an overpayment.

The Board and its Hearings Division can address an offset request under circumstances not involving a Determination Order. In SAIF v. Zorich, 94 Or App 661 (1989), the court held that the Board and its Hearings Division had jurisdiction to consider a request by a carrier to offset an overpayment made to a claimant as a result of a reimbursement check that was erroneously sent to the

claimant rather than to another carrier. The court held that the controversies there were "'matters concerning a claim' within the meaning of former ORS 656.708(3), because they are 'matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue.' ORS 656.704(3)."[1] Id. at 664; see also George K. O'Kelley, 43 Van Natta 90 (1991). The same reasoning applies in this case where a duplicate permanent disability payment was erroneously sent to claimant.

Furthermore, another avenue to recover an overpayment exists in a carrier's right to request a hearing pursuant to ORS 656.283. See Travis v. Liberty Mutual Ins., 79 Or App 126 (1986); Forney v. Western States Plywood, 66 Or App 155 (1983). In Travis, the court allowed an insurer to recover an overpayment by offsetting it against future compensation after obtaining approval from a referee or the Board. Id. at 129. In both Travis and Forney, the court stressed that an insurer may not unilaterally recoup an overpayment but, instead, must obtain approval from a referee or the Board.

ORS 656.283 provides, in part:

> "(1) 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. * * *"
>
> "* * * * *
>
> "(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."

Here, the insurer cross-requested a hearing seeking an offset of an overpayment of $10,523.32, which included the $1,800 duplicate payment. This cross-request satisfies the requirements of a hearing request. In addition, the insurer did not act unilaterally but requested authorization for the offset from a referee and the Board. Furthermore, we conclude that a duplicate payment of permanent disability made pursuant to a stipulation in which the remedy sought is an offset against any future awards of permanent disability is a question concerning a claim. Finally, claimant does not dispute that he received the duplicate payment of $1,800. (Tr. 6, 7, 8). Therefore, we agree with the Referee that the insurer is entitled to on offset of this amount against future awards of permanent disability.

In addition, we have allowed offsets of permanent disability overpayments previously paid on the same claim pursuant to Determination Orders. These offsets were allowed against future awards of permanent disability. Jose E. Sanchez, 42 Van Natta 2313 (1990), Shirley G. Helgeson, 42 Van Natta 1941 (1990). We see no reason to apply a different standard to a duplicate payment of permanent disability made pursuant to a stipulation.

ORDER

The Referee's order dated July 30, 1991, as amended August 9, 1991, is affirmed.

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[1] The relevant portions of former ORS 656.708(3) and 656.704(3) remain the same in the current versions of these statutes. However, former ORS 656.708(3) is now found at ORS 656.708.

In the Matter of the Compensation of
DANIEL T. MILLER, Claimant
WCB Case No. 91-06860
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Livesley's order that: (1) upheld the SAIF Corporation's "de facto" denial of his medical services claim for diagnostic services; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial. On review, the issues are medical services, penalties, and attorney fees. We vacate in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact and ultimate findings of fact with the following exception. We do not adopt the last sentence of the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that the Director has original jurisdiction over questions regarding the reasonableness and necessity of medical services. ORS 656.327; 656.704(3); Stanley Meyers, 43 Van Natta 2643 (1991). The Board and its Hearings Division have original jurisdiction over questions regarding whether the need for a diagnostic service is causally related to the compensable injury. Michael A. Jaquay, 44 Van Natta 173 (1992).

Here, the Referee decided both that the diagnostic test was not reasonable and necessary and that it was not causally related to the compensable condition. We find that the Referee was without jurisdiction to decide the issue of the reasonableness and necessity of the diagnostic test and vacate that portion of the Referee's order. However, with the following supplementation, we adopt the Referee's reasoning and conclusion regarding the lack of any causal relationship between the compensable left knee condition and the diagnostic test.

Claimant's back condition was found not compensable by a prior Referee's order which was affirmed by the Board. That Board order was not appealed. Thus, any diagnostic testing related solely to claimant's back condition is not compensable. However, ORS 656.245 extends to payment for diagnostic procedures performed as a result of an industrial injury even when the procedures ultimately reveal that claimant's condition is not compensable. Brooks v. D & R Timber, 55 Or App 688 (1982); Myrtle L. Thomas, 35 Van Natta 1093 (1983).

Claimant argues that the purpose of the diagnostic test, a lumbar myelography, was to determine if his altered gait was the cause of his back pain. However, the medical evidence does not support this argument. The record contains no medical evidence that relates the need for the lumbar myelography to a determination of the effect on claimant's back of an alleged altered gait or any other condition related to the compensable left knee injury.

Dr. Goins, treating neurologist, recommended the lumbar myelography and provides the only opinion regarding that recommendation. Dr. Goins stated that he recommended the lumbar myelography to exclude the possibility of lumbar disc disease and the less likely possibility of lumbar disc lesion to explain claimant's back and leg pain. (Exs. 3, 5A-2, 19). Thus, the purpose of the

diagnostic test was solely related to the noncompensable back condition. Accordingly, the diagnostic test is not compensable.

Penalties and Attorney Fees

We adopt the Referee's conclusions and reasoning concerning the penalty and attorney fee issue. See Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991).

ORDER

The Referee's order dated September 11, 1991 is vacated in part and affirmed in part. That portion of the order that addressed the reasonableness and necessity of the diagnostic test is vacated. The remainder of the order is affirmed.

June 23, 1992 Cite as 44 Van Natta 1202 (1992)

In the Matter of the Compensation of
WALLACE D. OUGHELTREE, Claimant
WCB Case Nos. 91-06804 & 91-09155
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Susan Ebner (Saif), Defense Attorney

Reviewed by Board Members Moller and Westerband.

The SAIF Corporation requests review of Referee Peterson's order that: (1) affirmed a Reconsideration Order which awarded claimant 13 percent (41.6 degrees) unscheduled permanent disability; and (2) ordered it to pay claimant's scheduled permanent disability award at a rate of $305 per degree. Claimant cross-requests review of that portion of the Referee's order which found that claimant's request for hearing on an alleged "de facto" denial of surgery was premature. On review, the issues are extent of unscheduled permanent disability, rate of scheduled disability, and medical services. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Disability

The Referee affirmed an Order on Reconsideration which awarded claimant 13 percent (41.6 degrees) unscheduled permanent disability. Claimant has the burden of proving the nature and extent of any disability resulting from a compensable injury. ORS 656.266.

The dispute over the extent of claimant's unscheduled permanent disability concerns which version of OAR 436-35-007(3) was applied by the Appellate Unit when rating claimant's disability. Both versions of OAR 436-35-007(3) deal with how a prior award for the same body part is offset against a current award.

SAIF contends that the Appellate Unit erroneously applied the version of OAR 436-35-007(3) which became effective April 1, 1991 (WCD Admin. Order 2-1991) instead of the version which was in effect at the time of the January 31, 1991 Determination Order. Claimant contends that the Appellate Unit correctly

applied the appropriate rule. The parties agree that the appropriate "standards" are WCD Admin. Orders 15-1990 and 20-1990 which were in effect when the Determination Order issued.

SAIF further argues that when the correct version of OAR 436-35-007(3) is applied, claimant is not entitled to an award of unscheduled permanent partial disability. We agree with SAIF's contentions.

Claimant's claim was closed by a January 31, 1991 Determination Order. Former OAR 436-35-270 through 436-35-440, as amended by temporary rules in effect at the time of closure, apply to the rating of claimant's unscheduled permanent disability. WCD Admin. Orders 6-1988, 15-1990 and 20-1990.

In determining claimant's award of unscheduled disability, the Appellate Unit offset factors for age, formal education, and skills. In doing so, the Appellate Unit purported to apply OAR 436-35-007(3)(b). Under the applicable version of the standards, OAR 436-35-007(3) did not contain a subsection (b). Consequently, we agree with SAIF that the Appellate Unit applied the incorrect version of the rule to this case.

The appropriate version of OAR 436-35-007(3) provides:

> "Where a worker has a prior award of permanent disability under Oregon Workers' Compensation Law in a different claim for injury to the same body part as that being evaluated on the current claim, the prior award of permanent disability shall be subtracted from the amount of disability determined under these rules on a degree-for-degree basis." (Emphasis added).

Claimant had previously been awarded 45 percent (144 degrees) unscheduled permanent partial disability for a prior low back injury. Claimant argues that the "low back" is not a body part as contemplated by OAR 436-35-007(3).

In Larry L. McDougal, 42 Van Natta 1544 (1990), we defined the phrase "body part" as one of the areas of the body that is dealt with as a separate unit or system by the "standards." In McDougal, we noted that although the "standards" do not define the term "body part," they do segregate and separately value various parts of the body. The "standards" treat the thoracolumbar spine as a separate body part. See OAR 436-35-360. Lost ranges of motion for a "low back" injury are rated under former OAR 436-35-360(6)-(9) as part of the thoracolumbar spine. Moreover, we have previously treated the "low back" as a body part for purposes of awarding disability for a chronic condition limiting repetitive use. See Thomas E. Siniscal, 43 Van Natta 2635 (1991). Consequently, we conclude that an award for a prior injury to the "low back" is an injury to a "body part" which may be offset under OAR 436-35-007(3).

Claimant further argues that the record does not indicate which specific portion of claimant's "low back" received an award of unscheduled disability. OAR 436-35-007(3) states that disability to the same body part should be offset on a degree for degree basis. It does not specify that particular factors or impairment findings be offset. Consequently, evidence which indicates the body part injured and the amount of disability awarded is sufficient evidence on which to apply OAR 436-35-007(3).

In order to apply OAR 436-35-007(3) to the present case, we must first determine claimant's unscheduled disability under the "standards."

A determination of unscheduled permanent disability under the "standards" is made by determining the appropriate values assigned by the "standards" to the

worker's age, education, adaptability and impairment. The education value is obtained by adding the values for formal education and skills. Under the "standards" applicable to this case, training is not assigned a separate value. See former OAR 436-35-300 (Temp). Once determined, the values for age and education are added. The sum is then multiplied by the appropriate adaptability value. The product of those two values is then added to the impairment value and yields the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

Age

The appropriate value for claimant's age of 60 years is 1. Former OAR 436-35-290 (Temp).

Formal Education

The appropriate value for claimant's 8 years of formal education without a high school diploma or GED certificate is 1. Former OAR 436-35-300(3)(b) (Temp).

Skills

Of those SVPs the worker met during the 10 years before the time of determination, the highest SVP number is used to determine the appropriate skills value from the table at former OAR 436-35-300(4)(e) (Temp).

In this case the "time of determination" is January 31, 1991, the date the Determination Order issued. The job title describing the job for which claimant met the highest SVP number during the 10 years prior to the time of determination was heavy truck driver, DOT # 905.663-014. That job title is assigned an SVP number of 4 by the SCODDOT. Therefore, claimant is entitled to a skills value of 3. Former OAR 436-35-300(4)(e) (Temp).

Claimant's total education value is 4, the sum of the values for formal education and skills. Former OAR 436-35-300(5) (Temp).

Adaptability

For workers who have not been offered, and have not returned to, work at the "time of determination," the adaptability value is determined from the table of values at former OAR 436-35-310(4) (Temp).

Here, the preponderance of evidence established that claimant's physical capacity is within the medium-light category or classification. Claimant does have "restrictions" as provided in the applicable "standards." Therefore, the appropriate adaptability value is 3.5.

Unscheduled impairment values are determined by application of former OAR 436-35-320 through 436-35-440, as amended by temporary rule (See e.g. WCD Admin. Orders 15-1990 & 20-1990). Individual impairment values are added or combined as provided by rule.

Both the Determination Order and the Order on Reconsideration found claimant's impairment to be 8 percent due to lost ranges of motion. Claimant had a laminectomy and discectomy at L4-5 for a value of 5 percent. OAR 436-35-350(2). These values are combined to equal 13 percent impairment.

Having determined each of the values necessary under the "standards," claimant's unscheduled permanent disability may be calculated. The sum of the value (1) for claimant's age and the value (4) for claimant's education is 5.

The product of that value and the value (3.5) for claimant's adaptability is 17.5. The sum of that product and the value (13) for claimant's impairment is 30.5. After rounding, that value (31) represents claimant's unscheduled disability. Former OAR 436-35-280.

If the prior award of 45 percent (144 degrees) is subtracted on a degree-for-degree basis from the present award of 31 percent (99.2 degrees), claimant is not entitled to an award of unscheduled permanent disability. Consequently, the Determination Order which offset the prior low back award pursuant to OAR 436-35-010(4) and awarded no unscheduled permanent partial disability was correct. Claimant is not entitled to an award of unscheduled permanent disability.

Rate of Scheduled Disability

We adopt the conclusions and reasoning on the rate of scheduled disability issue as set forth in the Referee's order.

Medical Services

The Referee found that the request for hearing on the "de facto" denial of surgery was premature. Regardless of whether the request for hearing on the "de facto" denial of surgery is premature, we do not have jurisdiction over the medical services dispute.

Subsequent to the Referee's order, we concluded that original jurisdiction over such disputes is no longer shared by the Director and the Hearings Division. Stanley Meyers, 43 Van Natta 2643 (1991). Rather, because such disputes do not constitute matters concerning a claim, original jurisdiction lies exclusively with the Director. See ORS 656.704(3); 656.327(1)(a); Stanley Meyers, supra. We have further reasoned that disputes regarding proposed medical treatment, as well as those regarding current medical treatment, are within the Director's original jurisdiction in accordance with ORS 656.327. Kevin S. Keller, 44 Van Natta 225 (1992).

The dispute here centers on whether the proposed surgery is reasonable and necessary. At the time of hearing, SAIF had already referred this claim to the Director for review. Accordingly, we conclude that we do not have jurisdiction over the reasonableness and necessity of claimant's proposed surgery.

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 permanent disability issue is $250, to be paid by the SAIF Corporation. 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 September 25, 1991 is reversed in part and affirmed in part. The Referee and Order on Reconsideration awards of unscheduled permanent disability are reversed. Claimant is not entitled to an unscheduled permanent disability award for this injury. 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 fee of $250, payable by the SAIF Corporation.

In the Matter of the Compensation of
CURTIS W. STINSON, Claimant
WCB Case No. 89-16397
CORRECTED ORDER ON RECONSIDERATION
Whitehead & Klosterman, Claimant Attorneys
David O. Horne, Defense Attorney

Claimant requested reconsideration of our May 22, 1992 order on review finding that claimant was barred by claim preclusion from litigating the proper rate of temporary total disability paid by the insurer pursuant to 1984 and 1988 Determination Orders. Our order further found, however, that claimant was not barred from litigating the proper rate of his permanent total disability benefits awarded in a former proceeding. Our order affirmed and adopted that portion of the Referee's order determining that claimant was entitled to a higher rate of permanent total disability.

On reconsideration, we found that claimant was entitled to an assessed fee because the insurer initiated the request and, on review, the Board did not disallow or reduce part of the compensation awarded by the Referee. Specifically, our order on reconsideration stated that "[h]ere, the insurer requested review and we did not reduce the increased temporary total disability benefits awarded by the Referee. Claimant's attorney therefore is entitled to an assessed fee for prevailing against the insurer's request for review regarding claimant's entitlement to an increased rate of his temporary total disability."

As explained above, by finding that claimant was barred from litigating that he was entitled to an increased rate of his temporary total disability, our order on review decreased claimant's temporary total disability benefits awarded by the Referee. Consequently, our order on reconsideration erroneously stated that claimant was entitled to an assessed fee for prevailing on this issue. However, in finding that claimant was not barred from litigating the proper rate of his permanent total disability benefits, our order on review did not reduce the increased permanent total disability benefits awarded by the Referee.

Therefore, our order on reconsideration is corrected to the extent that claimant is entitled to an assessed fee for prevailing against the insurer's request for review regarding claimant's entitlement to an increased rate of his permanent total disability.

Subsequent to this correction, we republish our May 22, 1992 Order on Review and June 19, 1992 Order on Reconsideration. The parties' rights of appeal shall continue to run from the date of our June 19, 1992 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RAYMOND THORNSBERRY, Claimant
Own Motion No. 66-0298M
OWN MOTION ORDER ON RECONSIDERATION
Rick Roll, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requested reconsideration of our January 15, 1992 Own Motion Order that denied his request for claim reopening on the basis of res judicata. On February 14, 1992, in order to fully consider the matter, we abated our prior order and granted the SAIF Corporation an opportunity to respond. After

receiving SAIF's response, and further considering the matter, we make the following conclusions.

Claimant contends that he is entitled to Own Motion relief on the basis that SAIF has not formally denied his right hip condition or alternatively on the basis that res judicata principles are inapplicable in this instance. We disagree.

Inasmuch as claimant's was injured prior to January 1, 1966, he does not have a lifetime right to medical services for his compensable low back injury. William A. Newell, 35 Van Natta 629 (1983). Therefore, in order to obtain medical services, claimant sole remedy is to petition the Board for own motion relief. ORS 656.278(1)(a). Since claimant is not entitled to medical services without Board authorization, SAIF does not have to formally deny an unrelated condition. See e.g. Roy Hansen, 43 Van Natta 990 (1991).

With regard to claimant's alternative argument, we have nothing further to add to our prior order and decline to discuss the issue further.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our former order, effective this date.

IT IS SO ORDERED.

June 24, 1992 Cite as 44 Van Natta 1207 (1992)

In the Matter of the Compensation of
GARY D. MOON, Claimant
WCB Case No. 91-02406
ORDER ON REVIEW
Bottini & Bottini, Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Hooton and Brazeau.

The insurer requests review of Referee T. Lavere Johnson's order that set aside its denial of claimant's aggravation claim for his current low back condition. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following correction. The epidural steroid injections occurred in June and July 1991. (Tr. at 32).

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's order, with the following supplementation. In addition to the increased loss of range of lumbar motion, claimant's former disc bulge at L5-S1 has become a frank herniated disc. (Ex. 30). Claimant's last award or arrangement of compensation was a June 11, 1990 Determination Order. The impairment rating in that order included disc bulges at L3-4 and L5-S1. Accordingly, we find that the worsening of the L5-S1 disc is more than any waxing and waning of symptoms contemplated at the time of claim closure. See ORS 656.273(8).

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. 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 attorney's services on review concerning the aggravation issue is $1,000, 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 October 25, 1991 is affirmed. Claimant's attorney is awarded $1,000 for services on Board review, to be paid by the insurer.

June 24, 1992 Cite as 44 Van Natta 1208 (1992)

In the Matter of the Compensation of
THOMAS C. MOORE, Claimant
WCB Case No. 91-09920
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Myers' order that: (1) declined to find that the insurer had denied, "de facto," an occupational disease claim previously found to be compensable by an Order on Review; and (2) declined to assess a penalty for the insurer's allegedly unreasonable failure to specifically accept the occupational disease claim. On review, the issues are enforcement of the Order on Review and penalties.

The Board affirms and adopts the order of the Referee, with the following supplementation. The insurer claims an offset of overpaid benefits made in claimant's June 28, 1988 compensable injury claim. (Ex. 21). Because that offset occurred with regard to claimant's 1988 injury claim, no offset may be taken against future benefits awarded in claimant's compensable occupational disease claim. Steven M. Ginther, 42 Van Natta 526 (1990).

ORDER

The Referee's order dated October 28, 1991 is affirmed.

June 24, 1992 Cite as 44 Van Natta 1208 (1992)

In the Matter of the Compensation of
TERRY D. STRICKLAND, Claimant
WCB Case No. 89-13252
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Janice Pilkenton, Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of that portion of Referee Quillinan's order that upheld the insurer's denial insofar as it denied chiropractic treatments in excess of two treatments per month. On review, the issue is medical services.

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

The Referee applied the Workers' Compensation Law in effect before the 1990 amendments became operative on July 1, 1990. We agree. Claimant requested a hearing in July 1989, and the hearing was originally convened in October 1989. Because claimant was not personally present at the hearing, the Referee dismissed the hearing request. On Board review, we vacated the Referee's dismissal order and remanded this matter for a hearing on the merits. Inasmuch as the hearing was requested before May 1, 1990 and originally convened before July 1, 1990, this matter must be determined pursuant to the law in effect before the 1990 amendments. See Or Laws 1990 (Special Session), ch. 2, 54(2).

On the merits, claimant contends that the Referee erred in limiting chiropractic treatments to two visits per month after June 19, 1989. He notes that, by denial letter dated June 19, 1989, the insurer had denied all chiropractic treatment as not reasonable and necessary. He argues, therefore, that the Referee did not have jurisdiction to consider whether treatments in excess of two visits per month were reasonable and necessary. We disagree.

This case is controlled by Freres Lumber Co., Inc. v. Murphy, 101 Or App 92 (1990). There, the court held that when an insurer denies the reasonableness and necessity of repetitive treatments, claimant bears the burden of proof, not only as to the reasonableness and necessity of the type of treatment, but also as to the frequency of the treatment. Id. at 95. Likewise, in this case, although the insurer denied all chiropractic treatments, claimant bears the burden of proving that treatments in excess of two visits per month were reasonable and necessary. We agree with the Referee that claimant did not sustain her burden of proof.

ORDER

The Referee's order dated March 6, 1991 is affirmed.

June 24, 1992 Cite as 44 Van Natta 1209 (1992)

In the Matter of the Compensation of
JOHN L. WILL, Claimant
WCB Case No. 91-03346
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Hooton and Brazeau.

The SAIF Corporation requests review of Referee Lipton's order that set aside its denial of claimant's aggravation claim for a right knee injury. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND REASONING

The Referee concluded that claimant had established a compensable worsening of his right knee condition and set aside SAIF's denial. We agree and adopt the Referee's conclusion with the following supplementation.

On review, SAIF contends that claimant has failed to prove that his alleged worsening was more than an anticipated waxing and waning of his symptoms.

SAIF acknowledges that the last award of compensation, a stipulation of October 2, 1990, did not expressly address whether future exacerbations were anticipated, but argues that such waxing and waning of symptoms were implicitly contemplated based on the medical records existing at the time of the stipulation. We disagree.

The medical record in existence prior to the stipulation is best summarized by Dr. Paluska's November 10, 1989 closing report, in which he noted that claimant walked with no limp, had no observable crepitation or swelling, had full extension and flexion, and exhibited no ligamentous instability. Paluska made no reference to the probability of future exacerbations and concluded that claimant was medically stationary with minimal disability. We recognize that, in his September 19, 1991 deposition, Paluska opined that claimant would experience periods of increased knee symptoms accompanied by a diminished earning capacity. That information, however, was obviously not available when the parties agreed to the stipulated order in 1990. See Gywnn v. SAIF, 304 Or App 345 (1987).

After our review of the record, we find no evidence that, in reaching a settlement in October 1990, the parties contemplated future flare-ups of claimant's knee condition. Accordingly, as supplemented herein, we adopt the Referee's conclusion that claimant has established a worsened condition resulting from the original injury since the last arrangement of compensation.

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. 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 attorney's services on review concerning the aggravation issue is $1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated October 28, 1991 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the SAIF Corporation.

June 25, 1992 Cite as 44 Van Natta 1210 (1992)

In the Matter of the Compensation of
DIANE B. ALLEN, Claimant
WCB Case No. 91-09909
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Roger Miller (Saif), Defense Attorney

Reviewed by Board Members Hooton and Kinsley.

Claimant requests review of Referee Holtan's order that dismissed her hearing request for lack of jurisdiction. Claimant contends that the Hearings Division has jurisdiction to consider whether the scheduled permanent disability benefits awarded by Notice of Closure on May 16, 1991 should be paid at the rate of $305 per degree and whether penalties and attorney fees should be assessed for the SAIF Corporation's failure to do so. On review, the issue is dismissal.

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

Claimant has not exhausted administrative remedies prescribed by ORS 656.268(4)(e) which provides that if a worker objects to a Notice of Closure, the worker first must request reconsideration by the Department of Insurance and Finance. Inasmuch as the issues raised by claimant arise from the Notice of Closure, and claimant has not requested reconsideration, the Referee properly dismissed her hearing request.

ORDER

The Referee's dismissal order dated October 17, 1991 is affirmed.

June 25, 1992 Cite as 44 Van Natta 1211 (1992)

In the Matter of the Compensation of
LYNN M. CHRISTENSEN, Claimant
WCB Case Nos. 90-18771 & 90-16058
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Cummins, Brown, et al., Defense Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation (on behalf of Twin Oaks Care Center) requests review of Referee Myzak's order that: (1) set aside its denial of claimant's occupational disease claim for her low back condition; and (2) upheld SAIF's (on behalf of Ranier Wood Products) denial of claimant's aggravation claim. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had established compensability of an occupational disease claim with Twin Oaks Care Center. We agree with the Referee's conclusion, and we add the following supplementation.

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

Compensability

Aggravation

We agree with the Referee that claimant has failed to establish compensability of an aggravation claim. Here, claimant's 1988 injury was accepted by Ranier as a lumbar strain. Although a CT scan taken at that time showed a possible disc bulge at L4-L5, it was not until a January 1989 MRI, that claimant was first diagnosed with degenerative disc disease.

Claimant's current condition has been diagnosed as degenerative disc disease of the lower back. (Exs. 78, 81, 81a, 83-20). There is no evidence that

claimant's worsened degenerative condition is attributable to the original 1988 injury. Accordingly, we agree with the Referee that claimant has failed to establish an aggravation claim with Ranier.

Because we have concluded that claimant has not established an aggravation claim, the responsibility issue is moot. Therefore, in order to establish compensability of her low back claim, claimant must prove that her employment with Twin Oaks was the major contributing cause of the worsening of her underlying degenerative disc disease. ORS 656.802(2).

Occupational disease

On review, Twin Oaks contends that the Referee should not have relied upon the opinion of Dr. LaFrance, claimant's treating physician, to find that claimant had sustained a worsening of her underlying degenerative disc disease. In a deposition, Dr. LaFrance testified that claimant's employment at Twin Oaks had worsened her underlying condition. Dr. LaFrance based his finding of a worsening upon several factors, including increased muscle spasm, decreased range of motion, urinary incontinence, and the fact that claimant required more physical therapy.

On review, Twin Oaks argues that claimant is an unreliable historian and doctors have noted that her expressed symptoms are out of proportion to objective physical findings. Twin Oaks, therefore, contends that Dr. LaFrance's opinion should not be deferred to as claimant's resistance to range of motion testing and her symptom magnification cannot be relied upon to establish a worsened condition. We disagree.

In a March 1, 1991 letter, Dr. LaFrance addressed the issue of claimant's behavior during examinations. He did not disagree that there were some elements of neurotic behavior present, however, he did not believe that claimant was deliberately manipulating examinations. Rather, he attributed claimant's behavior to poor body mechanics. Dr. LaFrance testified that, because he had treated claimant over a period of a year and a half, he would be in a better position to assess claimant's anxiety level and its effect upon her symptoms than someone who performed a single independent medical exam.

Under the circumstances, we do not find that the Referee erred by deferring to Dr. LaFrance. We agree that his opinion establishes that claimant's work activity at Twin Oaks was the major contributing cause of a worsening of her underlying degenerative disc disease condition. We, therefore, affirm the Referee on the issue of compensability.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the issue of compensability is $1,000, to be paid by SAIF on behalf of Twin Oaks. 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 May 20, 1991 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $1,000, to be paid by the SAIF Corporation, on behalf of Twin Oaks Care Center.

In the Matter of the Compensation of
DIANNA L. DOWELL, Claimant
WCB Case No. 91-03271
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Nelson, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

The insurer requests review of Referee Quillinan's order that: (1) found that the March 7, 1991 Notice of Closure prematurely closed claimant's right ankle claim; (2) set aside the insurer's "de facto" denial of claimant's claim for physical therapy treatment; (3) assessed a penalty and related attorney fee for the insurer's allegedly unreasonable delay in processing claimant's claim; and (4) found that claimant was entitled to temporary total disability benefits. On review, the issues are premature closure, medical services, penalties and attorney fees, and temporary total disability. We affirm in part and vacate in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Premature closure

We adopt the Referee's "Opinion" on the issue of premature closure.

Physical therapy

On review, the insurer contends that claimant's physical therapy treatments are palliative care and, therefore, the care is not compensable pursuant to amended ORS 656.245(1)(b). Claimant, however, argues that a component of the care is actually curative and that Dr. Neuman has stated that the purpose of the treatment was to improve claimant's condition and to allow her to reach maximum improvement.

We have concluded that ORS 656.327 provides a resolution procedure for those medical treatment disputes that are appropriate for review by a medical panel, such as the reasonableness and necessity of medical treatment for a compensable condition. See Stanley Meyers, 43 Van Natta 2643 (1991). Moreover, we have recently concluded that where the issue concerns whether claimant's medical treatments are palliative, rather than curative, such a dispute generally concerns the effectiveness and appropriateness of the medical treatment at issue. Gladys M. Theodore, 44 Van Natta 905 (1992). Accordingly, the legislature intended such a dispute to be resolved by a physician, rather than a referee. Therefore, because a procedure for resolving this medical treatment issue is otherwise provided in ORS 656.327, original jurisdiction lies exclusively with the Director. ORS 656.704; Meyers, supra; Theodore, supra.

We vacate that portion of the Referee's order that purported to set aside the insurer's "de facto" denial of claimant's physical therapy treatment, as we find that the issue does not involve a matter concerning a claim within the jurisdiction of the Hearings Division. We also vacate the Referee's assessed attorney fee award of $1,800 for claimant's counsel's services on the issue of the "de facto" denial.

Penalties and attorney fees

The Referee concluded that the insurer's delay in accepting or denying claimant's claim for physical therapy was unexplained. Accordingly, she assessed a penalty and related attorney fee. However, because we have vacated the Referee's order as it pertains to physical therapy, we find that there has been no unreasonable resistance to the payment of compensation. Under the circumstances, no penalties or attorney fees may be assessed. See Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991).

Temporary total disability

We adopt the Referee's "Opinion" on the issue of temporary disability benefits.

The insurer has requested review of an order awarding compensation. We have found that the compensation should not be disallowed. Accordingly, claimant is entitled to an assessed fee on the issues of premature closure and temporary disability benefits. 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 concerning the issues of premature closure and temporary disability is $800, to be paid by the insurer. 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 June 17, 1991 is affirmed in part and vacated in part. That portion of the Referee's order which purported to set aside the insurer's "de facto" denial of claimant's physical therapy treatment is vacated. The Referee's assessed attorney fee of $1,800 for services rendered in conjunction with the denial is also vacated. The Referee's penalty and related attorney fee for an unreasonable delay in accepting or denying the physical therapy claim is also vacated. The remainder of the Referee's order is affirmed. For services on review on the issues of premature closure and temporary disability benefits, claimant's counsel is entitled to a reasonable attorney fee of $800, payable by the insurer.

In the Matter of the Compensation of
CHARLENE J. ERSPAMER, Claimant
WCB Case No. 91-08403
ORDER ON REVIEW
Francesconi, et al., Claimant Attorneys
Roy W. Miller (Saif), Defense Attorney

Reviewed by Board Members Hooton and Brazeau.

Claimant requests review of Referee Holtan's order that dismissed her hearing request for lack of jurisdiction. Claimant contends that the Hearings Division has jurisdiction to consider her request that scheduled permanent disability, awarded by Notice of Closure or Determination Order, be paid at the rate of $305 per degree. On review, the issue is dismissal.

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

Claimant argues that her hearing request does not raise an objection to a Notice of Closure or Determination Order within the meaning of ORS 656.268(4)(e) and (5), and therefore, she was not required to request reconsideration by the Department of Insurance and Finance (DIF) before filing the hearing request. We disagree.

The rate issue arises directly from the scheduled permanent disability awarded by the Notice of Closure or Determination Order. Contrary to claimant's assertion, an objection to a Notice of Closure or Determination Order is not limited to extent of disability issues; it concerns the amount of compensation awarded. Inasmuch as the rate issue raises an objection to the amount of compensation awarded by the Determination Order or Notice of Closure, claimant must first request reconsideration by DIF before filing a hearing request. Lorna D. Hilderbrand, 43 Van Natta 2721 (1991). Claimant's citation to Harry E. Forrester, 43 Van Natta 1480 (1991), is not persuasive here, because that case did not involve a Notice of Closure or Determination Order.

ORDER

The Referee's dismissal order dated September 25, 1991 is affirmed.

June 25, 1992 Cite as 44 Van Natta 1215 (1992)

In the Matter of the Compensation of
ERWIN L. FARMEN, Claimant
WCB Case Nos. 92-01495 & 92-01494
ORDER DENYING MOTION TO DISMISS
Whitehead & Klosterman, Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

The insurer has requested Board review of Referee Quillinan's April 27, 1992 Opinion and Order. Claimant has moved for dismissal of the insurer's request, contending that the Referee's order does not constitute a final order. We deny the motion.

FINDINGS OF FACT

On April 27, 1992, the Referee issued her Opinion and Order. Finding that the Director, who found claimant ineligible for additional vocational assistance, did not follow the correct steps in determining a "suitable" wage for claimant, the Referee concluded that the matter should "be remanded to the Department of Insurance and Finance for further proceedings consistent with this order."

Consequently, the Referee set aside the Director's order and remanded the matter to the Director for determination of a suitable wage for claimant. The Referee's April 27, 1992 order included a statement explaining the parties' rights of appeal under ORS 656.289(3) and 656.295.

On May 21, 1992, the insurer mailed, by certified mail, to the Board its request for review of the Referee's April 27, 1992 order. That same date, the insurer also mailed a copy of its request to claimant's attorney. On May 26, 1992, the Board mailed a computer-generated letter to the parties acknowledging the request for review.

CONCLUSIONS OF LAW AND OPINION

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, if the Referee's order is correct, it is not a final order because it does not finally determine the rights of parties concerning claimant's rights to vocational benefits. Nevertheless, if the Referee's order is incorrect, the order will have finally determined the rights of the parties by effectively dismissing the only request for hearing which would allow for litigation and modification of the Director's order. See Mickey L. Platz, 44 Van Natta 16 (1992).

Inasmuch as claimant's entitlement to additional vocational assistance is potentially impacted by the Referee's order, we conclude that it is an appealable final order. See Mickey L. Platz, supra. Because the insurer timely requested Board review, the Referee's order has not become final. See ORS 656.289(3). Consequently, we hold that we have authority to consider the matters raised by the insurer's request for Board review of that order.

Accordingly, claimant's motion to dismiss is denied. A transcript of the oral proceedings has been ordered. Upon its receipt, copies will be distributed to the parties along with a briefing schedule. Thereafter, the case will be docketed for Board review.

IT IS SO ORDERED.

In the Matter of the Compensation of
LYLE J. JOHNSON, Claimant
WCB Case No. 91-17457
SECOND ORDER OF DISMISSAL
Bonnie Laux (Saif), Defense Attorney

On May 28, 1992, we abated our May 15, 1992 Order of Dismissal. We took this action in response to a submission from claimant contending that our dismissal order was erroneous. In abating our order, we granted the SAIF Corporation an opportunity to respond within 14 days of our order. Inasmuch as SAIF's response has been timely submitted, we proceed with our reconsideration.

On May 15, 1992, we dismissed claimant's request for Board review because claimant's March 15, 1992 letter, although dated within 30 days of the Referee's March 2, 1992 order, was received by the Board on April 17, 1992. Inasmuch as claimant's letter was not mailed by certified or registered mail, we presumed that the letter was filed untimely. See OAR 438-05-046(1)(b). In reaching our conclusion, we noted that "an uncontested statement from a party that a request was mailed to the Board on a particular date" would be sufficient to rebut a presumption of untimely filing.

In response to our order, claimant has submitted a May 18, 1992 letter stating that he mailed his March 15, 1992 letter on March 15, 1992 to the Board, as well as to SAIF. Contending that his letter was timely "filed," claimant requests that we proceed with our review. In response, SAIF represents that it did not receive claimant's March 15, 1992 letter until April 24, 1992. SAIF argues that such circumstances provide further support for a conclusion that claimant's March 15, 1992 letter was untimely filed.

In dismissing claimant's request for review, we stated that the "rebuttable presumption" of untimely filing required by OAR 438-05-046(1)(b)

could be overcome by a party's affidavit declaring that a request for review was mailed to the Board within 30 days of the Referee's order. See Greg Carpenter, 40 Van Natta 100, 349 (1988). We further reasoned that "an uncontested statement from a party that a request was mailed to the Board on a particular date would likewise be sufficient" to rebut the rule's presumption of untimeliness. (Emphasis supplied).

Here, claimant has not submitted an affidavit swearing under oath that his request for review of the Referee's order was timely mailed to the Board. Moreover, his statement that he timely mailed his request for review to the Board has been contested. Thus, we are left with a record which consists of the following relevant matters: (1) a March 15, 1992 letter from claimant marked "2nd copy" (received by the Board on April 17, 1992), which is contained in an envelope marked April 16, 1992 and addressed to the Workers' Compensation Board; (2) claimant's unsworn written statement that he mailed his March 15, 1992 letter to the Board and to SAIF on March 15, 1992; and (3) SAIF's written response that it did not receive a copy of claimant's March 15, 1992 letter until April 24, 1992

There is no affidavit from claimant swearing to the accuracy of the statements he has previously made. For that reason alone, and setting aside any other questions about the facts that might be raised by SAIF had an affidavit been filed, the record as currently developed fails to rebut the presumption of untimely filing as set forth in OAR 438-05-046(1)(b). Consequently, we have no alternative but to reinstate our May 15, 1992 order dismissing claimant's request for review.

Accordingly, as supplemented herein, we republish our May 15, 1992 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

June 25, 1992 Cite as 44 Van Natta 1217 (1992)

In the Matter of the Compensation of
RAYMOND D. LINDLEY, Claimant
WCB Case No. 91-08273
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

The SAIF Corporation requests review of Referee Garaventa's order that awarded claimant 8 percent (25.6 degrees) unscheduled permanent partial disability, whereas a Reconsideration Order had awarded no permanent disability. In his respondent's brief, claimant requests that the award be increased. On review, the issue is extent of unscheduled disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

For purposes of determining injury-related permanent partial disability, ORS 656.214(5) requires application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f). ORS 656.283(7) provides that the evaluation of the worker's disability shall be as of the date

of issuance of the Reconsideration Order. Because claimant became medically stationary after July 1, 1990, and the Determination Order issued September 12, 1990, the extent of claimant's permanent disability is properly analyzed under the standards effective January 1, 1989. (WCD Admin. Order 1-1989).

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.

On review, neither party disputes the values assigned by the Referee for claimant's age, education or adaptability. After our review, we adopt the Referee's conclusions and reasoning concerning those values and address only the issue of impairment.

Impairment

Based on the medical arbiter's findings, the Referee concluded that claimant was entitled to 3 percent impairment for lost range of motion in the cervical area. Relying on an independent medical examiner's report and claimant's credible testimony, the Referee also concluded that claimant was entitled to an additional 5 percent impairment for a chronic condition limiting repetitive use. SAIF challenges the Referee's latter conclusion, asserting that there is no valid medical evidence of such impairment. We agree.

With the exception of a medical arbiter appointed pursuant to ORS 656.268(7), "only the attending physician at the time of closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability." ORS 656.245(3)(b)(B); Dennis E. Connor, 43 Van Natta 2799 (1992). Accordingly, the findings of an independent medical examiner may not be used to assign impairment values under the standards. Furthermore, any finding of fact regarding the worker's impairment must be established by medical evidence supported by objective findings. ORS 656.268(7). Therefore, claimant's testimony, without more, is not sufficient to establish permanent impairment. See Suzanne Robertson, 43 Van Natta 1505 (1991).

Claimant contends that the Referee erred in awarding a total of 3 percent impairment for lost range of cervical motion. He contends that the proper award for 35 degrees of retained right lateral flexion is 1.33 percent, not .67 percent, and that, consequently, his total award equals 4 percent. We disagree. Former OAR 436-35-360(4) provides an award of .67 percent for 35 degrees of retained right lateral flexion. Adding that value to an award of .33 percent impairment for 40 degrees left lateral flexion, former OAR 436-35-360(4), 1 percent impairment for 60 degrees right rotation, former OAR 436-35-360(5), and 1 percent impairment for 60 degrees left rotation, former OAR 436-35-360(5), the total rating for lost range of motion in the cervical area equals 3 percent.

ORDER

The Referee's order dated September 30, 1991 is modified. In lieu of the Referee's increased award, claimant is awarded 3 percent (9.6 degrees) unscheduled permanent partial disability. Claimant's attorney fee shall be modified accordingly.

In the Matter of the Compensation of
DAVID W. LITTLE, Claimant
WCB Case Nos. 89-12899 & 89-20047
ORDER ON REMAND
Bischoff & Strooband, Claimant Attorneys
Brian L. Pocock, Defense Attorney
Dennis Ulsted (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. City of Eugene v. Little, 112 Or App 270 (1992). The court reversed our prior order which found claimant's occupational disease claim for a bilateral hearing loss compensable because he had established that his work activities were a material contributing cause of his condition. Citing Aetna Casualty Co. v. Aschbacher, 107 Or App 494, rev den 312 Or 150 (1991), the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In Donna E. Aschbacher, 41 Van Natta 1242 (1989), we held that, under the 1987 amendments to former ORS 656.802(1), a claimant could prove a compensable claim under former ORS 656.802(1)(c) by merely showing that work was a material contributing cause of a claimed condition or a worsening of the symptoms of a preexisting disease. Relying on former ORS 656.802(1)(c), but without explicitly stating the quantum of proof required, the Referee concluded that the medical evidence established a compensable occupational disease claim. We adopted that portion of the Referee's "Conclusions and Opinion" regarding compensability, finding that the Referee concluded that claimant's work exposure with the City of Eugene materially caused his bilateral hearing loss. We also found that the City of Eugene, acting in its self-insured capacity, was responsible for this occupational disease claim. Finally, we reversed the Referee's penalty-related attorney fee assessment for an allegedly untimely denial.

The Court of Appeals subsequently reversed our order in Aschbacher, holding that to establish the compensability of an occupational disease under former ORS 656.802(1)(c), a claimant must prove that his work activities were the major contributing cause of his condition or the worsening of his underlying condition. Aetna Casualty Co. v. Aschbacher, supra. Here, the court reversed our prior order and remanded for reconsideration in light of its decision in Aschbacher. City of Eugene v. Little, supra.

Major contributing cause means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening of his condition than all other conditions, explanations, or exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); David K. Boyer, 43 Van Natta 561 (1991), aff'd mem Boyer v. Multnomah County School District No. 1, 111 Or App 666 (1992).

The record contains three opinions regarding causation. In our prior order, we adopted the Referee's reasoning for relying on the opinion of Dr. Lundmark, examining otolaryngologist, rather than Dr. Hiatt, examining otolaryngologist, or Dr. Ediger, examining audiologist. On further consideration, we continue to find the observations rendered by Dr. Lundmark to be more persuasive than those offered by Drs. Hiatt and Ediger.

Dr. Hiatt stated that he did not feel that claimant's hearing loss was related to his employment. (Ex. 33). However, he did not explain his opinion,

and we do not find his conclusory opinion persuasive. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980).

Dr. Ediger opined that claimant's hearing loss was caused by exposure to gunfire noise during his recreational hunting activities. He discounted the noise from claimant's fire fighting truck, stating that the noise was within non-risk limits during an eight hour day. (Ex. 32). However, unlike Dr. Lundmark, Dr. Ediger did not consider the effects of repeated exposure to this occupational noise over a period of years. Furthermore, Dr. Ediger reasoned that a hearing loss due to occupational exposure would be symmetric, whereas claimant's hearing loss is greater in his left ear. (Ex. 30-4). Such circumstances persuaded Dr. Ediger that claimant's hearing loss was attributable to gunfire noise (claimant is a right-handed shooter). (Ex. 32-2).

Dr. Lundmark disagreed with Dr. Ediger's opinion. Dr. Lundmark opined that, given the severity of the hearing loss and claimant's young age, it would be very unusual for his hearing loss to be caused by hunting and the noises of life. (Exs. 26A-2, 37-16, 37-31, 37-33, 37-35). Noting that the fire truck's siren produced a noise over 100 decibels, Dr. Lundmark opined that such a noise level was capable of producing hearing loss. (Exs. 37-27, 37-28). Although the increased hearing loss in the left ear could be explained by claimant's exposure to gunfire, Dr. Lundmark concluded that the hearing loss was more likely caused by his exposure to the siren noise while driving the fire truck with the window down.

Throughout claimant's work as a fire fighter, he has been exposed to industrial noise including noise from the fire truck engine, sirens, air horns, and various noisy rescue equipment, such as chain saws and the "jaws of life." Claimant worked as an engineer from December 1976 until 1985. This work included driving the fire truck and involved increased overall noise because the siren and air horns were directly above the driver's position in the cab. Furthermore, during warm weather, the windows of the cab were open which further increased the noise exposure, particularly to claimant's left ear. The city became self-insured on July 1, 1979. Dr. Lundmark opined that claimant's hearing markedly worsened between 1977, the first time claimant's hearing was tested, and 1988. (Ex. 37-9). The city was self-insured during most of this period. After considering claimant's exposures to noise, Dr. Lundmark opined that claimant's industrial noise exposure was more significant than his exposure to gunfire noise. (Exs. 37-25, 37-30, 37-32, 37-33).

We find Dr. Lundmark's opinion to be more through and well-reasoned. See Somers v. SAIF, 77 Or App 259 (1986). On that basis, we find his opinion more persuasive. We note that, although Dr. Ediger stated that isolated daily exposure to the industrial noise would not cause claimant's hearing loss, unlike Dr. Lundmark, he did not consider the cumulative effects of exposure over a period of years.

Having found Dr. Lundmark's opinion to be more persuasive, we further conclude that it satisfies claimant's burden of proving that employment conditions were the major contributing cause of his bilateral hearing loss. To be sufficient to establish the compensability of a claim, medical evidence is not required to consist of a specific incantation or to mimic the statutory language. Liberty Northwest v. Cross, 109 Or App 109 (1991); McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986) ("Magic words" not required). Inasmuch as Dr. Lundmark persuasively explained why the noise exposure due to the recreational hunting was not a significant factor and conclusively related claimant's bilateral hearing loss to his noise exposure at work, we hold that claimant has established that his occupational disease claim is compensable under former ORS 656.802.

Moreover, because the city, in its self-insured capacity, has neither established that claimant's exposure while SAIF was on the risk was the sole cause of claimant's hearing disability nor that claimant's exposure while the city was self-insured did not contribute to claimant's hearing disability, we continue to find the city, as a self-insured employer, responsible for claimant's bilateral hearing loss claim. Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our April 19, 1991 order in its entirety.

Inasmuch as claimant has finally prevailed before the Board after remand from the court, he is entitled to a reasonable attorney fee for services before every forum. See ORS 656.388(1). Since claimant's counsel provided services before the court, a reasonable fee for such efforts shall be awarded. Id. After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable fee for claimant's counsel before the court is $2,000, to be paid by the employer. This fee is in addition to claimant's prior attorney fee awards for services rendered at the hearings level and on Board review. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate brief), the complexity of the issue, the value of the issue involved, and the risk that claimant's attorney's efforts may go uncompensated.

IT IS SO ORDERED.

June 25, 1992 Cite as 44 Van Natta 1221 (1992)

In the Matter of the Compensation of
KEITH A. REYNOLDS, Claimant
WCB Case Nos. 91-06912 & 91-06911
ORDER ON REVIEW
James W. Powers, Claimant Attorney
Bonnie Laux (Saif), Defense Attorney
Daryl Nelson, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Liberty Northwest Insurance Corporation requests review of those portions of Referee Nichols' order which: (1) set aside its denial of claimant's "new injury" claim for bilateral carpal tunnel syndrome; and (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's work exposure at Liberty's insured was the major contributing cause of a worsening of his carpal tunnel syndrome. Consequently, the Referee found that responsibility shifted to Liberty. We agree.

Claimant has an accepted carpal tunnel syndrome claim with SAIF. Therefore, responsibility for that condition would remain with SAIF unless claimant sustained a new compensable occupational disease involving the same condition while Liberty was on the risk. ORS 656.308; Donald C. Moon, 43 Van Natta 2595 (1991); Rodney H. Gabel, 43 Van Natta 2662 (1991).

In order to establish a "new compensable injury" against Liberty, claimant or SAIF must prove that the work activities at Liberty's insured were the major contributing cause of a pathological worsening of his carpal tunnel syndrome. ORS 656.802(2); Donald C. Moon, supra. Existence of the disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings. Id.

Whether claimant's existing carpal tunnel syndrome was worsened by his employment while Liberty was at risk presents a complex medical question that requires expert medical opinion to resolve. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986). Claimant's attending physician, Dr. Sproat, opined that claimant's job at Liberty's insured contributed to his symptomatology, and to the worsening of his symptomatology, but did not offer an opinion as to whether claimant's underlying condition had been worsened. Claimant was also seen by Drs. Phipps and Radecki for independent medical exams. Dr. Phipps, neurologist, opined that claimant's employment at Liberty's insured in 1990 was the major contributing cause of his need for treatment in late 1990, including his need for surgery. He stated that with the significant exacerbation of symptoms, there was "perhaps some change in his underlying condition, although that is always hard to tell." (Ex. 17-4). Dr. Radecki also examined claimant. He opined that claimant's underlying carpal tunnel condition had worsened pathologically in 1990. Radecki further opined that claimant's employment at the mill was the major contributing cause of this worsening. There is no medical opinion to the contrary, since the other physicians either offered no opinion on causation, or suggested that "perhaps" the underlying condition had changed.

Based on this record, we conclude that claimant has proven that his employment at Liberty's insured was the major contributing cause of a worsening of his carpal tunnel syndrome. Accordingly, responsibility for that condition shifts to Liberty.

Inasmuch as claimant did not file a timely respondent's brief, no attorney fee shall be awarded. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated September 17, 1991 is affirmed.

June 26, 1992 Cite as 44 Van Natta 1222 (1992)

In the Matter of the Compensation of
TERRY L. BALCOM, SR., Claimant
WCB Case Nos. 91-06086 & 91-05009
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Beers, et al., Defense Attorneys
Roderick Peters (Saif), Defense Attorney

Reviewed by Board Members Hooton and Brazeau.

Connecticut Indemnity (EBI) requests review of Referee Knapp's order that: (1) denied its motion to reopen the record for admission of post-hearing medical reports; (2) set aside its denial of claimant's aggravation claim for a current right shoulder condition; and (3) upheld the SAIF Corporation's denial of claimant's new injury or new occupational disease claim for the same condition. In his brief, claimant requests attorney fees for his services on review. On

review, the issues are remand, responsibility and attorney fees. We deny EBI's motion and affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for his "Ultimate Findings of Fact," with the following supplementation.

ULTIMATE FINDINGS OF FACT

Claimant did not suffer a right shoulder injury at work after January 1, 1991.

Claimant's employment after January 1, 1991 was not the major contributing cause of his current right shoulder condition.

CONCLUSIONS OF LAW AND OPINION

Motion to remand

EBI requests reopening of the record, or alternatively, remand for consideration of post-hearing medical reports. We treat the motion to reopen the record as a motion to remand. Judy A. Britton, 37 Van Natta 1262 (1985).

The medical reports in question are not attached and there are no copies in the record. However, EBI contends that they are material evidence offered in response to Dr. Neitling's report, (Ex. 33), and to claimant's alleged change in reporting regarding his symptoms. EBI argues that the reports were not available or obtainable with due diligence at the time of hearing, because it was surprised by Neitling's opinion and claimant's testimony. We disagree.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Osborn, 37 Or App 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986).

Assuming that EBI was surprised at hearing by Neitling's report and claimant's testimony, its remedy was to request postponement or a continuance. See OAR 438-06-081; 438-06-091. Inasmuch as EBI made no such request, it has not shown that material evidence was not obtainable with due diligence at the time of hearing. Therefore, the motion to remand is denied.

Responsibility

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

EBI argues that claimant's current condition is not the same as the injury-related condition which it accepted and that responsibility for the current condition must be assigned to SAIF under the last injurious exposure rule. In this regard, EBI contends that, because it accepted an injury-related condition, and claimant's current problems result from an occupational disease, the condition is not "the same," for responsibility purposes. We disagree.

It is undisputed that claimant's right shoulder condition is compensable, based on uncontroverted expert evidence establishing that the August 1990

compensable injury and subsequent heavy work activities caused his preexisting asymptomatic degenerative condition to become symptomatic and require treatment. Moreover, there is no evidence that claimant's current right shoulder condition differs materially from his injury-related condition, except that the condition is now permanently worsened. Therefore, and regardless of EBI's attempt to limit its acceptance, the current claim involves the same condition as did the August 1990 compensable injury.[1]

In reaching this conclusion, we note that Dr. Mandiberg, treating physician, reported that claimant's right shoulder pain "recurred" on January 24, 1991 and that claimant had "reaggravated" his degenerative arthritis of the AC joint. (Ex 20). Later, Mandiberg recalled telling claimant to expect future right shoulder problems if he continued with his regular employment. Mandiberg opined that, if the problems "recurred by work, then the problem would be work-related again." (Ex. 23). In February 1991, he observed, "Unfortunately, this is exactly what has happened." (Id.) In addition, although Dr. Mandiberg opined that claimant's right shoulder condition had returned to preinjury status on November 7, 1990 (Ex. 15-2), he also concurred with Western Medical Consultants' November 13, 1990 diagnosis of acute traumatic synovitis (work-related) of the right shoulder acromioclavicular joint superimposed upon degenerative joint disease (not work-related). (See Exs. 16-3 & 18).

Considering Mandiberg's references to a "reaggravation" and "recurrence" of problems after the November 1990 Notice of Closure, as well as claimant's credible testimony that his current symptoms are the same as his prior symptoms, we conclude that the current condition is the same as the prior compensable condition. Consequently, EBI remains responsible for medical services and disability relating to that condition, "unless the worker sustains a new compensable injury involving the same condition." ORS 656.308(1).

The Referee decided that responsibility does not shift from EBI to SAIF, because claimant's work exposure after January 1, 1991, when SAIF came on the risk, did not independently contribute to a pathological worsening of his underlying condition. We agree that responsibility does not shift; however, we offer the following analysis.

ORS 656.308(1) provides:

> "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."

We have interpreted the statute to mean that, in cases in which an accepted injury is followed by an increase in disability, involving the same condition, during employment with a later carrier, responsibility rests with the original carrier unless the claimant sustains an actual, independent compensable

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[1] We are not saying that the scope of EBI's acceptance included more than a temporary worsening; we are saying, however, that EBI is initially responsible for the current condition, because it is the same condition which is compensable as to them. Cf. Boise Cascade Corp. v. Katzenbach, 104 Or App 732, 735 (1990) ("Employer's acceptance of the strain is not an acceptance of a claim for avascular necrosis.").

injury during the subsequent work exposure. Ricardo Vasquez, 43 Van Natta 1678 (1991). Thus, in this case, EBI, as the last insurer with whom claimant had a compensable right shoulder claim, remains presumptively responsible. In order to shift responsibility, EBI has the burden of establishing that claimant sustained a new compensable injury or new occupational disease involving the same condition while working under SAIF's coverage. ORS 656.308(1); see Donald C. Moon, 43 Van Natta 2595, 2596 n.1 (1991) (The statute applies to occupational disease claims as well as to injury claims.); Rodney H. Gabel, 43 Van Natta 2662, 2664 (1991) (The last insurer with whom claimant had a compensable occupational disease claim remains responsible unless it establishes that work activities with the later insurer were the major contributing cause of an occupational disease involving the same condition).

Resolution of the causation issue is a complex medical question. Consequently, the causal impact of the employment must be established by expert medical testimony. Uris v. Compensation Department, 247 Or 420 (1967), Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986). When there is conflicting medical evidence, we generally defer to the opinion that is well-reasoned and based upon an accurate history. Somers v. SAIF, 77 Or App 259 (1986).

In the present claim we defer to the opinion expressed by Dr. Neitling. First, we do not accept Dr. Mandiberg's presumption that claimant's 20 years of heavy labor did not contribute to the condition accepted by EBI, but that one or two weeks of the same activity can, and did, permanently worsen it. Second, Dr. Neitling has provided an explanation which fully considers all of claimant's employment contributions, and considers the significance of his varying symptomatic history. Neitling also explained that claimant's history of symptoms is consistent with the natural history of his disease, rather than any pathological worsening arising from a subsequent employment exposure. (See Ex. 33). Accordingly, we conclude that EBI has not established that claimant suffered a new injury or occupational disease during SAIF's coverage. Therefore, responsibility for claimant's continuing right shoulder condition remains with EBI.

Attorney fee

Compensability was not litigated at hearing. There is no evidence that claimant's compensation would have been reduced if responsibility had shifted to SAIF. Because there is no evidence that claimant's compensation was at risk, claimant's attorney is not entitled to an attorney fee for services on review. See ORS 656.382(2); Riley E. Lott, 43 Van Natta 209, 212 (1991).

ORDER

The Referee's order dated August 2, 1991 is affirmed.

In the Matter of the Compensation of
SANTIAGO A. CRUZ, Claimant
WCB Case No. 91-02209
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Steven R. Cotton (Saif), Defense Attorney

Reviewed by Board Members Brazeau, Kinsley and Gunn.

The SAIF Corporation requests review of that portion of Referee Holtan's order that set aside its denial of claimant's injury claim for a back strain. In his brief, claimant requests a penalty and attorney fee for SAIF's allegedly unreasonable failure to provide discovery of claimant's statement regarding his claim until the close of lay testimony at hearing. On review, the issues are compensability and penalties and attorney fees. We affirm.

Compensability

We affirm and adopt the Referee's order concerning the compensability issue, with the following correction and supplementation. The insurer's denial was dated in 1991 not 1990.

We reject SAIF's argument that claimant did not establish his back injury by medical evidence supported by objective findings. See Brian S. Mode, 44 Van Natta 419 (1992).

Penalty and Attorney Fee

Contending that SAIF had no reasonable basis for withholding his written statement until testimony was completed, claimant seeks the assessment of a penalty or related attorney fee.

OAR 438-07-017 provides, in relevant part:

> "Other documents reasonably believed relevant and material only for purposes of impeachment of a witness need not be disclosed in advance of hearing and may be offered and admitted solely for impeachment. Documents so offered shall not be considered by the referee as substantive evidence. Upon request, all such documents shall be disclosed prior to the close of the hearing, whether or not offered, at which time the other party may offer the documents as substantive evidence."

Here, SAIF's counsel represented that the only purpose of claimant's written statement was for its use as impeachment evidence. Following claimant's testimony, the written statement was disclosed by SAIF and, at both parties' request, admitted into evidence solely for consideration concerning the alleged discovery violation and not for any substantive purposes regarding the compensability issue.

In light of SAIF's counsel's representation, as well as the fact that the written statement was not subsequently used for substantive purposes, the record establishes that SAIF had a reasonable belief that the withheld statement was relevant and material only for impeachment purposes. Consequently, penalties and attorney fees are not warranted.

Claimant is entitled to an insurer-paid attorney fee for prevailing against SAIF's request for review. 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 attorney's services on review concerning the compensability issue is $800, to be paid by the SAIF Corporation. 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 July 10, 1991 is affirmed. For his services on review, claimant's attorney is awarded a reasonable assessed fee of $800, to be paid by SAIF.

Board Member Gunn dissenting in part.

I agree that claimant has proved the compensability of his back injury claim. However, because I also believe that SAIF should be assessed an attorney fee for its unreasonable delay in disclosing claimant's written statement, I dissent.

An insurer is generally required to furnish the claimant copies of all relevant claims documents within 15 days after mailing of the hearing request or a written demand for such documents. OAR 438-07-015(2). Other documents "reasonably believed relevant and material only for purposes of impeachment" of a witness need not be disclosed in advance of hearing and may be offered and admitted solely for impeachment. OAR 438-07-017. Upon request, such documents must be disclosed prior to the close of the hearing. Id.

SAIF waited until the close of testimony to disclose claimant's written statement. SAIF's counsel asserted that it properly withheld claimant's statement for use as impeachment evidence. (Tr. 20). I disagree.

As the majority observes, OAR 438-07-017 requires a reasonable belief that the withheld document is relevant and material only for impeachment purposes. I find no evidence to support a finding that SAIF had a reasonable basis for believing claimant's written statement would be used for impeachment purposes. It appears that SAIF withheld the statement based on speculation that claimant might give contradictory testimony at hearing. Such speculation, without a basis in the record, does not justify withholding a relevant claim document.

I would conclude that the withholding of this statement after its discovery had been properly requested constituted an unreasonable "fishing expedition," as described above. SAIF's conduct forced claimant to develop the record with testimony regarding information which was already available but was withheld by SAIF until the close of testimony. That placed an unreasonable burden on claimant to prove his compensable claim and constituted an unreasonable resistance to the payment of compensation. Accordingly, I would assess an attorney fee under ORS 656.382(1). See Charles E. Condon, 44 Van Natta 726 (1992); Nicolasa Martinez, 43 Van Natta 1638 (1991).

In the Matter of the Compensation of
EDWARD T. GWILLIM, Claimant
WCB Case No. 91-02031
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Brazeau's order that: (1) found that claimant's current treatment is "palliative"; and (2) granted the self-insured employer's motion to dismiss claimant's request for review. On review, the issue is jurisdiction. We vacate in part and affirm in part.

FINDINGS OF FACT

In April 1988, claimant compensably injured his back. After being declared medically stationary, claimant received chiropractic treatment. On August 1, 1990, the employer refused to pay for the chiropractic treatments. Claimant requested a hearing, asserting that the chiropractic medical services were compensable. Review of the medical treatment by the Director was not requested nor did claimant's attending physician request approval for the chiropractic treatment from the employer or the Director.

CONCLUSIONS OF LAW AND OPINION

ORS 656.327(1)(a) provides that, for "medical treatment that is excessive, inappropriate, ineffectual or in violation of the rules regarding the performance of medical services," review of the treatment by the Director may be sought. ORS 656.327(2) provides the procedure for review by the Director. We have construed these provisions, in conjunction with ORS 656.704(3), as placing original jurisdiction of disputes concerning medical treatment that allegedly is "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services" exclusively with the Director. See Stanley Meyers, 43 Van Natta 2643, 2645 (1991).

ORS 656.245(1)(b) provides:

> "* * * [A]fter the worker has become medically stationary, palliative care is not compensable, [except in certain circumstances not applicable here.] * * * If the worker's attending physician referred to in ORS 656.005(12)(b)(A) believes that palliative care which would otherwise not be compensable under this paragraph is appropriate to enable the worker to continue current employment, the attending physician must first request approval from the insurer or self-insured employer for such treatment. If approval is not granted, the attending physician may request approval from the director for such treatment. * * *"

We recently considered our jurisdiction to consider whether or not a claimant's medical treatment is palliative, thereby rendering such treatments noncompensable under ORS 656.245(1)(b) absent prior approval from the carrier or Director. See Gladys M. Theodore, 44 Van Natta 905, 907-08 (1992). In Theodore, we found that, because the characterization of medical treatment as palliative or curative generally concerned the effectiveness and appropriateness of such medical treatment, original jurisdiction of such a dispute was with the Director. Id. at 908.

Here, the Referee found that the chiropractic treatment provided to claimant qualified as "palliative" treatment. The Referee, however, found that he was without jurisdiction to consider the compensability of the medical treatment based on his finding that claimant failed to comply with ORS 656.245(1)(b) by first requesting approval from the carrier or Director.

Based on our holding in Gladys M. Theodore, supra, we conclude that, because the dispute at issue here concerns whether or not the chiropractic treatment is palliative or curative, original jurisdiction of the matter lies exclusively with the Director. The Referee therefore lacked jurisdiction to determine that the medical treatment qualified as palliative care and we vacate that portion of his order. However, we affirm the Referee's grant of the motion to dismiss on the ground provided by this order.

ORDER

The Referee's order dated September 3, 1991 is vacated in part and affirmed in part. That portion of the order concluding that chiropractic treatment constituted palliative treatment is vacated. We affirm the Referee's grant of the employer's motion to dismiss on the ground that we lack jurisdiction of the matter.

June 26, 1992 Cite as 44 Van Natta 1229 (1992)

In the Matter of the Compensation of
OPHA D. RICHARDS, Claimant
WCB Case No. 91-03244
ORDER ON REVIEW
Glenn M. Feest, Claimant Attorney
Julie Bolt (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

The SAIF Corporation requests review of that portion of Referee Bethlahmy's order that set aside its denial of claimant's coronary artery disease. Claimant cross-requests review of that portion of the Referee's order that declined to assess a penalty for SAIF's allegedly unreasonable denial and failure to provide discovery. On review, the issues are the procedural propriety of the denial and penalties. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Medical Services

The Referee found that SAIF had accepted claimant's heart condition, diagnosed as coronary artery disease, as part of his 1959 industrial injury claim. Accordingly, the Referee concluded that SAIF was bound by that acceptance and could not issue a "back-up" denial under the rule set forth in Bauman v. SAIF, 295 Or 788 (1983). We agree.

In Bauman, an insurer specifically accepted an injured worker's claim for a bursitis condition and began making payments. When the worker sought to reopen the claim for additional medical treatment, the insurer denied the compensability of the initial injury. The court found the denial improper, reasoning that allowing an insurer to deny a previously accepted claim would "encourage

degrees of instability in the workers' compensation system that we do not believe the statute contemplates." 295 Or at 793. Thus, it held that if an "insurer officially notifies claimant that the claim has been accepted, the insurer may not, after that 60 days [1] have elapsed, deny the compensability of the claim unless there is a showing of fraud, misrepresentation or other illegal activity." Id. at 794.

In this case, SAIF does not allege fraud, misrepresentation or other illegal activity. It argues that the Bauman rule does not apply, because there is no evidence in the record that it officially or specifically accepted claimant's coronary artery disease. It relies on Johnson v. Spectra Physics, 303 Or 49 (1987), in which the Court stated:

> "Bauman applies only to a claim 'specifically' or 'officially' accepted by the insurer. ORS 656.262(6) requires that the insurer or self-insured employer furnish the claimant with '[w]ritten notice of acceptance or denial of the claim * * * within 60 days after the employer has notice or knowledge of the claim.' An insurer must accept a particular claim in writing * * * before Bauman applies." 303 Or at 55. (Citations omitted.)

Contrary to SAIF's allegations, we find that SAIF did furnish written notice to claimant indicating that it had accepted responsibility for his heart condition. The record reveals that, in July 1982, claimant notified SAIF that his treating physician, Dr. Lautenbach, had questioned whether SAIF would pay for services rendered for claimant's heart condition. In response to claimant's concerns, SAIF wrote Lautenbach on July 16, 1982, stating that "[t]he conditions that we cover involve [claimant's] heart and low back," and informed him that payment for a March 22, 1982 office visit, in which claimant received treatment for angina pectoris, "will be forwarded under separate cover." (Ex. 40). Clearly, that letter indicates that SAIF had accepted compensability of claimant's current heart condition and, because a copy of that letter was sent to claimant, SAIF had notified claimant of that acceptance. While that acceptance failed to contain all the information required by ORS 656.262(6), we do not consider that deficiency, caused by SAIF's failure to comply with its statutory obligations, sufficient to preclude a finding that SAIF had "officially" accepted claimant's heart condition under ORS 656.262(2).[2]

In reaching our decision, we also recognize that the acceptance lacked specificity in that it referred only to claimant's heart. As noted by claimant, however, the Court has clearly stated that an "acceptance need not meet any degree of specificity." Georgia Pacific v. Piwowar, 305 Or 494, 500 (1988). Rather, the Court clarified that the scope of an acceptance corresponds to the condition specified in the acceptance notice. Moreover, it also held that the acceptance of a condition includes acceptance of compensability of the disease causing that condition. Piwowar, supra, at 501. In this case, the evidence shows that SAIF accepted claimant's underlying heart condition, diagnosed as coronary artery disease, when it either accepted the heart condition as discussed above or accepted claimant's angina, a symptom of coronary artery disease.

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[1] ORS 656.262(6), as amended by the 1990 legislature, now requires that written notice be given within 90 days after an employer has notice or knowledge of a claim.

[2] We note that, under the court's recent decision in SAIF v. Tull, 113 Or App 449 (1992), furnishing written notice to a claimant is not a legal prerequisite for an acceptance to occur under ORS 656.262(2). Rather, whether an acceptance occurs is an issue of fact, to be decided on a case by case basis. Under that standard, we would also conclude that, on this record, SAIF had accepted compensability of claimant's heart condition.

After our review of the record, we agree with the Referee's conclusion that SAIF cannot deny compensability of claimant's coronary artery disease, because it had previously accepted a claim for that condition.

Penalties

The Referee concluded that, although SAIF could not deny compensability of claimant's heart condition, its denial was not unreasonable and that no penalty was warranted. We agree and adopt her conclusions. Given the unique facts and extended history of this case, we conclude that SAIF had a legitimate doubt as to its liability. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

The Referee also dismissed claimant's request for a penalty based on SAIF's failure to provide discovery of several claims-related documents. Specifically, she found that SAIF had failed to provide claimant with a copy of the 1982 letter to both claimant and his treating physician, in which SAIF acknowledged responsibility for claimant's heart condition. She also found the discovery violation to be unreasonable, as SAIF had given no explanation for its actions. See Lester v. Weyerhaeuser, 70 Or App 307 (1984). We agree and adopt those conclusions. The Referee concluded, however, that under Eastmoreland Hospital v. Reeves, 94 Or App 698 (1989), no penalty could be assessed because medical benefits could not constitute "amounts then due" under ORS 656.262(10).

Subsequent to the Referee's order, we issued Kim S. Jeffries, 44 Van Natta 824 (1992), in which we concluded that medical services could not form the basis for a penalty for unreasonable processing arising prior to the determination of compensability. Such a limitation, however, is not applicable for purposes of computing a penalty where a claim is for medical services for an accepted condition, as distinct from an initial injury or condition. Clinton F. Seals, Jr., 42 Van Natta 268 (1990). Because the medical benefits which SAIF refused to pay in this case were and are related to an accepted condition, those benefits are "compensation" under ORS 656.005(8), the amount of which can be considered in determining a penalty.

Accordingly, we conclude that SAIF's failure to comply with discovery requirements constituted an unreasonable resistance to the payment of compensation and justifies the assessment of a penalty equal to 25 percent of all compensation due, one half of which is payable to claimant's attorney in lieu of an attorney fee. ORS 656.262(10).

Attorney Fee on Review

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. 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 attorney's services on review concerning the procedural propriety of the denial is $1,400, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and statement of services), the complexity of the issue, and the value of the interest involved. In reaching this decision, we note that claimant is not entitled to an additional fee for services rendered concerning the penalty issue.

ORDER

The Referee's order dated October 14, 1991 is affirmed in part and reversed in part. That portion of the order that refused to assess a penalty for SAIF's discovery violation is reversed. For SAIF's unreasonable failure to

provide discovery, claimant is awarded a penalty equal to 25 percent of the compensation then due as a result of the Referee's order, payable by SAIF. One-half of the penalty is payable to claimant's attorney in lieu of an attorney fee. The remainder of the order is affirmed. For services on Board review concerning the propriety of SAIF's denial, claimant's attorney is awarded an assessed fee of $1,400, to be paid by SAIF.

June 26, 1992 Cite as 44 Van Natta 1232 (1992)

In the Matter of the Compensation of
RONALD D. ROBINSON, Claimant
WCB Case No. 91-08084
INTERIM ORDER (REMANDING)
Gatti, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

The insurer requests review of Referee Peterson's order that dismissed claimant's request for hearing without prejudice. Claimant moves to strike the insurer's reply brief on the ground that the insurer has raised issues not previously raised at hearing or in its appellant's brief. On review, the issue is whether claimant's request for hearing should have been dismissed with prejudice. We remand.

FINDINGS OF FACT

Claimant requested a hearing on June 20, 1991. Contending that the insurer had failed to pay interim compensation from May 30, 1991 to the time of the request for hearing, claimant sought interim compensation, penalties and attorney fees. On September 13, 1991, claimant filed a supplemental request for hearing, alleging entitlement to interim compensation from May 28, 1991 to the time of the request for hearing, and penalties and attorney fees.

On the date set for hearing, September 23, 1991, neither claimant nor his counsel appeared at hearing. The Referee informed the insurer's counsel that claimant had earlier phoned to request withdrawal of his hearing request.

Counsel for the insurer requested that the Referee dismiss claimant's request for hearing with prejudice.

On October 16, 1991, the Referee dismissed claimant's request for hearing on the ground that the request had been withdrawn. The Referee's order did not provide whether the dismissal was granted with or without prejudice.

On October 31, 1991, the insurer requested Board review of the Referee's dismissal order.

On November 19, 1991, the Board denied claimant's motion to dismiss the insurer's request for review of the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Motion to strike

As a preliminary matter, we address claimant's motion to strike the insurer's reply brief. Claimant contends that the insurer's reply brief contains factual and legal issues not previously raised either at hearing or in the insurer's appellant's brief.

We agree that the insurer may not raise issues not addressed at hearing.

Accordingly, we consider the insurer's reply brief only as it pertains to matters raised before the Referee. Therefore, in our review of the case, we do not consider the extraneous comments or matters raised by the insurer's reply brief.

Order of dismissal

On review, the insurer contends that the Referee abused his discretion by dismissing claimant's hearing request without prejudice. Here, the Referee's order did not state whether the matter was dismissed with or without prejudice. However, we have previously held that, unless an order of dismissal specifically states that the dismissal is with prejudice, the dismissal order shall be considered to have been entered without prejudice. Robert L. Murphy, 40 Van Natta 442 (1988). Accordingly, we agree with the insurer that the Referee dismissed the matter without prejudice.

The insurer argues that the Referee abused his discretion in dismissing the request for hearing without prejudice because the insurer appeared at hearing and argued for a dismissal with prejudice. The insurer contends that, because claimant did not appear and argue to the contrary, the Referee should have ruled in the insurer's favor.

We have concluded that the Referee has discretion to set the terms and conditions of an order of dismissal as he or she deems proper. Julie Mayfield, 42 Van Natta 871 (1990). In Mayfield, we concluded that we will not disturb the terms and conditions imposed by the Referee except upon a showing of abuse of discretion. Additionally, in Roger D. Estep, 43 Van Natta 196 (1991), we concluded that, where claimant withdrew his request for hearing and the employer did not raise, argue or move for an order of dismissal with prejudice, the Referee had discretion to dismiss the request for hearing and to set the terms and conditions of the order. In Estep, supra, we found no abuse of discretion by the Referee with regard to the order of dismissal without prejudice.

In the present case, however, we agree with the insurer that Estep is distinguishable, as the insurer in this case appeared at hearing and specifically moved for an order of dismissal with prejudice. We note, however, that neither the transcript nor the order of dismissal provides any reasoning regarding the Referee's decision to issue the order of dismissal without prejudice.

We have previously concluded that, without a record containing the Referee's reasoning on an issue involving an exercise of the Referee's discretion, we are subsequently unable to review for an alleged abuse of discretion. James D. Brusseau II, 43 Van Natta 541 (1991). In the present case, we find that the record contains no indication regarding the Referee's reason for dismissing the request for hearing without prejudice. Under the circumstances, we find this record "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5); Brusseau, supra. Consequently, we remand this matter to the Referee to determine whether claimant's hearing request shall be dismissed with or without prejudice. The Referee shall proceed in any manner that achieves substantial justice.

We retain jurisdiction over this matter. After conducting the aforementioned further proceedings, a transcript of any further hearing, along with any admitted exhibits, shall be forwarded to the Board. In addition, Referee Peterson shall provide an interim order on remand explaining his reasons for issuing the dismissal order either with or without prejudice. Thereafter, a revised briefing schedule shall be implemented.

IT IS SO ORDERED.

In the Matter of the Compensation of
HAROLD F. SCHULTZ, Claimant
Own Motion No. 92-0009M
OWN MOTION ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys

Claimant has requested reconsideration of our June 2, 1992 Order on Reconsideration that declined to authorize reimbursement from the Reopened Claim Reserve for the self-insured employer's voluntary reopening.

On August 13, 1991, we received the self-insured employer's submission which indicated that claimant's claim had been voluntarily reopened and requested reimbursement from the Reopened Claims Reserve. On March 22, 1992, we issued our Own Motion Order in this matter which denied reimbursement on the basis that we lacked evidence of a causal relationship between claimant's compensable injury and his need for surgery.

On April 22, 1992, we abated our March 22, 1992 order at claimant's request. Thereafter, claimant submitted evidence establishing a causal relationship between his compensable injury and need for surgery. On June 2, 1992, we issued our Order on Reconsideration in which we again declined to grant reimbursement. However, our reconsideration was based on the Court of Appeals decision in SAIF v. Holmstrom, 113 Or App 242 (1992), which held that the Board does not have the authority to grant or deny reimbursement from the Reopened Claims Reserve. On June 11, 1992, claimant again requested reconsideration on the basis that the employer had terminated temporary disability benefits as of our March 22, 1992 order.

After further consideration of the matter we withdraw our June 2, 1992 Order on Reconsideration and issue the following order.

We find that claimant's bilateral carpal tunnel syndrome is causally related to his compensable shoulder, neck and low back injury. Therefore, we conclude that claimant's February 22, 1982 compensable injury has worsened requiring surgery and the reopening of claimant's claim was appropriate. We, therefore, have the authority to confirm and authorize the reopening of claimant's claim for temporary disability compensation commencing the date of claimant's surgery. See ORS 656.278(1)(a). When claimant is medically stationary, the employer shall close the claim pursuant to OAR 438-12-055.

Claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by the employer, directly to claimant's counsel.

Although we have confirmed and authorized reopening of claimant's claim for the payment of temporary disability compensation, we do not have the authority to grant the employer's request for reimbursement from the Reserve. SAIF v. Holmstrom, supra. Therefore, we are unable to grant the employer's request for reimbursement.

IT IS SO ORDERED.

In the Matter of the Compensation of
VERNON D. FEAGINS, Claimant
WCB Case No. 91-02412
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Jerome Larkin (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Brazeau's order which: (1) upheld the SAIF Corporation's "de facto" denial of claimant's aggravation claim; and (2) granted SAIF's motion to dismiss claimant's request for hearing concerning the medical services issue. On review, the issues are compensability, aggravation and medical services. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the last two sentences.

CONCLUSIONS OF LAW AND OPINION

Compensability of Current Condition

The Referee found that claimant's current condition resulted from his preexisting degenerative disease rather than the compensable injury. Consequently, the Referee concluded that claimant had failed to establish a compensable aggravation. We disagree.

An aggravation has two components: causation and worsening. See Thomas L. Fitzpatrick, 44 Van Natta 877 (1992). Both must be established, unless one is conceded. Here, both elements are challenged. Accordingly, we first address whether claimant's current condition is causally related to his compensable injury. If so, then we determine whether claimant's condition is worse. See Fitzpatrick, supra; Bertha M. Gray, 44 Van Natta 810 (1992); Lareta C. Creasey, 43 Van Natta 1735 (1991).

In this case, the medical evidence shows that claimant's current condition is a result of a combination of his compensable low back injury and a preexisting degenerative disc disease. Because the injury combined with a preexisting disease to cause the need for treatment and disability, the appropriate statute for determining compensability of the resultant condition is ORS 656.005(7)(a)(B). See Creasey, supra. Accordingly, claimant must prove that the compensable injury, rather than the preexisting condition, is the major contributing cause of his disability or need for treatment. See LaDonna F. Burk, 44 Van Natta 781 (1992); Bahman N. Nazari, 43 Van Natta 2368 (1991). We conclude that claimant has sustained this burden.

The medical evidence is in agreement that claimant's degenerative disc disease preexisted his September 1988 compensable injury but was asymptomatic prior to that injury. In April 1990, Dr. Farris, claimant's attending physician at the time of his 1988 injury, noted that claimant's chronic low back pain was superimposed upon degenerative disc disease at the L4-5 and L5-S1 levels. After Dr. Farris moved his practice, claimant's care was assumed by Dr. Manley. Dr. Manley diagnosed severe degenerative disc disease at L4-5 and L5-S1 and chronic low back strain. Dr. Manley opined that claimant's 1988 "injury is, and continues to be, the major contributing cause of the worsening, aggravation, and progression of the arthritis or, at least his continued heavy work in combination

with the original injury is and continues to be the major contributing cause of the worsening, aggravation and progression of the arthritis."

The other medical opinion in the record is that of Dr. Gritzka who performed an independent medical exam. Dr. Gritzka testified at his deposition that the September 1988 injury caused the preexisting degenerative arthritis to become symptomatic. Gritzka explained that claimant's natural bodily defenses or compensatory mechanisms were in balance with the preexisting condition, but with the further added insult of the September 1988 injury the natural protective responses were overwhelmed and the disease became symptomatic.

Gritzka further opined that although the injury of September 14, 1988 initiated the process that claimant now experiences, the physical effect of the 1988 injury had long since subsided and the major contributing cause for claimant's current need for treatment is the degenerative disc disease at L4-5 and L5-S1 and not the injury of September 14, 1988. However, at his deposition, Dr. Gritzka clarified that his opinion on the causation of claimant's current condition was based not on the physical examination he performed, but rather on current medical knowledge and theories of the causation of back pain. Dr. Gritzka testified that it was impossible to determine which of claimant's two conditions, sprain and degenerative disease, was causing claimant's current back pain.

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). Here, we find no persuasive reasons not to rely on Dr. Manley's opinion. Moreover, we do not find the opinions of Manley and Gritzka to be greatly in conflict. Both doctors agree that the degenerative disease was not caused by the 1988 injury. Further, both doctors also agree that the 1988 injury made the preexisting condition symptomatic for the first time. Gritzka felt that the September 1988 injury "tipped the balance" toward pain and disability. Manley felt that the 1988 injury was the major contributing cause of the worsening and progression of claimant's preexisting disease. Furthermore, neither doctor opined that claimant's condition had reached a point to which it would have naturally progressed in the absence of the compensable injury. Consequently, based on the medical evidence in this record, we conclude that claimant has established that his compensable injury is the major contributing cause of his current condition.

In reaching this conclusion, we wish to emphasize that we are finding claimant's current resultant disability and medical treatment compensable. This is not a determination that claimant's underlying degenerative disc disease is itself compensable. Rather, it is a conclusion that claimant's current disability and need for treatment is attributable to his symptoms from the preexisting degenerative disc disease, the major cause of which remains, at this time, the compensable injury.[1] Because we have concluded that claimant's current condition is causally related to his compensable injury, we proceed to an analysis of whether claimant's compensable injury has worsened.

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[1] Moreover, we note parenthetically that the medical evidence in this case suggests that claimant's underlying condition has been worsened by claimant's heavy work. In this regard, Dr. Manley opined on March 18, 1991 that claimant's degenerative condition was progressing much more rapidly than it otherwise would without claimant's heavy work and that claimant's continued heavy work had worsened claimant's arthritis. This evidence arguably establishes compensability of the underlying condition as an occupational disease. However, this case did not proceed on an occupational disease basis, and hence, we do not decide it on that basis.

Aggravation

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 worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting 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 worsened condition must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

In March 1991, Dr. Manley noted that claimant was having progressive problems with his back and that claimant's heavy work had worsened claimant's arthritis condition. When Dr. Gritzka examined him, claimant had objective findings of flattened kyphosis, flattened lumbar lordosis, tightness of his upper back muscles and mild restriction of motion in his low back. We conclude that claimant sustained a worsened condition supported by objective findings.

Claimant has also demonstrated that his worsened condition resulted in diminished earning capacity; because of the worsening of his condition, claimant has missed time from work and has been unable to accept overtime work that he would have performed prior to the worsening. Under these circumstances, we conclude that claimant has established a compensable aggravation.

Medical Services

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

The Referee concluded that the medical treatment was palliative and granted SAIF's motion to dismiss claimant's request for hearing because he concluded he was without jurisdiction to consider the issue. We agree.

Subsequent to the Referee's order, we held that the Hearings Division does not have jurisdiction to determine issues regarding entitlement to palliative care. Robert D. Cox, 43 Van Natta 2726 (1991); George T. Cooper, 44 Van Natta 493 (1992). We have further held that when a dispute concerns the causal relationship of the treatment to the compensable injury, such disputes are matters concerning a claim over which the Hearings Division has jurisdiction. Michael A. Jaquay, 44 Van Natta 173 (1992). However, this case involves a dispute concerning whether a worker's medical treatments are palliative or curative. Such a dispute generally concerns the effectiveness and appropriateness of the medical treatment at issue and, therefore, lies within those matters the legislature intended to be resolved by a physician, rather than a referee. Gladys M. Theodore, 44 Van Natta 905 (1992). This matter does not, therefore, present a matter concerning a claim over which the Hearings Division has jurisdiction.

Accordingly, the Referee did not err in granting the motion to dismiss.

Claimant is entitled to an assessed attorney fee for prevailing on the aggravation issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the aggravation issue is $3,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by appellate briefs and the record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated September 17, 1991 is affirmed in part and reversed in part. That portion of the Referee's order which upheld the SAIF Corporation's "de facto" denial of an aggravation claim is reversed. SAIF's aggravation denial is set aside and the claim is remanded to SAIF for processing according to law. The remainder of the Referee's order is affirmed. For services at hearing and on review concerning the aggravation issue, claimant's counsel is awarded $3,500 to be paid by SAIF.

June 29, 1992 Cite as 44 Van Natta 1238 (1992)

In the Matter of the Compensation of
GLENDA D. KENNA, Claimant
WCB Case No. 90-21878
ORDER ON REVIEW
Allen, et al., Claimant Attorneys
Jacqueline A. Weber, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Brazeau's order which: (1) declined to find that her cervical strain injury claim had been prematurely closed; (2) upheld the self-insured employer's denial of claimant's current condition claim and declined to find that claimant sustained an aggravation of her cervical spine; (3) modified a Determination Order to award claimant 4 percent (12.8 degrees) unscheduled permanent partial disability for the cervical spine whereas a prior Determination Order awarded no permanent disability; and (4) declined to award scheduled permanent disability for claimant's cervical strain condition. On review, the issues are premature closure, aggravation, compensability, and extent of scheduled and unscheduled permanent disability.

We affirm and adopt the order of the Referee with the following supplementation concerning the unscheduled permanent disability issue.

The Referee modified the November 20, 1990 Determination Order which awarded temporary disability only. The Referee found claimant entitled to 4 percent (12.8 degrees) unscheduled permanent partial disability for the cervical spine. In making this determination, the Referee relied on the range of motion measurements taken by Dr. Lyons, an independent medical examiner. (Ex. 33). We agree with the Referee's conclusion, but offer the following analysis.

Under applicable law, disability is rated as of the date of hearing, not the date of claim closure. Gettman v. SAIF, 289 Or 609 (1980). 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. 544(3); Stephen A. Roberts, 43 Van Natta 1815 (1991).

Section 54(3) of the 1990 Act provides that the amendments to certain statutes apply to all claims which become medically stationary after July 1, 1990. In this case, claimant became medically stationary in June 1990. However, ORS 656.245 is not one of the statutes included in section 54(3). Accordingly, amended ORS 656.245 applies to the present case.

Amended ORS 656.245(3)(b)(B) provides, in pertinent part, that "[e]xcept as otherwise provided in this chapter, only the attending physician at the time of claim closure may make findings regarding the workers' impairment for the purpose of evaluating the workers' disability." Thus, the clear language of the

statute as applied to the present case means that, although the disability is rated at the time of hearing, the attending physician at the time of claim closure provides the findings regarding the workers' impairment. See Dennis E. Conner, 43 Van Natta 2799 (1991).

Here, we find that Dr. Lawton as claimant's attending physician at the time of claim closure must make the findings regarding claimant's impairment. See Alex J. Como, 44 Van Natta 221, 222-23 (1992). Although we note that Dr. Lyons' May 17, 1991 findings regarding claimant's impairment are the more recent range of motion measurements, Dr. Lawton did not concur with, nor adopt Dr. Lyons' findings. Therefore, we rely upon the most recent range of motion measurements taken by Dr. Lawton. (Ex. 31). On February 21, 1991, Dr. Lawton reported that:

> "Examination today demonstrated excellent forward flexion and extension in her neck with flexion of 45 degrees and extension 30 degrees. She rotates to the left of [sic] 60 degrees but to the right limited to 45 degrees. She has full ROM in her shoulders with good strength in abduction against resistance. Gross neurological examination is normal on the right aside from some hyperthesia over the dorsal radial aspect of her hand." (Ex. 31-1).

In determining the extent of claimant's disability, we apply the "standards" in effect on the date of the Determination Order. WCD Admin. Order 6-1988. Accordingly, claimant is entitled to a value of 1 percent for 30 degrees retained of cervical extension. Former OAR 436-35-360(3). Claimant is entitled to a value of 1 percent for 60 degrees retained of left cervical rotation. Former OAR 436-35-360(5). Claimant is entitled to a value of 2 percent for 45 degrees retained of right cervical rotation. Former OAR 436-35-360(5). No value is given for 45 degrees retained of cervical forward flexion. Former OAR 436-35-360(2).

Claimant's impairment values due to loss of motion in the cervical area are added, not combined, for a total impairment value of 4 percent. Former OAR 436-35-360(10).

ORDER

The Referee's order dated August 23, 1991 is affirmed.

June 29, 1992 Cite as 44 Van Natta 1239 (1992)

In the Matter of the Compensation of
HILARIO LUNA, Claimant
WCB Case No. 91-00948
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
David O. Horne, Defense Attorney

Reviewed by Board Members Moller and Westerband.

Claimant requests review of Referee Brazeau's order that found that claimant was not entitled to temporary disability compensation for the period commencing December 26, 1990. On review, the issue is interim compensation. We affirm.

FINDINGS OF FACT

The parties stipulated to the facts as follows:

Claimant suffered a compensable injury to the head and neck on April 30, 1990. The claim was accepted and benefits were paid. The claim was closed by Determination Order on December 18, 1990 with an award of temporary disability and 14 percent unscheduled permanent partial disability.

On December 26, 1990, the insurer received a Form 829 dated December 20, 1990 from Dr. Buttler, a chiropractor. The form indicated that claimant had been examined on December 17, 1990 and that claimant's condition was worsening and that he was not released for work. The insurer did not commence payment of temporary disability compensation after receipt of the Form 829.

CONCLUSIONS OF LAW AND OPINION

Because claimant requested a hearing after May 1, 1990 and a hearing was convened after July 1, 1990, his claim is properly analyzed under the 1990 revisions to the Workers' Compensation Law. See Ida M. Walker, 43 Van Natta 1402 (1991).

Claimant argues that he is entitled to time loss benefits effective December 26, 1990, the date the insurer received Dr. Buttler's 829 form. The Referee found that Dr. Buttler did not qualify as claimant's "attending physician" as defined by ORS 656.005(12) and OAR 436-10-005. Therefore, the Referee held, pursuant to ORS 656.245(3)(b), Dr. Buttler could not authorize time loss. Claimant argues that Dr. Buttler had the authority to serve as an attending physician when he authorized the time loss because the administrative rule which limits a chiropractor's authority to serve as an attending physician to the initial claim is invalid.

We agree with the Referee that claimant has not established entitlement to time loss benefits. However, we do not address the question of whether a chiropractor may act as an attending physician on a aggravation claim because, even if Dr. Buttler was authorized to serve as an attending physician at the time he submitted the 829 form, that form was insufficient to trigger the insurer's duty to pay interim compensation.

Claimant's claim was closed on December 18, 1990. Claimant seeks temporary disability benefits for a period thereafter commencing December 26, 1990. Because claimant seeks time loss benefits for a period commencing after closure of his claim, his entitlement to such benefits, if any, must result from a claim for aggravation. See William E. Hamilton, 41 Van Natta 2195 (1989). We note that claimant argues that the insurer's obligation to pay time loss benefits resulted from the insurer's receipt of "medical verification of claimant's worsened condition and consequential inability to work." (Appellant's Brf. p. 8). We interpret claimant's claim as one for interim compensation on a claim for aggravation.

In this regard, entitlement to interim compensation on an aggravation claim depends on whether there was "a medically verified inability to work resulting from a compensable worsening supported by objective findings." ORS 656.273(6). Therefore, even if Dr. Buttler qualifies as an attending physician who is able to authorize temporary disability benefits, claimant must otherwise establish entitlement to such benefits under ORS 656.273(6). In Doris A. Pace, 43 Van Natta 2526 (1991), we construed the language of ORS 656.273(6) as requiring notice or knowledge of an inability to work as documented in a medical report that constitutes prima facie evidence of a compensable worsening.

Here, Dr. Buttler's report does not constitute prima facie evidence of a compensable worsening. Dr. Buttler's report recites that claimant is unable to work due to a worsened condition and contains a recitation of objective findings. However, Dr. Buttler's report indicates that claimant's condition worsened prior to claim closure, i.e., as of December 17, 1990, the date of the examination. However, in order to establish a prima facie compensable aggravation, claimant must show a worsened condition since the last arrangement of compensation. ORS 656.273(1). Thus, by definition, claimant may not establish a compensable aggravation prior to claim closure. Theodore W. Lincicum, 40 Van Natta 1760 (1988), aff'd mem 100 Or App 100 (1989). Moreover, even if Dr. Buttler's December 20, 1990 report could be interpreted as asserting that claimant's condition has worsened since the December 18, 1990 Determination Order, the report does not establish a prima facie case that the worsened cervical condition is more than a waxing and waning of symptoms contemplated by the last award of compensation (the December 18, 1990 Determination Order). See ORS 656.273(8); James B. Palmer, 43 Van Natta 2803 (1991); Theresa L. Loomis, 44 Van Natta 231 (1992); Tony M. Zuniga, 44 Van Natta 427 (1992).

Therefore, Dr. Buttler's report was not prima facie evidence of a compensable worsening. Thus, assuming arguendo that Dr. Buttler was authorized to serve as an attending physician when he released claimant from work, his report is insufficient to establish that claimant is procedurally entitled to interim compensation benefits. We note parenthetically that our decision is confined to the question of claimant's procedural entitlement to additional temporary disability benefits. We express no opinion on claimant's substantive entitlement to benefits in the event of a reopening of his claim. Such entitlement is first determined at the time of closure.

ORDER

The Referee's order dated May 30, 1991 is affirmed.

June 29, 1992 Cite as 44 Van Natta 1241 (1992)

In the Matter of the Compensation of
MARIA SALCEDO-SERRANO, Claimant
WCB Case No. 91-07889
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Myers' order which: (1) found a valid notice of denial; and (2) found that claimant did not timely file a request for hearing from the denial. On review, the issues are validity of the denial and timely filing. We affirm.

FINDINGS OF FACT

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

On January 4, 1991, claimant received a letter from the insurer stating the following:

"[The insurer] is in receipt of your claim filed for a contused right small finger you alleged occurred while employed with Northwest Onion Company.

"After review of the information received to date, it appears [the insurer] was not the insurance carrier for your employer at the time of injury. It is our recommendation that you complete a new accident report and submit it to your employer's insurance carrier at the time of injury.

"Therefore, without waiving further issues of compensability and responsibility, this formal denial is hereby made.

"[The insurer] does not waive any remedy should fraud or material misrepresentation be involved in filing this claim.

"IF YOU THINK THIS DENIAL IS NOT RIGHT, WITHIN 60 DAYS AFTER THE DATE OF THIS LETTER YOU MUST FILE A LETTER WITH THE WORKERS' COMPENSATION BOARD * * *. YOUR LETTER MUST STATE THAT YOU WANT A HEARING, YOUR ADDRESS AND THE DATE OF YOUR ACCIDENT IF YOU KNOW THE DATE. IF YOUR CLAIM QUALIFIES, YOU MAY RECEIVE AN EXPEDITED HEARING WITHIN 30 DAYS. * * * IF YOU DO NOT FILE A REQUEST WITHIN 60 DAYS, YOU WILL LOSE ANY RIGHT YOU MAY HAVE TO COMPENSATION UNLESS YOU CAN SHOW GOOD CAUSE FOR DELAY BEYOND 60 DAYS. AFTER 180 DAYS ALL YOUR RIGHTS WILL BE LOST. YOU MAY BE REPRESENTED BY AN ATTORENY OF YOUR CHOICE AT NO COST TO YOU FOR ATTORNEY FEES."

Copies of the letter also were sent to the Workers' Compensation Division and the employer. (Ex. 3).

CONCLUSIONS OF LAW AND OPINION

Validity of notice of denial

ORS 656.262(8) provides that, if a carrier denies a claim for compensation, it must give "written notice of such denial, stating the reason for the denial, and informing the worker of the Expedited Claim Service and of hearing rights under ORS 656.283[.]" The statute also requires that a copy of the notice of denial be mailed "to the director and to the employer" and provides that the "worker may request a hearing pursuant to ORS 656.319." Former OAR 436-60-140(4) further requires that the notice of denial "comply with the rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law" and "specify the factual and legal reasons for the denial." Finally, OAR 438-05-055 requires the notice of denial to contain, in prominent or bold-face type, a notice such as the one contained in the insurer's letter.

Claimant challenges the Referee's finding that the insurer's letter constituted a valid notice of denial. In attacking the validity of the letter as a notice of denial, however, claimant does not assert that the letter does not comply with statutory and administrative requirements. Instead, claimant bases her challenge on her contention that the letter "does not actually deny the compensability of the injury" but only denies that the insurer was the carrier at the time of injury. Further, claimant contends that only denials of "compensability" are subject to the time limitations in ORS 656.319(1).

We disagree with claimant's position. Under her contention, notices of denial would be effective only if they denied the compensability of a claim. Neither the statutes nor the administrative rules support such a theory. ORS 656.262(8) speaks in terms of the carrier denying "a claim for compensation" and

requiring the carrier to "state the reason for the denial." Former OAR 436-60-140(4) requires that the notice "specify the factual and legal reasons for the denial." Based on this language, we find no basis for concluding that valid notices of denial are limited to denying compensability. Instead, any notice that denies "a claim for compensation," whatever the reason, and complies with the statutory and administrative requirements for the notice's contents, constitutes a valid notice of denial. Moreover, neither ORS 656.319(1), nor any cases interpreting that statute, distinguish denials of claims for compensation based upon "compensability" from those based upon "responsibility."

In this case, the insurer's letter denied "a claim for compensation" in that it refused to pay compensation on the basis that it was not the carrier during injury. Furthermore, the letter's contents complies with statutory and administrative requirements. We therefore agree with the Referee that the letter constituted a valid notice of denial, and that her appeal of that denial was subject to the timeliness requirements of ORS 656.319(1).

Timeliness of request for hearing from the denial

Claimant next asserts that, if the letter is a valid notice of denial, her request for a hearing was timely. Although she concedes that she did not comply with ORS 656.319(1)(a) because her request was not within 60 days of being notified of the denial, she asserts that she complied with ORS 656.319(1)(b) in that her request was within 180 days and she established good cause for her failure to file the request within 60 days. We agree with the Referee that claimant did not prove good cause and adopt that portion of the order.

ORDER

The Referee's order dated September 30, 1991 is affirmed.

June 29, 1992 Cite as 44 Van Natta 1243 (1992)

In the Matter of the Compensation of
WILLIE A. SOWERS, Claimant
WCB Case Nos. 91-01613, 91-00552 & 91-01612
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys
Foss, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Quillinan's order which: (1) upheld Georgia-Pacific Corporation's denial of claimant's "new injury" claim for a right leg and back condition; and (2) found that claimant had untimely filed his claim against Georgia-Pacific. In the alternative, claimant asserts that his worsened condition is the result of an occupational disease and responsibility rests with Liberty Northwest on a "new injury" theory. On review, the issues are timeliness, responsibility and compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Responsibility

Citing case law prior to the 1990 amendments, the Referee found that Georgia Pacific had not established that claimant's work activities while Liberty Northwest was on the the risk contributed to a pathological worsening of claimant's accepted condition. Therefore, she concluded that Georgia Pacific remained responsible for claimant's current condition under the accepted Own Motion "aggravation" claim. We adopt the Referee's reasoning and conclusion, except for her citation to case law, and supplement her reasoning as follows.

Because claimant requested a hearing after May 1, 1990 and a hearing was convened after July 1, 1990, his claim is subject to the 1990 amendments to the Workers' Compensation law. See Ida M. Walker, 43 Van Natta 1402 (1991). We have held that under Section 49 of Senate Bill 1197 (enacted as ORS 656.308), a carrier that is responsible for a compensable injury remains responsible for continued and increased disability during employment with a later carrier, unless the claimant sustains a new injury or occupational disease during the subsequent employment. Donald C. Moon, 43 Van Natta 2595 (1991); Ricardo Vasquez, 43 Van Natta 1678 (1991). Thus, having accepted the 1981 low back injury claim, Georgia Pacific remains responsible for any increased disability unless it is due to a new compensable injury or occupational disease sustained while working for Liberty Northwest's insured. ORS 656.005(7)(a) and 656.802.

For the reasons stated by the Referee, we find that there is no persuasive evidence in the record that claimant sustained a new injury or occupational disease while employed at Liberty Northwest's insured. Therefore, responsibility remains with Georgia Pacific.

Aggravation or New Injury at Georgia Pacific

Georgia Pacific accepted claimant's claim as an aggravation of the 1981 injury. Claimant argues that his claim should have been accepted as a new injury occurring on May 2, 1990. The Referee concluded that claimant failed to establish, by a preponderance of the evidence, that he suffered a compensable injury on May 2, 1990, and hence, the claim was properly accepted by Georgia Pacific as an "aggravation" subject to the Board's Own Motion authority (claimant's aggravation rights having expired). We adopt the Referee's reasoning and conclusion with the following supplementation.

The only medical evidence which supports claimant's argument that a new injury occurred on May 2, 1990 which was a material contributing cause of his current condition is the opinion of Dr. Whitney, claimant's treating physician. The Referee found his opinion equivocal and uncertain on the point, and understood him to conclude, for the most part, that claimant's current condition came on gradually and progressively, as opposed to being the result of some incident followed by the onset of symptomology during a discrete period of time. See Valtinson v. SAIF, 56 Or App 184 (1982).

The Referee's difficulty with Dr. Whitney's opinions is due to their inconsistencies, because of which we accord them little weight. Steven v. Blue Cross of Oregon, 43 Van Natta 127 (1991). Specifically, Dr. Whitney first saw claimant in October 1990 (i.e. 5 months after the alleged work incident). He reported that claimant recovered in 1986 from his 1981 back injury and was doing well "until 4 month ago when he noticed the slow onset of mild tingling in his right leg." (Ex. 56). On December 6, 1990, claimant telephoned Dr. Whitney to discuss whether his condition was an aggravation or a new injury. (Ex. 60). Dr. Whitney's chart note reflects that he believed claimant's condition was a

"new injury on top of the old injury." (Ex. 5-22). In February 1990, Dr. Whitney reported that claimant's symptoms had come on "progressively." (Ex. 71). At a deposition, he opined that claimant's flare up of symptoms in 1990 represented an aggravation and a new injury. He further noted that: "Whether this happened in one incident or over a period of incidents, I can't say for sure." (Ex. 80).

We also distrust and discount Dr. Whitney's opinions because the record shows he lost his objectivity and became an advocate. Mike Sepull, 42 Van Natta 470, 472 (1990). Specifically, on October 29, 1990, he took claimant off work due to his increased symptoms. (Ex. 58). On January 9, 1991, at claimant's request, he released claimant to light duty work to support claimant's application for unemployment benefits. (Ex. 64-2). Subsequently, he agreed to change the date of claimant's release for light duty to December 10, 1990 to further assist claimant in the pursuit of the unemployment compensation claim. (Ex. 64-3). On January 14, 1991, again at claimant's behest, he agreed to rescind the light duty release because: "It didn't work for unemployment reasons." (Ex. 64-4). In his deposition, he testified that claimant's status was manipulated in order for claimant's to gain some financial ground. (Ex. 80). He also indicated that claimant's medical record was manipulated "to a certain extent" due to his belief that the "insurance company [was] manipulating claimant too." (Id).

To prove that he sustained a new injury on May 2, 1990, claimant also relies on a note he wrote to himself dated May 2, 1990. The note says that he injured himself at work on May 2, 1990 while restacking a load of fallen veneer. (Ex. 53A). Claimant testified that he found the note (which he had allegedly misplaced and forgotten) seven months after the alleged work injury. At hearing, the Referee declined to give any weight to the note because she questioned its authenticity and trustworthiness, stating that it is "just too convenient in light of the surrounding circumstances." We agree. There is considerable evidence in the record that claimant's account of the cause of his problem evolved over time as he came to understand that proof of a new injury (rather than an aggravation) would be more financially rewarding. For example, in a November 8, 1990 statement taken from claimant by a Georgia Pacific representative, claimant pointedly denied the occurrence of an injurious event. "I didn't hurt myself one single . . . bit. Did nothing. (pause) It just . . . slowly started with a tingling in my legs and, uh it's just . . . gotten worse. It got to be pain that'd run from hip [sic] clear down to my feet." (Ex. 75-11). Sometime in December 1990, claimant discussed his claim with a Maria Carrera, whom claimant indicated was with the "State Workers' Compensation." Claimant was asked whether the claim was "a new injury or an old injury." (Tr. 33). Ms. Carrera then explained that he would receive only medical benefits for an "old injury" but full benefits for a "new injury." (Tr. 33, 34). Claimant subsequently inquired of Dr. Whitney regarding whether his problems were attributable to the 1981 injury or to a new injury. (Tr. 33).

Claimant was examined by Dr. Woolpert on December 13, 1990. Dr. Woolpert noted that, in the history given him by claimant, claimant recalled the onset of symptoms in May 1990, but did not feel at that time that there was any specific cause. (Ex. 62-2). It was not until later when claimant went through his personal notes that he retrospectively associated the onset of symptoms with picking up a load of veneer. (Id). On December 17, 1990, claimant filled out an 801 form claiming that he injured himself on May 2, 1990 while restacking a load of veneer. (Ex. 61). In a letter to claimant's attorney dated march 7, 1991, Dr. Whitney said that "unfortunately, there is no way I can evaluate the date of the injury." The letter also states that when "I saw him in October of 1990, he dated the onset of pain approximately 4 months prior to my seeing him," but "[t]o my recollection, he did not know of a particular incident which was associated with the increase in symptoms at that time." (Ex. 73D).

In short, the record gave the Referee ample reason to distrust (as do we) the note and claimant's testimony about the alleged work incident on May 2, 1990. We adopt the Referee's reasoning and conclusion.

Timeliness

The Referee found that the employer did not have notice of the claimed injurious incident of May 2, 1990 until December 17, 1990, and consequently, she concluded that claimant's injury claim was not timely filed. We adopt the Referee's reasoning and conclusion that the employer did not have notice of the claim until December 17, 1990. However, we must disagree with the ultimate conclusion that the claim was time barred.

A claimant is required to give the employer written notice of the claim within 30 days of the injury. ORS 656.265(1) and (2). Failure to give notice of the claim within this period bars a claim unless, in relevant part, the employer was not prejudiced by the failure to provide notice.

Here, the employer asserts that it was prejudiced because the plant was closed in the interim and "records and personnel were apparently no longer on the location." (Resp. Brf. at 8). However, an employer must show not simply the possibility of prejudice, but actual prejudice. Aetna Casualty Co. v. Kupetz, 106 Or App 670 (1991). Here, Georgia Pacific has not carried this difficult burden of proof.

In any event, claimant has not carried his burden to prove that an injury occurred on May 2, 1990 which is a material contributing case of his current condition. Therefore, the Referee's order will be affirmed.

ORDER

The Referee's order dated July 5, 1991 is affirmed.

In the Matter of the Compensation of
DONALD S. WADE, Claimant
WCB Case No. 91-00005
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of those portions of Referee Livesley's order that: (1) found its investigator's notes of two co-workers' statements admissible; (2) set aside its denial of claimant's low back injury claim; and (3) assessed a penalty and attorney fee under ORS 656.262(10). SAIF also objects to the Referee's post-hearing ruling that claimant was entitled to discovery of its investigator's notes. Claimant cross-requests review of that portion of the order declining to award a penalty-related attorney fee under ORS 656.382(1). On review, the issues are discovery, evidence, compensability, and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

In November 1990, claimant worked for Skookum Reforestation, an Oregon corporation that "slash burned" and "mopped up" tracts of land that had been

logged; the work site at that time was located in California. In the afternoon of November 18, 1990, claimant was "holding the line" on a steep grade of land by ensuring that sparks or hot ash did not cross the fire line. Claimant jumped up on a stump and fell into a hole. The stump rolled onto his back and then a log rolled over the stump. Claimant was helped to his feet by two co-workers and, with their assistance, he walked to the fire line and rested for a period of time. At hearing, claimant identified those workers as Mike Regar and Charles Lucas. For reasons not related to the accident, claimant returned to Oregon the next day. Shortly after the accident, claimant sought medical treatment and was diagnosed with an acute lumbar strain.

On January 16, 1992, SAIF denied the claim. After the denial, a SAIF investigator contacted Regar and Lucas and obtained statements from them, summarizing their comments in notes. Regar could not recall any accident involving claimant but did recall that he complained of back pain due to work duties. Lucas recalled that a worker had jumped on a stump and fell when it broke loose. Lucas identified that worker as "Jerry" and stated that he continued working for the remainder of the day following the accident. SAIF did not disclose the notes of the statements to claimant. Neither Regar or Lucas testified at hearing.

As a result of the investigator's testimony at hearing, claimant discovered the notes and moved for their disclosure. Initially, the Referee denied the motion. Following the hearing, however, the Referee set aside the ruling and ordered SAIF to disclose the notes to claimant. Following SAIF's compliance with that ruling, claimant's motion to admit the notes into evidence was granted.

CONCLUSIONS OF LAW AND OPINION

Discovery

SAIF contends that the Referee improperly set aside his ruling that claimant was not entitled to discovery of the notes. SAIF specifically asserts that discovery of such documents is not warranted under former OAR 438-07-015 or the Oregon Rules of Civil Procedure and that the documents are privileged as attorney "work product." We disagree.

The applicable portions of former OAR 438-07-015 provide:

> "(2) Documents pertaining to claims are obtained by mailing a copy of the Request for Hearing or a written demand * * * to the insurer or self-insured employer. Within fifteen (15) days of said mailing, the insurer or self-insured employer 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). * * *
>
> "* * * * *
>
> "(4) Documents acquired after the initial exchanges shall be provided to the other parties within seven (7) days after the disclosing party's receipt of the documents.
>
> "(5) It is the express policy of the Board to promote the full and complete disclosure of all facts and opinion pertaining to the claim being litigated before the Hearings Division. * * *" (Emphasis added).

SAIF does not assert that the investigator's notes at issue here do not contain facts and opinion pertaining to the claim. Moreover, SAIF does not contend that it reasonably believes that the statements were relevant and material only for purposes of impeachment. See OAR 438-07-017. Rather, SAIF contends that, as a policy matter, investigative documents should not come within the requirements of former OAR 438-07-015 in order to promote witness candor.

We do not dispute that parties would prefer to protect the confidentiality of their investigative reports. However, former OAR 438-07-015 does not support such a position; rather, the rule explicitly evidences an intent to require disclosure by both parties of all documents pertaining to the claim. Consistent with this intent, the Board has included investigative reports as coming under OAR 438-07-015. See Kenneth K. Kessel, 39 Van Natta 416, 417 (1987). Therefore, we find that the Referee properly found that claimant was entitled to disclosure of SAIF's investigator's notes.

Because we have found that former OAR 438-07-015 is applicable, we need not look for guidance to the Oregon Rules of Civil Procedure, and therefore do not address SAIF's argument that, under ORCP 63B(3), claimant is not entitled to discovery of the investigator's notes. See Julie Mayfield, 42 Van Natta 871, 872 (1990). Furthermore, we find no basis for concluding that the "attorney work-product doctrine" extends to an investigator's notes. See Upjohn v. United States, 449 US 383, 399, 101 S Ct 677 (1981).

Evidence

SAIF next asserts that the Referee erred in admitting the notes because they contained "unreliable hearsay" and neither Regar nor Lucas testified at hearing.

ORS 656.283(7) provides that "the referee is not bound by common law or statuory rules of evidence * * * and may conduct the hearing in any manner that will achieve substantial justice." The statute gives broad discretion to the Referee in regards to the admissibility of evidence. See e.g., Brown v. SAIF, 51 Or App 389, 394 (1981). A referee's decision to admit an exhibit will be upheld as long as the evidence has some probative value, see Lucke v. Compensation Dept., 254 Or 439, 442-43 (1969). Evidence is not deemed inadmissible solely on the basis that it is hearsay, see Armstrong v. SAIF, 67 Or App 498, 501 n 2 (1984).

We find no abuse of discretion by the Referee in admitting the investigator's notes into evidence. Because the statements pertained to whether claimant was injured on the job, they were of some probative value. Furthermore, SAIF's reliance on Article I, Section 11, of the Oregon Constitution and the Sixth Amendment of the U.S. Constitution in arguing that the notes were not admissible because they were unable to cross-examine Regar and Lucas is not proper because those provisions apply only to criminal proceedings. However, because the notes summarized the investigator's conversations with the co-workers, and neither Regar nor Lucas testified at hearing, we accord the exhibits little weight. See Pinky P. Holder, Jr., 42 Van Natta 568 (1990).

Compensability

SAIF next contends that claimant failed to prove the compensability of his claim. Specifically, SAIF asserts that, due to inconsistencies between a prior statement and testimony at hearing, the Referee's finding that claimant is a credible witness should be rejected and that, because claimant's testimony regarding the accident is not corroborated, he failed to prove that any injury to his back was caused by a work-related accident.

Claimant asserted that he was injured on November 18, 1990 when he jumped up onto a stump whose roots had been burned, creating a hole. (Tr. 27). Claimant testified that he fell when the stump broke off and that the stump then fell on his back and a log that had been resting behind the stump rolled over the stump. (Id). Although there was no direct evidence corroborating claimant's testimony, we find that claimant carried his burden of proof. First, the Referee, based on demeanor, found claimant to be a credible witness. Although not statutorily required to do so, we generally defer to the Referee's determination of credibility. See Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). Second, claimant promptly sought treatment for back pain within a week of the accident. (Ex. 3). Furthermore, claimant provided a consistent description of the accident to his doctors, telling them that he fell into a hole and a stump fell onto his back. (Exs. 2, 4-1). Finally, claimant's roommate testified that, when he picked up claimant upon his return to Oregon, he observed claimant stooped over and complaining of pain from a work accident. (Tr. 7).

As SAIF asserts, there are inconsistencies between a statement claimant made to a SAIF investigator on January 15, 1991 and his testimony at hearing. In his statement, claimant reported that, after falling, a log rather than the stump fell on him. (Ex. 8-2). Claimant also stated that he then crawled up the hill for a short distance and rested for about 45 minutes, when he was helped up the hill by two co-workers. (Id. at 3). At hearing, however, claimant stated that, after the accident, he was immediately helped up the hill by Regar and Lucas. (Tr. 55-56). Although we agree with SAIF that there are inconsistencies, we do not find them of sufficient force to outweigh our reasons, stated above, for finding the claim compensable. Furthermore, we find that SAIF's witnesses' testimony that they failed to observe the accident or notice that claimant was injured are of little relevance since none of the witnesses testified that they actually observed claimant at the time of the accident or before leaving the work site. Consequently, as supplemented herein, we adopt the Referee's opinion that the claim is compensable.

Penalties and Attorney Fees

Finally, SAIF asserts that the Referee improperly assessed and penalty and attorney pursuant to ORS 656.262(10) based on the investigator's notes. We agree.

A penalty and attorney fee may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10). Whether a denial or delay is unreasonable depends on whether, at the time of denial, the carrier had a legitimate doubt as to its liability. See Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988). Even though a carrier reasonably denies a claim, however, continuation of the denial becomes unreasonable if new evidence destroys any legitimate doubt about liability. See id. at 592. Here, the Referee found that SAIF unreasonably continued to deny the claim after it received the statements from claimant's two co-workers, Mike Regar and Charles Lucas.

We find that the statements from Regar and Lucas are not sufficient to have destroyed any legitimate doubt about SAIF's liability for the claim. Regar could not recall any accident involving claimant, although he did state that claimant complained of back pain. (Ex. 6a-1). However, Regar stated that claimant told him that the pain was due to work duties rather than an accident. (Id). Lucas could not recall the accident until SAIF's investigator read the accident report to him. (Id. at 2). Although Lucas stated that he recalled claimant jumping on a stump that gave way, he stated that claimant had been lighting a slash burn at the time, immediately stood up after the accident, and worked the rest of the day. (Id). Lucas also thought that claimant's name was

Jerry. (Id). We find that, although Lucas did corroborate claimant's assertion that he was injured when he stepped on a stump, his statement was sufficiently inconsistent from claimant's version that it did not destroy any doubt concerning compensability. Thus, we conclude that the continuation of the denial following SAIF's receipt of the two statements was not unreasonable and that a penalty is not warranted under ORS 656.262(10) on this basis.

Claimant contends that he is entitled to a separate attorney fee award under ORS 656.382(1) based on SAIF's failure to disclose its investigator's notes of the statements of Regar and Lucas. We agree that claimant is entitled to a penalty on this basis. Former OAR 438-07-015(5) provides that "[f]ailure to comply with this rule shall, if found unreasonable, be considered delay or refusal under ORS 656.262(10)." As discussed above, SAIF failed to comply with the rule when it did not voluntarily disclose its investigator's notes. Moreover, given the clear language of the rule requiring disclosure of "all other documents pertaining to the claim," as well as our order in Kenneth K. Kessel, supra, we conclude that SAIF's actions were unreasonable. However, we do not agree with claimant that the penalty should be awarded pursuant to ORS 656.382(1) since the rule expressly provides that failure to comply constitutes delay or refusal under ORS 656.262(10), as the Referee found.

Claimant's attorney is entitled to an assessed attorney fee for prevailing against the SAIF Corporation's request for review. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that 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 issue (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 August 20, 1991 is affirmed in part and reversed in part. That portion of the order finding that SAIF was unreasonable in continuing its denial after obtaining statements from two co-workers is reversed. Nevertheless, since SAIF was unreasonable in failing to comply with former OAR 438-07-015, the Referee's award of a penalty under ORS 656.262(10) on that basis is affirmed. The remainder of the order is affirmed. For services on Board review concerning the compensability issue, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
ELDON BURBANK, Claimant
WCB Case Nos. 89-25312 & 90-14100
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Janelle Irving (Saif), Defense Attorney
Edward C. Olson, Defense Attorney

Reviewed by Board Members Neidig and Brazeau.

Claimant requests review of that portion of Referee Davis' order that: (1) set aside North Pacific Insurance Company's denial of claimant's aggravation claim for a low back condition; and (2) upheld the SAIF Corporation's responsibility denial (on behalf of the noncomplying employer) of his "new injury" claim for the same condition. SAIF cross-appeals those portions of the Referee's

order which: (1) found that claimant was entitled to interim compensation for the period November 22, 1989 to January 17, 1990; and (2) assessed a penalty for SAIF's failure to pay interim compensation. In its brief, SAIF also contends that the Referee should not have found that the claim was untimely and unreasonably denied. On review, the issues are compensability, responsibility, interim compensation, untimely denial, unreasonable denial, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The present case was convened and continued on June 25, 1990. Therefore we analyze the matter under the law in effect prior to July 1, 1990.

Compensability

Claimant contends that SAIF's denial of compensability should be set aside. Inasmuch as the Referee has already set aside SAIF's denial of compensability, we conclude this is not an issue on review. Moreover, we adopt the Referee's "Conclusions of Law and Opinion" on the issue.

Responsibility

Claimant contends that the responsibility for his current condition should be assigned to SAIF on the basis of his history and medical evidence. We disagree.

In order to shift responsibility to a later employer under the pre-July 1, 1990 law, two requirements had to be met. First, it had to be shown that there was a pathological worsening of the underlying condition; a symptomatic worsening alone was insufficient. Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986). Second, it had to be shown that the later employment caused the pathological worsening to occur.

Whether claimant's October 2, 1989 lifting incident during his later employer caused a pathological worsening of his preexisting low back condition is a complex medical question requiring expert medical opinion. Kassahn v. Publishers Paper Co., 76 or App 105, 109 (1985).

Here, Dr. Poulson, claimant's treating physician and surgeon, declined to state that claimant experienced a pathological worsening in October 1989. Accordingly, we agree with the Referee that claimant has failed to establish that he experienced a worsening in October 1989 sufficient to shift responsibility to the later employer. Therefore, we affirm the Referee's finding that responsibility remains with North Pacific Insurance Company.

Entitlement to Interim Compensation

We first determine whether claimant has established entitlement to interim compensation. In a claim for aggravation, interim compensation is payable from the date of a medically verified inability to work resulting from the worsened condition. Former ORS 656.273(6).

Here, on November 27, 1989, claimant notified his employer that Dr. Poulson had taken him off work as of November 22, 1989 due to a worsening of his

industrial injury symptoms. (Exs. 28-30). Further, Dr. Poulson reported objective findings that claimant's condition had worsened from a medical standpoint as required by ORS 656.273(1). Specifically, he noted that a recent MRI done on October 24, 1989 showed a bulging at L5-6 and might represent a disc fragment. (Ex. 28). Under these circumstances, we conclude that Dr. Poulson's report was sufficient to establish a compensable worsening. The Director referred the claim to SAIF as the processing agent for the noncomplying employer on January 18, 1990. Accordingly, claimant is entitled to interim compensation from the date of medically verified inability to work resulting from the worsened condition after January 18, 1990 and continuing to March 22, 1990. See Kenneth R. Derrick, 42 Van Natta 274, 275 (1990).

The Referee found, and we agree, that SAIF paid the interim compensation during the period at issue. Accordingly, we reverse that portion of the Referee's order that found claimant entitled to interim compensation benefits from November 22, 1989 to January 17, 1990. The Referee's attorney fee award of 25 percent of the increased compensation created by the award is also reversed.

Penalties and Attorney Fees/Unreasonable Delay of Interim Compensation

The Referee concluded that SAIF unreasonably delayed paying interim compensation when it did not begin payment within 14 days of the claimed injury. We disagree.

Claims processing requirements for noncomplying employers are set forth in ORS 656.054. ORS 656.054 provides, in pertinent part:

> "(1) A compensable injury to a subject worker while in the employ of a noncomplying employer is compensable to the same extent as if the employer had complied with ORS 656.001 to 656.794. A claim for compensation made by such a worker shall be processed by the State Accident Insurance Fund Corporation in the same manner as a claim made by a worker employed by a carrier-insured employer, except that the time within which the first instalment of compensation is to be paid, pursuant to ORS 656.262(4), shall not begin to run until the director has referred the claim to the State Accident Insurance Fund Corporation." (emphasis supplied).

Here, the Director referred the claim to SAIF on January 24, 1990. Thus, SAIF had no duty to begin paying interim compensation until 14 days after that date. See Kenneth R. Derrick, supra. SAIF began paying interim compensation on January 18, 1990. Accordingly, we conclude that SAIF did not unreasonably delay paying interim compensation. The Referee's penalty and associated attorney fee for allegedly unreasonable delay will be reversed.

Late Denial

The Referee also concluded that SAIF unreasonably delayed the denial of claimant's claim. We disagree.

Based on Kenneth R. Derrick, supra, we conclude that SAIF did not have a duty to process the claim until the Director referred the claim to SAIF. In Derrick, we found that despite SAIF's being notified of the claimant's workers' compensation claim while employed with a noncomplying employer, the first installment of compensation was not due to be paid until the Director referred the claim to SAIF. See ORS 656.054(1).

Here, claimant left work with the noncomplying employer in November 1989 due to back pain. Because SAIF was not the employer's insurer, it had no duty

to accept or deny claimant's claim. Rather, its obligation to begin processing was not triggered until it received the claim on referral on or about January 18, 1990. We find no authority which would require an insurer or self-insured employer to process a claim before a claim has been made against it or it has been determined to be the responsible party.

Moreover, the Referee specifically found that SAIF promptly paid interim compensation payments after the Director referred the claim. We agree with those findings and conclude that, under the circumstances, there was no unreasonable delay in payment of compensation. Accordingly, no penalty or attorney fee may be assessed.

Unreasonable Denial of Compensability

Citing Anna M. Monson, 42 Van Natta 889 (1990), SAIF contends that the Referee improperly bifurcated its denial into a "compensability denial" and a "responsibility denial" and set aside the "compensability denial". We agree that the denial should not be bifurcated.

SAIF issued one denial, stating: "We have carefully reviewed all information in your file and find that your injury did not arise from your employment at [the noncomplying employer's]. Therefore, without waiving further questions of compensability, we must deny your claim." (Ex. 38-1). Inasmuch as the denial was upheld and the noncomplying employer was found not liable, we conclude SAIF's denial, as a whole, was proper.

ORDER

The Referee's order dated March 29, 1991 is affirmed in part and reversed in part. That portion which found claimant entitled to interim compensation from November 22, 1989 through January 17, 1990 is reversed. The Referee's attorney fee award of 25 percent of the increased compensation created by the award is also reversed. That portion of the Referee's order which assessed a penalty with a $300 attorney fee for the SAIF Corporation's alleged unreasonable delay in denying claimant's claim is also reversed. In addition, that portion of the Referee's order which found claimant's compensability denial unreasonable is reversed. The remainder of Referee's order is affirmed.

June 30, 1992 Cite as 44 Van Natta 1253 (1992)

In the Matter of the Compensation of
JOHN F. COADY, Claimant
WCB Case Nos. 90-21283 & 90-21282
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Steve Cotton (Saif), Defense Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Brazeau and Kinsley.

Aetna Casualty Company (Aetna) requests review of Referee Holtan's order that: (1) set aside its denials of claimant's injury-related and occupational disease claims for current right hip, low back and leg length discrepancy conditions; and (2) upheld the SAIF Corporation's denial of claimant's occupational disease claim for the same conditions. In their briefs, claimant and SAIF argue that Aetna's acceptance included the disease underlying the claimed symptoms, so that Aetna is precluded from denying the current claims. On review, the issues

are claims processing, compensability and responsibility. We reverse in part and modify in part.

FINDINGS OF FACT

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

The Referee found: "Claimant's degenerative arthritis of the right hip, accelerated degenerative arthritis of the low back, and chronic lumbosacral strains were caused in major part by his work activities as a handyman during the time the employer was insured by Aetna."

In lieu of the Referee's findings, we find that claimant's disability and need for treatment for right hip and low back conditions, as well as his need for right leg surgery, are due, in major part, to claimant's work activities while the employer was insured by Aetna and SAIF.

CONCLUSIONS OF LAW AND OPINION

Scope of Aetna's acceptance/compensability as related to 1988 injury

Claimant filed a claim with Aetna for a January 11, 1988 right hip and groin injury. On the 801 form, claimant entered "possible hernia" in the box labelled "nature of injury or disease" and described the injurious incident as follows: "I lifted and turned with a full 5 gallon bucket of paint. When I started to carry the paint bucket a dull ache was felt in my right hip or groin area. The pain worsened the more I worked." (Ex. AA). On February 25, 1988, Aetna received an 827 form signed from Dr. Gaiser. (Ex. AAA). On the form, claimant described the mechanism of his lifting injury and the onset of pain in his right hip. On the same form, Dr. Gaiser reported claimant's then-current right groin pain and a diagnosis of right adductor tendon strain. (Id.)

On March 1, 1988, Aetna accepted the claim as a nondisabling injury, by checking the appropriate boxes on the 801 form. (Ex. AA).

On October 24, 1990, Aetna partially denied claimant's claims for treatment for "left leg [length] discrepancy and lumbar scoliosis." (Ex. 3B). The denial stated that the claim was not denied in its entirety, but only insofar as the claimed treatment was not related to the January 11, 1988 work injury. At hearing, Aetna expanded its denial to include claimant's then-current low back and right hip conditions. (Tr. 5-7).

Based on the 801 claim form, the Referee decided that the scope of Aetna's check-the-box acceptance included the diseases underlying the symptoms described on the claim form and that Aetna may not now "back up" and deny those conditions. We disagree.

The 801 injury claim form described claimant's right hip and groin pain and the possibility that he had a hernia. However, according to the 827 form, the then-current diagnosis was a tendon strain. Reasonably interpreted, the injury claim was for a hernia and/or a right adductor tendon strain. Considering the specificity of the body parts mentioned on the claim and Dr. Gaiser's 1988 diagnosis of tendon strain, we are unwilling to find that Aetna's acceptance was broad enough to encompass claimant's degenerative conditions of the right hip and low back or his chronic lumbosacral strain. Therefore, we conclude that the current conditions are separate from those claimed in 1988 and the scope of Aetna's 1988 acceptance does not include the later diagnosed hip and low back conditions, nor does it include the leg treatment necessitated by the hip and

low back conditions. See Johnson v. Spectra-Physics, 303 Or 49 (1987) (when a single claim encompasses two separate conditions, acceptance of one of the conditions does not constitute acceptance of the other); Cf. Georgia Pacific v. Piwowar, 305 Or 494 (1988) (acceptance of the compensability of specific symptoms includes acceptance of the compensability of the disease causing the symptoms).

Moreover, even if the current claim involved a condition previously accepted by Aetna, Aetna would not be procedurally precluded from denying the compensability of claimant's condition within two years of its acceptance. See ORS 656.262(6); see also Anthony G. Ford, 44 Van Natta 240 (1992).

However, inasmuch as we agree that claimant has not established that the conditions currently claimed are related to his 1988 work injury, we uphold Aetna's written partial denial.

Compensability of occupational diseases & Responsibility

The Referee decided that Aetna remains responsible for the accepted conditions, because claimant's later work activities, under SAIF's coverage, were not the major cause of his low back and right hip conditions. We disagree.

We have determined that the conditions currently claimed have not been previously accepted. Because the claimed conditions have not yet been determined to be compensable, and compensability is not conceded, it is a threshold issue in this responsibility dispute. If the claim is compensable, then the trier of fact must address the issue of responsibility. See Runft v. SAIF, 303 Or 493, 498-99 (1987).

Here, the medical evidence establishes that claimant's degenerative right hip and low back conditions, as well as his chronic lumbosacral strain, progressed gradually. It is undisputed that claimant's repetitive work activities, particularly walking, contributed to his current disability and need for treatment for these conditions. (See Exs. 7-2, 14-12-14; 14-21-26; 14-30). Therefore, his claim is properly analyzed as an occupational disease. See ORS 656.802(1)(c); see Fred A. Nutter, 44 Van Natta 854 (1992); see also Valtinson v. SAIF, 56 Or App 184 (1982); O'Neal v. Sisters of Providence, 22 Or App 16 (1975). Furthermore, ORS 656.308 is not applicable to the initial assignment of liability for an occupational disease claim where there has been no previously accepted condition. Fred A. Nutter, supra.

Claimant filed occupational disease claims for leg length discrepancy, right hip and low back degenerative conditions, and a chronic lumbosacral strain with both Aetna and SAIF. SAIF denied the claims in writing and Aetna expanded its denial at hearing to include these conditions. (Tr. 5-7).

The Referee found, and we agree, that there is no medical evidence contrary to Dr. Paluska's opinion that claimant's need for treatment for his right hip and low back conditions is due, in major part, to his work activities. Based on this evidence, we find claimant's right hip and low back conditions to be compensable. See ORS 656.802(1)(c) and (2). Because claimant has not established that a particular insurer is responsible, but has established that his claim is work-related generally, he has successfully relied on the last injurious exposure rule's "rule of proof." In such cases, the last injurious exposure rule applies to determine the initial assignment of responsibility. See Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Bracke v. Baza'r, 293 Or 239, 248 (1982).

The last injurious exposure rule provides that where, as here, a worker proves that an occupational disease is caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, supra; Meyer v. SAIF, 71 Or App 371, 373 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, supra. The onset of disability is the date upon which the claimant first becomes disabled as a result of the compensable condition or, if the claimant does not become disabled, the date he first seeks medical treatment for the condition. Progress Quarries v. Vaandering, 80 Or App 160 (1986); SAIF v. Carey, 63 Or App 68 (1983).

In this case, claimant was first disabled due to his compensable conditions on December 7, 1990, when Dr. Paluska operated on claimant's right leg. That surgery was necessary to treat claimant's compensable low back and right hip conditions. (See Exs. 1, 2, 14-25). Because SAIF came on the risk in October 1990 and claimant was disabled thereafter, responsibility is initially assigned to SAIF, the insurer on the risk when claimant became disabled due to his compensable conditions.

SAIF can shift responsibility to Aetna, the prior insurer, by showing that claimant's work exposure while Aetna was on the risk was the sole cause of the claimed conditions or that it was impossible for claimant's exposure while SAIF was on the risk to have caused claimant's disability. FMC Corporation v. Liberty Mutual Ins. Co., 70 Or App 370 (1984). On this record, we conclude that SAIF has established neither. Accordingly, responsibility for claimant's right hip and low back occupational disease claims remains with SAIF.

Finally, we note that claimant has not claimed that his leg length discrepancy is itself work-related. In reaching this conclusion, we note that claimant's leg length discrepancy condition preexisted the relevant work exposures. (See Tr. 32-33). Moreover, uncontradicted medical evidence relates this condition to a fractured left femur, which occurred when claimant was 15 years old. (See Exs. 1-1; 14-7-10). In addition, we note Dr. Paluska's reasoned opinion that the leg length condition was a contributing cause (not an effect) of claimant's current disability and need for treatment. (Ex. 14-10).

However, as we have stated, the medical evidence indicates that the leg surgery was required as treatment for the hip and back conditions. Consequently, the leg surgery is compensable, even though the shortened leg condition itself is not. See Van Blokland v. Oregon Health Sciences University, 87 Or App 694 (1987).

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 on review is $1,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's statement of services and his respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated July 30, 1991 is modified in part and reversed in part. Aetna Casualty Company's denials of claimant's claims for right hip degeneration, accelerated low back degeneration, chronic lumbosacral strain, and right leg surgery are reinstated and upheld. The SAIF Corporation's denial of these conditions and treatment is set aside and the claims are remanded to SAIF

for further processing in accordance with law. That portion of the order addressing claimant's leg length discrepancy condition is modified, so that SAIF is responsible for the treatment claimed, but not for the condition. Claimant's attorney is awarded an assessed fee of $1,000, for his services on review, payable by SAIF. SAIF, rather than Aetna, shall pay the attorney fee awarded by the Referee.

June 30, 1992 Cite as 44 Van Natta 1257 (1992)

In the Matter of the Compensation of
ROLAND DIR, Applicant
WCB Case No. CV-92001
ORDER ON RECONSIDERATION (CRIME VICTIM ACT)
Michael O. Whitty, Assistant Attorney General

On June 5, 1992, Special Hearings Officer Roger C. Pearson issued "Findings of Fact, Conclusions and a Proposed Order." Pursuant to the proposed order, the Special Hearings Officer recommended that the Department of Justice Crime Victims' Compensation Program's November 4, 1991 decision to deny applicant's claim for compensation under the Crime Victims Act be affirmed.

In response to that proposed order, applicant has submitted his letter, accompanied by two dental bills. Contending that these bills are attributable to his injuries resulting from the incident in question, applicant makes a "final plea for help in this matter, so this matter could finally be resolved."

As recognized in the proposed order, the physical and financial trauma to applicant caused by this tragic event is apparent. Nevertheless, we concur with the Special Hearings Officer's conclusions that applicant's injuries are substantially attributable to his own wrongful actions and that applicant substantially provoked his assailant.

Inasmuch as the legislature has mandated that to receive benefits as a victim of a crime under the Act an applicant's injury must not be substantially attributable to his own wrongful act or to his substantial provocation of his assailant, we agree with the Special Hearings Officer's reasoning that applicant is not entitled to any compensation. In other words, applicant's claim does not satisfy the statutory requirements which would entitle him to benefits under the Act. This decision also pertains to applicant's current request for payment of his dental bills.

Accordingly, as supplemented herein, we affirm and adopt the Special Hearings Officer's June 5, 1992 proposed order.

IT IS SO ORDERED.

In the Matter of the Compensation of
PAMELA E. FLEISCHER, Claimant
WCB Case Nos. 91-06499 & 91-02287
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Schwabe, et al., Defense Attorneys
Michael O. Whitty (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of that portion of Referee Schultz's order that set aside its denial of claimant's injury claim for post-traumatic stress disorder and injury to claimant's right hand. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

On October 8, 1989, while working at Good Samaritan Hospital, claimant was the victim of an attempted rape. As a result of this assault, claimant injured her back and subsequently developed post-traumatic stress disorder. Good Samaritan, a self-insured employer, accepted the claim for claimant's back injury and psychological condition.

Claimant stopped working at Good Samaritan Hospital at the end of May 1990. About that time, she received a telephone call from her assailant at home, although her telephone number was unlisted. The man indicated that he was still around and had "not forgotton her." Claimant changed her telephone number to another unlisted number. Nevertheless, the attacker called again on October 8, 1990 to wish claimant a "happy anniversary" of the attempted rape.

In July 1990, claimant went to work as a file clerk at SAIF's insured, a medical clinic. The clinic is located in Northwest Portland. At the suggestion of her supervisor, claimant eventually agreed to arrive at the office at 8:00 a.m., although most of the other staff arrived at 8:30 a.m., in order to more easily complete her filing work. Claimant entered the office by unlocking a door located in the rear of the building. Although the door stood in a recessed space, a small parking lot and the William Temple House faced the back door. A school also was located across the street from the clinic.

On October 12, 1990, at approximately 8:00 a.m., claimant arrived at the office. As claimant was unlocking the back door, a man put a knife to her back and forced her inside the office. Claimant later identified him as the same person who attempted to rape her approximately a year earlier. The man instigated a sexual assault against claimant. Claimant, however, was able to interrupt the assault and fight off her assailant who then ran from the clinic building.

Claimant again sought psychiatric therapy as a result of the second attack and was diagnosed with post-traumatic stress disorder. SAIF denied this condition, as well as an injury to claimant's right hand, on the basis that any injuries resulting from the second attempted rape were not compensable.

CONCLUSIONS OF LAW AND OPINION

ORS 656.005(7)(a) provides that a "compensable injury" is an injury "arising out of and in the course of employment requiring medical services or resulting in disability or death[.]" The Referee concluded that the second attempted rape at SAIF's insured did arise out of and in the course of employment based on his finding that, although "the attacker in this case clearly

sought claimant out, he did so at a time when claimant was required by the conditions of her employment to be alone and thus more vulnerable to attack." (O & O at 10).

In order for an injury to arise out of and be in the course of employment, there must be a sufficient relationship between the injury and the employment. Rogers v. SAIF, 289 Or 633, 642 (1980). If the injury results from the "mere fact" that the employment places the worker at the site of the accident, then the injury is not compensable. Wallace v. Green Thumb, Inc., 296 Or 79, 83 (1983).

In Carr v. U.S. West Direct Co., 98 Or App 30 (1989), the Court of Appeals discussed the compensability of injuries to the claimant when she was sexually harrassed, assaulted, and raped by her supervisor in the course of her work as an outside sales representative. Specifically, the court examined whether a sufficient "work connection" existed between claimant's injuries and her employment. The court first found that claimant was injured in the course of her employment because she was performing her job when she was assaulted and that this factor weighed in favor of compensability. Id. at 35.

The court further found, however, that the claimant failed to prove causation, or that the injury "arose out of" the employment, stating that:

> "The source of the injury bears little or no relationship to the employment. There is no evidence that the assaults were provoked by anything related to the work. [Cite omitted.] There is no evidence that the nature of the job or the job environment created or enhanced the risk of assault. The fact that the employment placed plaintiff and [her supervisor] together is not, in itself, enough. [Cite omitted.] An employer is not subject to the workers' compensation law for all injuries to an employe irrespective of the cause merely because the employe is injured while working at the place of employment. There must be some causal link between the occurrence of the injury and a risk connected with the employment. [Cite omitted.] That link has not been established here, and we conclude, therefore, that the evidence on summary judgment does not compel the conclusion that the occurrence was covered by the workers' compensation law." Id.

In a similar vein, Larson finds a causal connection between an assault and work if there is proof that the work environment increased the risk of attack or that the attack was motivated by something related to the employment. 1A Larson, Workmen's Compensation Law 11.11(b) (1979). For example, under Larson's theory, a worker who is assaulted while working in a dangerous environment, such as a lonely and isolated spot at night, would have a compensable claim since the risk of assault was increased by the requirements of the job. Id.

Like the claimant in Carr, claimant here was injured in the course of her employment because she was performing her job at the time that she was attacked. However, like the court in Carr, we find that claimant failed to prove causation--that is, that the attack arose out of her employment. First, we note that the evidence indicates that the attack was not motivated by any factor related to claimant's employment. After the first attempted rape, claimant's attacker stalked her, calling her twice at home to threaten her, and then attempting to rape her a second time. We find that such evidence demonstrates that the second attempted rape was directed at claimant personally, rather than a result of her position in the clinic.

Claimant argues that the work environment enhanced the risk of assault in

that she was made more vulnerable to attack because she arrived at the office before anyone else and entered through a door that was partially hidden from view. Claimant's assertion may be correct, but she provides no evidence to prove a greater likelihood of assault in that area at that time of the morning. On the contrary, claimant herself testified that she did not feel "threatened" by arriving early and that she felt "as safe as I feel any other time after having been attacked." (Tr. 28-29). Claimant's supervisor also testified that she considered the area "safe" at that time of the morning. (Tr. 40). In light of such testimony, we are unable to equate claimant's work environment with an inherently dangerous environment such as a lonely and isolated spot at night.

In view of the lack of proof demonstrating that the work environment appreciably increased the risk of attack and our conclusion that the assault was not motivated by any factors related to claimant's job, we are compelled to conclude that claimant failed to establish a sufficient employment nexus to render the assault compensable.

ORDER

The Referee's order dated September 6, 1991, as reconsidered September 19, 1991, is reversed in part and affirmed in part. That portion of the order finding that claimant's injuries, including post-traumatic stress disorder and a right hand injury, compensable is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's assessed attorney fee award of $2,600, payable by SAIF, is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
LESTER M. GIBSON, Claimant
WCB Case No. 91-02736
ORDER ON REVIEW
J. Michael Casey, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

The self-insured employer requests review of Referee McWilliams' order which directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree. On review, the issue is the rate of scheduled permanent disability.

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

The employer argues that claimant is precluded from challenging the rate at which the July 26, 1990 Determination Order award of 3 percent scheduled permanent disability was paid. We disagree.

The July 26, 1990 Determination Order did not become final. Although the Determination Order awarded a specific amount of scheduled permanent disability compensation which corresponded to a rate of $145 per degree, the prior referee replaced that award with an 8 percent scheduled disability award. The prior referee did not award a specific sum of compensation, and the parties did not stipulate to any particular amount or rate of scheduled permanent disability. Cf. Michael E. Morrison, 44 Van Natta 372 (1992). Accordingly, the rate of payment of the entire 8 percent scheduled disability awarded by the prior referee

remained a viable issue. Claimant is not precluded from raising the rate issue in this proceeding. See, e.g., Henry K. Schwane, 44 Van Natta 679 (1992).

Claimant's attorney is entitled to an assessed attorney fee for prevailing against the self-insured employer's request for review. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the rate of permanent disability issue is $250, to be paid by the self-insured 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 to claimant of the interest involved.

ORDER

The Referee's order dated July 22, 1991 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $250, to be paid by the self-insured employer.

June 30, 1992 Cite as 44 Van Natta 1261 (1992)

In the Matter of the Compensation of
WILLIAM GIBBONS, Claimant
WCB Case No. 91-06977
ORDER ON REVIEW
Francesconi, et al., Claimant Attorneys
Roberts, et al., Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Peterson's order that affirmed a Determination Order award of 5 percent (7.5 degrees) scheduled permanent disability award for the loss of use or function of his right arm (elbow). In its respondent's brief, the insurer contends that claimant's request for hearing was not timely filed. On review, the issues are timeliness and extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Timeliness

The insurer first raises its timeliness argument on appeal. Generally, we will not address an issue raised for the first time on appeal. Gunther H. Jacobi, 41 Van Natta 1031 (1989). An exception is made for matters involving subject matter jurisdiction. See Schlect v. SAIF, 60 Or App 449 (1982) (subject matter jurisdiction may be raised at any time during the course of litigation). However, timeliness of a hearing request from a Determination Order does not raise an issue of subject matter jurisdiction. SAIF v. Roles, 111 Or App 597 (1992). Therefore, we conclude that the insurer's defense regarding timeliness of claimant's hearing request is itself untimely. But see Oliver M. Payton, 43 Van Natta 2738 (1991). Alternatively, we address the insurer's argument on the merits and reject it.

A request for hearing on a Determination Order must be filed within 180 days after the date on which copies of the order were mailed to the parties.

Former ORS 656.319(4). In the present case, the 180th day was June 4, 1991. Claimant's request for hearing was received by the Hearings Division on June 4, 1991 and was, therefore, within the 180-day period. Accordingly, we conclude that claimant's request for hearing was timely filed.

Extent of Permanent Disability

For the 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 disability adopted by the Director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. Former OAR 438-10-010.

Claimant's condition became medically stationary on May 15, 1989, and his claim was closed by Determination Order on December 6, 1990. Therefore, 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.

Claimant contends that the "standards" do not adequately compensate him for the loss of use or function of his right arm. In this regard, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability sustained by a claimant is more or less than the extent indicated by the standards. 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).

In the present case, the Referee found that there was a lack of evidence that claimant has been precluded from earning a potentially higher income in the future than his current wages or the wage he received at his at-injury job. The Referee, therefore, concluded that there is not clear and convincing evidence that claimant has suffered a higher degree of scheduled permanent disability than the entitlement indicated by the "standards." We agree with the Referee that no additional award is warranted, but we offer the following analysis.

All permanent disability is not rated based on loss of earning capacity. Paul E. Denue, 42 Van Natta 44 (1990). A disability to a scheduled body part is a disability under ORS 656.214(2), not 656.214(5). Accordingly, disability to scheduled body parts is rated based on loss of use or function only. Paul E. Denue, supra.

Claimant contends that he is not claiming an additional award of permanent disability based upon a loss of earning capacity. Rather, claimant asserts that he has proven by clear and convincing evidence that he has lost more use or function than that allowed under the standards because "what is a 5 percent loss of use and function to the average individual, does not adequately describe the loss and [sic] use and function to an individual with the heightened use and function of the body part as in the case of this professional athlete." (App. Br. at 2). Here, however, claimant has not specifically pointed to loss of use or function beyond that awarded by the "standards." Further, claimant has cited no authority for his contention. Nor are we aware of any authority in support of his position.

We conclude that claimant has failed to establish that the record, as a whole, constitutes clear and convincing evidence that claimant's degree of loss of use or function is greater than that contemplated under the "standards." Former ORS 656.283(7); 656.295(5). Therefore, we do not award claimant disability based on clear and convincing evidence. Also see Surratt v. Gunderson

Bros., 259 Or 65, 72-73 (1971) (in evaluating scheduled disability, the examiner deals merely with the injured part and the evaluation appraises the resulting loss by comparing the claimant's present structure or function with the claimant's preinjury structure or function).

ORDER

The Referee's order dated September 11, 1991 is affirmed.

June 30, 1992 Cite as 44 Van Natta 1263 (1992)

In the Matter of the Compensation of
ROBERT W. GILLIAM, Claimant
WCB Case No. 90-05835
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Moller.

Claimant requests review of those portions of Referee Livesley's order that: (1) found that his psychological condition claim was not prematurely closed by a February 27, 1990 Determination Order; and (2) upheld the SAIF Corporation's partial denials of his diabetes mellitus and hyperlipidemia conditions. On review, the issues are premature closure and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Premature closure

We adopt the Referee's Conclusions of Law and Opinion on the issue of premature closure, with the following supplementation.

On review, claimant notes that his treating psychiatrist, Dr. Carter, has opined that claimant will not be medically stationary until "three months after successful placement in a stable job that he can do and demonstrates his ability to function in that setting." Additionally, claimant argues that even Dr. Turco, an independent medical examiner, observed that claimant would not "feel entirely good about himself until he is gainfully employed at a job consistent with his limitations."

We agree with the Referee's conclusion that such comments do not necessarily equate to a finding that claimant's condition is expected to improve. See e.g. Milford W. Hayes, 42 Van Natta 2865 (1990) (seeking vocational assistance for claimant is not necessarily an indication that the doctor expected claimant to improve); Harold D. Ward, 42 Van Natta 381 (1990) (a worker who continues to need vocational services may be medically stationary).

Under the circumstances, we agree with the Referee that claimant has failed to establish that he was not medically stationary at the time of claim closure.

Compensability

Diabetes mellitis

The Referee concluded that claimant had not established that his weight gain (resulting from his compensable injury) was the major contributing cause of his diabetes condition. We agree with the Referee's conclusion with the following supplementation.

Under ORS 656.005(7)(a)(A), a worker who suffers a second injury or disease as a consequence of the original compensable injury will be compensated for the second condition only if the compensable injury is the major contributing cause of that condition. See Julie K. Gasperino, 43 Van Natta 1151 (1991); aff'd Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

In the present case, we agree with the Referee that claimant has not established that the compensable injury is the major contributing cause of his diabetes mellitis condition.

Hyperlipidemia

We adopt the Referee's Conclusions of Law and Opinion on the issue of compensability of claimant's hyperlipidemia condition. See Julie K. Gasperino, supra.

ORDER

The Referee's order dated July 17, 1991 is affirmed.

June 30, 1992 Cite as 44 Van Natta 1264 (1992)

In the Matter of the Compensation of
CHERYL M. HICKOX, Claimant
WCB Case No. 90-13905
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Hallock & Bennett, Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of Referee Thye's order that upheld the insurer's denial of her mental stress occupational disease claim. In her brief, claimant asks the Board to strike the testimony of the insurer's witness. On review, the issues are motion to strike and compensability. We deny the motion and affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact as supplemented. The insurer planned to call Ms. Senn[-Battershell], claimant's former supervisor, as its only witness. Prior to the hearing, Ms. Senn ceased employment with the insured and, without the insurer's knowledge, moved out of state. Although the witness was willing to testify, she was unable to travel to Oregon for the hearing as she had begun a new job only five days earlier.

At the hearing, the insurer moved to take Ms. Senn's testimony by telephone. Claimant objected, contending the Referee would be unable to discern the truthfulness of the witness if she were not before him. Finding that extraordinary circumstances existed, the Referee granted the motion. Following the close

of claimant's case in chief, counsel for the insurer and claimant, as well as the Referee, conducted telephonic examination of Ms. Senn. Claimant then presented rebuttal testimony.

The hearing was conducted in a manner that achieved substantial justice.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike Testimony

The initial question presented on review is whether the Referee erred in allowing Ms. Senn to testify via telephone. A hearings referee is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice. ORS 656.283(7). The Board and the courts have long encouraged the exercise of discretion in evidentiary matters in favor of admission so long as the fundamental fairness of the proceeding is not compromised. See Lucke v. Compensation Department, 254 Or 439, 442-43 (1969); Cristofano v. SAIF, 19 Or App 272, 273, 274 (1974); Cherry Walker, 40 Van Natta 1973 (1988). Similarly, the rules grant referees broad discretion in allowing testimony to be taken in any manner that will afford substantial justice. OAR 438-07-022.

OAR 438-07-022 provides that:

> "Testimony of lay witnesses shall be taken by personal appearance of the witness before the referee at the hearing unless the witness is unable to attend the hearing due to extraordinary circumstances beyond the control of the party offering the testimony and all parties and the referee agree, or the referee finds, that the testimony should be taken other than by personal appearance of the witness at the hearing and that the testimony of the witness cannot be taken by a telephone deposition or in-person deposition. In such cases, the referee may allow testimony to be taken in any manner that will afford substantial justice and insure a complete and accurate record of all examination and testimony."

Claimant argues that the witness "could have physically come, and the only thing that stopped her from coming was her fear of losing her job." Therefore, it contends, the witness was "not 'unable' to attend the hearing" within the meaning of the rule. There is nothing in the rule to support claimant's contention that a witness must be "physically" unable to attend a hearing to constitute "extraordinary circumstances." We decline to adopt such a narrow interpretation.

Claimant further argues that the witness' testimony should be stricken because her unavailability was "due to the failure of defense counsel to secure her attendance." In this regard we note that at the time of the hearing, the witness had left the employ of the insured and, thus, the insurer had no leverage to obtain her personal appearance. Moreover, although subpoenas may be served for the attendance of witnesses and the production of testimony before any hearing, because Ms. Senn had left the jurisdiction of the Hearings Division, the viability of a subpoena under such circumstances would be subject to question. See ORS 656.726(2)(c).

Finally, and most importantly, in lieu of her personal appearance, the insurer did secure Ms. Senn's testimony via telephone before the Referee, and the witness was available for cross-examination by claimant's counsel. In this regard, we note that in the event a witness is unable to attend a hearing, testimony may be taken by "telephone deposition or in-person deposition." OAR 438-

07-022. Had Ms. Senn's testimony been secured in either of those manners, as would have been proper, the Referee would not have been present during the testimony or able to question the witness as he did in this case.

The Referee did not abuse his discretion in permitting the insurer's witness to testify by telephone. "Substantial justice" was served. See ORS 656.283(7). Accordingly, we decline to strike the witness' testimony.

Compensability

Turning to the merits of the claim, we adopt the Referee's conclusions and reasoning that claimant has not proven by clear and convincing evidence that her employment conditions were the major contributing cause of her recurrent depression and need for treatment.

ORDER

The Referee's order dated June 21, 1991 is affirmed.

June 30, 1992 Cite as 44 Van Natta 1266 (1992)

In the Matter of the Compensation of
ROGER A. LIBKE, Claimant
WCB Case No. 90-15905
ORDER ON REVIEW
Paul S. Bovarnick, Claimant Attorney
Paul Silver, Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of those portions of Referee Otto's order that: (1) declined to increase claimant's 20 percent (64 degrees) unscheduled permanent disability awarded by a Determination Order for a left shoulder injury; and (2) declined to award claimant temporary total disability for the period of April 5, 1988 through May 22, 1989. On review, the issues are extent of unscheduled permanent disability, timeliness and the res judicata effect of a prior Determination Order. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Permanent Disability

We adopt that portion of the Referee's order regarding extent of unscheduled permanent partial disability.

Timeliness and Res Judicata

The Referee, relying on former ORS 656.319(4), found that he lacked jurisdiction to address claimant's request for temporary total disability for the period of April 5, 1988 though May 22, 1989. Alternatively, the Referee concluded that, even if he had jurisdiction to address the issue, claimant was not entitled to such benefits because he was not enrolled and actively engaged in an authorized training program during that period.

We first note that the current versions of ORS 656.319(4) and 656.268 do not apply to this case because claimant was medically stationary before July 1, 1990. See Or Laws 1990, ch 2, 54(3). Former ORS 656.319(4) provided that:

> "[w]ith respect to objections to a determination or notice of closure under ORS 656.268, a hearing on such objections shall not be granted unless a request for hearing is filed within 180 days after the copies of the determination or notice of closure were mailed to the parties."

Similarly, former ORS 656.268(6) provided that any party who received a determination from the Department of Insurance and Finance "may request a hearing * * * within 180 days after copies of the determination are mailed."

These provisions recently were construed by the Court of Appeals in Roles v. SAIF, 111 Or App 597 (1992). The court found that a request for hearing that was not timely filed under former ORS 656.319(4) and 656.268(6) did not deprive the Hearings Division of subject matter jurisdiction to decide the issues put in dispute by the request for hearing. Id. at 602. However, the court also concluded that the Referee erroneously exercised his authority by denying a motion to dismiss on the ground that the request for hearing was untimely filed. Id.

Here, claimant filed a request for hearing on August 6, 1990, asserting that he is entitled to temporary total disability for the period of April 5, 1988 through May 22, 1989. Although timely as to the July 17, 1990 Determination Order, claimant's request for hearing was not timely filed regarding the November 17, 1988 Determination Order. See former ORS 656.319(4), 656.268(6). Therefore, because the insurer challenged claimant's present action on the ground that he did not timely file a request for hearing regarding the November 17, 1988 Determination Order, we conclude that the Referee lacked authority to address the November 17, 1988 Determination Order. See Roles v. SAIF, supra.

Moreover, because claimant withdrew his request for hearing regarding the November 17, 1988 Determination Order and that matter was dismissed, (see Ex. 43), the November 17, 1988 Determination Order became final by operation of law. Therefore, claimant also is precluded by res judicata from challenging any issues or claims decided by the November 17, 1988 Determination Order.

Res judicata is comprised of two doctrines, claim preclusion and issue preclusion. Issue preclusion bars future litigation between the same parties concerning an issue that was "actually litigated and determined" in a setting where "its determination was essential to" the final decision reached. North Clackamas School Dist. v. White, 305 Or 48, 53, modified 305 Or 468 (1988). Claim preclusion, on the other hand, does not require actual litigation of an issue or that the determination of the issue be essential to the final decision reached. Rather, a claim is barred if it is based on the same factual transaction that was at issue in a prior action between the same parties. Drews v. EBI Companies, 310 Or 134, 140 (1990). Moreover, there must be a prior opportunity to litigate the claim, whether or not used, and there must be a final judgment. Id.

Even assuming that the November 17, 1988 Determination Order did not "actually litigate" claimant's entitlement to temporary disability after April 4, 1988, we conclude that claimant is barred by claim preclusion from litigating the temporary disability issue. Claimant was enrolled in an authorized training program until his eligibility for vocational assistance was terminated on April 15, 1988. (Ex. 30). Having issued on November 17, 1988 but awarding temporary total disability only through April 4, 1988, (Ex. 28-1), the Determination Order was based on the same factual transaction at issue here -- claimant's

entitlement to temporary disability after his vocational assistance was terminated. Furthermore, claimant had the opportunity to litigate the Determination Order but withdrew his request for hearing after the insurer agreed to restore claimant's eligibility for vocational assistance. (See Exs. 34, 43).

Accordingly, although we find that the Referee had subject matter jurisdiction of the temporary disability issue, we conclude that the request for hearing regarding the November 17, 1988 Determination Order was subject to dismissal as untimely. Moreover, claimant is barred by claim preclusion from litigating the temporary disability issue in the present action.

ORDER

The Referee's order dated May 31, 1991 is affirmed.

In the Matter of the Compensation of
RONALD J. LUCIER, Claimant
WCB Case No. 90-11600
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Ronald K. Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Brazeau.

The SAIF Corporation requests review of that portion of Referee Holtan's order that set aside its denial of claimant's aggravation claim for a herniated cervical disc. Claimant argues in his brief that we lack jurisdiction of this matter because SAIF untimely requested Board review. On review, the issues are timeliness of the request for Board review, compensability and aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's "FINDINGS OF FACT" with the exception of the last full sentence on page 1 and the last paragraph on page 2, and substitute the following for the last sentence in the first paragraph on page 1: Claimant tried to catch himself with his right arm. He experienced pain in the right upper shoulder and right interscapular region.

We also make the following correction and additions. Claimant's on-the-job injury occurred on November 23, 1987, not on November 25, 1987. (Ex. 3). Dr. Hearns declared claimant medically stationary on March 16, 1990. (Ex. 5-E1). Claimant was diagnosed with cervical spondylosis at C4-5 and C5-6. (Ex. 5-I and 5-M).

FINDINGS OF ULTIMATE FACT

Claimant's compensable 1987 injury was not the major contributing cause of his left C4-5 herniated disc.

CONCLUSIONS OF LAW AND OPINION

We first address claimant's contention that SAIF untimely requested Board review. Although the Referee's Opinion and Order issued on December 13, 1990, that order was abated by Order of Abatement dated January 8, 1991, and the referee subsequently issued a January 24, 1991 Order on Reconsideration which

republished the prior order, thereby recommencing the 30-day appeal period as of January 24. Because SAIF filed its request for review on February 15, 1991, its request was timely, and we properly have jurisdiction of this matter. ORS 656.289(3).

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Because claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990, we agree that this matter should be analyzed under the 1990 Act. Or Laws 1990 (Special Session), ch. 2, 54; Ida M. Walker, 43 Van Natta 1402 (1991).

The Referee, applying both ORS 656.005(7)(a)(A) and ORS 656.273(1), concluded that claimant had proven that his 1987 upper back injury was the major contributing cause of his current C4-5 herniated disc and, thus, that his aggravation claim was compensable. We disagree.

The SAIF Corporation contends that the major contributing cause of claimant's current disc condition was an April 1990 off-the-job injury and that claimant's aggravation claim is, therefore, not compensable under ORS 656.273(1). We need not reach the aggravation issue, however, because we conclude that claimant's current disc condition is not a compensable consequence of his November 1987 injury. See Thomas L. Fitzpatrick, 44 Van Natta 877 (1992).

The only evidence to support a finding that claimant's current disc condition arose directly from the injurious incident on November 23, 1987 is provided by Dr. Campagna, who opined that the mechanism of injury is consistent with a disc herniation. However, Dr. Campagna also suggests his agreement with the analysis provided by Dr. Hearns, an analysis wholly inconsistent with a direct causal relationship. We conclude, therefore, that the evidence will not support a conclusion that the cervical disc herniation arises directly from the November 1987 injury.

Dr. Hearns, claimant's treating chiropractor, initially opined that claimant's work activities were the major contributing cause of his current condition. (Ex. 5-5). In explanation of this conclusion, however, Dr. Hearns later characterized the 1987 injury as "a significant factor" in the current condition, explaining that the injury to the cervical spine resulted in mechanical problems which, in turn, put increased physical stress on the intervertebral disc with consequential degeneration or derangement. (Ex. 6-A). This analysis is consistent with the indirect development of a condition as a result of the consequences of a compensable condition. Under ORS 656.005(7)(a)(A), such a condition would be compensable only if the compensable injury is the major contributing cause of the consequential condition. See Julie K. Gasperino, 43 Van Natta 1151 (1991), aff'd Albany General Hospital v. Gasperino, 113 Or App 411 (1992). However, Dr. Hearns', by characterizing the 1987 event as a "significant factor" appears to be retreating from his prior, unsupported, conclusion that the November 1987 injury is the major contributing cause of the cervical disc herniation.

The causation issue in this claim presents a complex medical question which must be resolved largely on the basis of expert medical evidence. See Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986). Because we find that claimant has failed to present evidence establishing a direct causal relationship, and because the reports of Dr. Hearns limit the indirect causal impact of the November 1987 injury to a "significant factor", we find that claimant has failed to carry his burden of proving the major causal relationship between the November 1987 injury and claimant's current cervical disc herniation.

Because claimant has failed to establish the requisite causal relationship, we need not discuss the relationship of the April 1990 off-the-job events to claimant's current condition.

ORDER

The Referee's order dated December 13, 1990, as reconsidered January 24, 1991, is reversed in part and affirmed in part. The SAIF Corporation's May 23, 1990 aggravation denial is reinstated and upheld. The assessed attorney fee of $2,000 is reversed. The remainder of the order is affirmed.

June 30, 1992 Cite as 44 Van Natta 1270 (1992)

In the Matter of the Compensation of
BRYAN E. MITCHELL, Claimant
WCB Case Nos. 91-08784 & 91-07232
ORDER ON REVIEW
Clayton C. Patrick, Claimant Attorney
Ainsworth, et al., Defense Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

The noncomplying employer requests review of that portion of Referee Brown's order that set aside the SAIF Corporation's denial of claimant's left knee injury claim. Claimant has filed a motion to dismiss the employer's request, asserting that a noncomplying employer lacks authority to request Board review. On review, the issues are dismissal and compensability. We deny the motion to dismiss and affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Dismiss

Claimant has filed a motion to dismiss the employer's request for review, asserting that a noncomplying employer lacks authority to request Board review once the claim has been forwarded to SAIF for processing. We disagree.

Inasmuch as SAIF had denied the left knee injury claim, claimant, rather than the employer, initiated this proceeding by requesting a hearing pursuant to ORS 656.283. See Clark v. Linn, 98 Or App 393, 397 (1989). Nonetheless, the employer is a "party," which is defined to include "the employer of the injured worker at the time of the injury." ORS 656.005(20). Accordingly, after the Referee found the claim compensable and set aside SAIF's denial, the employer became entitled to request Board review of that decision, notwithstanding SAIF's decision not to appeal the Referee's order. See ORS 656.295; Blain v. Owen, 106 Or App 285 (1991); Hamid R. Amini, 42 Van Natta 188 (1990). Claimant's motion to dismiss is denied.

Compensability

We adopt the Referee's conclusions and reasoning regarding the compensability of claimant's left knee injury claim.

Claimant is entitled to an assessed attorney fee for prevailing over the employer's request for review. 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 attorney's services on review concerning the compensability issue is $750, to be paid by the SAIF Corporation 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 issue, and the value of the interest involved.

ORDER

The Referee's order dated September 12, 1991 is affirmed. For services on Board review, claimant's counsel is awarded $750, to be paid by the SAIF Corporation on behalf of the noncomplying employer.

June 30, 1992 Cite as 44 Van Natta 1271 (1992)

In the Matter of the Compensation of
ALAN C. MOORE, Claimant
WCB Case No. 91-04783
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The self-insured employer requests review of Referee Peterson's order which: (1) awarded an assessed attorney fee for claimant's counsel's services in obtaining rescission, prior to hearing, of its denial of claimant's aggravation claim; and (2) assessed penalties and attorney fees for an allegedly unreasonable denial. In its brief, the employer contends that the $2,000 attorney fee awarded for the rescinded denial is excessive. Claimant contends in his brief that the Referee had jurisdiction to rate the extent of his unscheduled permanent partial disability. On review, the issues are penalties and attorney fees and jurisdiction. We affirm in part, modify in part and reverse in part.

FINDING OF FACTS

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

CONCLUSIONS OF LAW AND OPINION

Pre-Hearing Denial Rescission - Attorney Fees

The Referee concluded that claimant's counsel was entitled to an attorney fee for a denial rescinded prior to hearing. The Referee found that had it not been for claimant's attorney forcing this matter to hearing the denial would still be in effect. Therefore, the Referee found that claimant's attorney was instrumental in having the denial rescinded, which resulted in compensation for claimant.

The employer contends that claimant's counsel was not instrumental in obtaining compensation for claimant because he failed to prove that the rescission of the denial was brought about by any efforts on his part. We are not persuaded by the employer's argument.

We find that claimant's attorney's request for hearing preserved claimant's rights because the employer rescinded the denial more than 60 days after the date of the denial. Therefore, by preserving claimant's rights, claimant's attorney was instrumental in obtaining compensation for claimant without a hearing. Linda M. Akins, 44 Van Natta 108, 109 (1992). Under the circumstances, we conclude that an assessed attorney fee for services prior to hearing is warranted under ORS 656.386(1).

Amount of Attorney Fee

The employer challenges the Referee's $2,000 attorney fee award for claimant's attorney services concerning the pre-hearing rescinded denial issue. 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 concerning the pre-hearing rescinded denial issue is $1,250, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved. Accordingly, we modify the Referee's attorney fee award from $2,000 to $1,250.

Penalties and Attorney Fees

We adopt the Referee's opinion and conclusion that the employer's denial was reasonable when it was issued on April 3, 1991, but that it became unreasonable after the May 1991 telephone conference between claimant's physician and the employer's attorney which destroyed any legitimate doubt about reopening the claim. See Brown v. Argonaut, 93 Or App 588 (1988). However, the Referee both awarded claimant a 25 percent penalty of all amounts due for its unreasonable denial and assessed an attorney fee of $500 for claimant's attorney prevailing on this issue.

We have previously determined, however, that when a penalty is assessed under ORS 656.262(10), we do not also assess an attorney fee under ORS 656.382(1) for unreasonable resistance to payment of compensation if the factual basis for both awards is the same. Otherwise, the legislative intent expressed in ORS 656.262(10) that claimant's attorney receive one-half the penalty "in lieu of an attorney fee" would be contravened. Nicolasa Martinez, 43 Van Natta 1638 (1991); Harry F. Forrester, 43 Van Natta 1480, 1481 (1991). Therefore, since claimant has already received a penalty under ORS 656.262(10) for the same conduct, we do not award claimant an attorney fee under ORS 656.382(1). Accordingly, we reverse the attorney fee of $500. Additionally, we modify the 25 percent penalty of all amounts due to reflect that one-half of that penalty is payable to claimant's attorney.

Jurisdiction

At hearing and on Board review, claimant raises the issue of extent of unscheduled permanent disability. Claimant contends that the Referee had jurisdiction to rate his unscheduled permanent partial disability. The Referee did not address this issue, as he found that the parties agreed that he lacked jurisdiction over the matter. We agree that the Referee lacked jurisdiction over this issue.

At hearing, the employer accepted claimant's aggravation claim, effective March 5, 1991. Accordingly, at the time of the July 3, 1991 Order on Reconsideration, claimant's claim was in open status. Under these circumstances, we agree that it would be improper for the Referee to rate the extend of claimant's permanent disability. See ORS 656.283 (referee to evaluate disability as of the date of reconsideration order).

We note that, because claimant did not successfully prevail on the jurisdiction issue and claimant's entitlement penalties and to attorney fees were the only other issues on review, he is not entitled to an attorney fee for services rendered on review concerning 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 August 8, 1991 is affirmed in part, modified in part and reversed in part. In lieu of the $2,000 attorney fee award for services at hearing concerning the pre-hearing rescinded denial issue, claimant's attorney is awarded $1,250 to be paid by the employer. That portion of the Referee's order that awarded an attorney fee of $500 for the employer's unreasonable denial is reversed. That portion of the Referee's order that assessed a 25 percent penalty of all amounts due for the self-insured employer's unreasonable denial is modified to reflect that one-half of that penalty is payable to claimant's attorney. The remainder of the order is affirmed.

In the Matter of the Compensation of
MARY H. MORRIS, Claimant
WCB Case No. 91-00101
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Pamela Schultz, Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Baker's order finding that claimant was precluded from litigating the compensability of her occupational disease claim for a tendonitis condition. In its respondent's brief, the insurer challenges the Referee's order insofar as it set aside its denial of claimant's carpal tunnel syndrome. The insurer asserts that claimant also is precluded from litigating the compensability of her carpal tunnel syndrome. On review, the issue is the preclusive effect of the insurer's prior denial of claimant's claim.

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

An uncontested denial bars future litigation of the denied condition unless the condition has changed and claimant presents new evidence to support the claim that could not have been presented earlier. See Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560, 563-64 (1989).

Claimant's present claim is for tendonitis and carpal tunnel syndrome. The insurer asserts that claimant is barred by a 1988 denial from litigating the compensability of her carpal tunnel condition. Specifically, it contends that the carpal tunnel condition was part of claimant's 1987 claim because it was diagnosed at that time and "pre-existed the 1990 claim." We disagree.

Although there is evidence that claimant was diagnosed with "possible early carpal tunnel" in October 1987, (Ex. 2-5), there is no indication that claimant's 1987 claim included this condition. Claimant's 1987 "801" cited "tendonitis" as the nature of the injury or disease for which claimant was seeking compensation. (Ex. A). The insurer's denial letter also characterized the claim as a "condition diagnosed as tendinitis to your left and right arms."

(Ex. D). Claimant is not precluded by the unappealed 1988 denial from seeking compensation for her carpal tunnel syndrome.

Claimant challenges the Referee's conclusion that her current claim for tendonitis is precluded by the 1988 denial. We find no evidence of a change in claimant's tendonitis condition. Both claimant's testimony and the medical evidence demonstrate that claimant has been experiencing the same symptoms since 1987, although claimant maintains that her symptoms are presently more severe. Treatment for claimant's condition also has changed very little, consisting of wrist braces or splints and anti-inflammatories. Having failed to show a change in her condition, we agree with the Referee that claimant is precluded from now litigating the compensability of her tendonitis condition.

Claimant's attorney is entitled to an assessed attorney fee for successfully defending the Referee's finding that claimant's occupational disease claim for carpal tunnel syndrome is compensable. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee 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 reply brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 30, 1991 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $500, to be paid by the insurer.

In the Matter of the Compensation of
RALPH D. STINSON, JR., Claimant
WCB Case No. 91-06071
ORDER ON RECONSIDERATION
Gatti, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Claimant requests reconsideration of our June 11, 1992 order which affirmed and adopted a Referee's order that awarded an approved attorney fee equal to 25 percent of the increased compensation created by the Referee's decision to award 15 percent (48 degrees) unscheduled permanent disability rather than the 8 percent (25.6 degrees) granted by a Determination Order. Contending that his attorney fee should be based on the increased compensation between the Referee's 15 percent award and a 3 percent Order on Reconsideration award, claimant asserts that our decision is contrary to OAR 438-15-085 in that the Referee effectively applied an offset to claimant's attorney fee award.

We disagree with claimant's reasoning. A Determination Order awarded claimant 8 percent unscheduled permanent disability. Claimant secured legal counsel and requested reconsideration. An Order on Reconsideration reduced claimant's award to 3 percent. Pending the reconsideration order, the SAIF Corporation had paid claimant the entire 8 percent award. Claimant requested a hearing.

Prior to the hearing, the parties expressly stipulated that claimant was "entitled to at least eight percent permanent partial disability" as granted by the Determination Order. Following the hearing, the Referee found that claimant

was entitled to 15 percent unscheduled permanent disability. Consequently, the Referee increased claimant's award from the stipulated 8 percent to 15 percent.

We conclude that claimant's compensation was increased by 7 percent (the Referee's 15 percent award minus the 8 percent stipulated award). Considering the fact that claimant's 8 percent Determination Order award had been previously paid and in light of the parties' pre-hearing stipulation, the 8 percent award was not a "prior overpayment of compensation to the claimant." See OAR 438-15-085(2). Thus, no overpayment existed to be offset against the "increased compensation" created by the Referee's order. Inasmuch as the Referee increased claimant's unscheduled permanent disability award by 7 percent, claimant's attorney was entitled to 25 percent of this increase, not to exceed $2,800. See OAR 438-15-040(1).

Accordingly, we withdraw our June 11, 1992 order. On reconsideration, as supplemented herein, we adhere to and republish our June 11, 1992 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

June 30, 1992 Cite as 44 Van Natta 1275 (1992)

In the Matter of the Compensation of
EDITH I. WALCKER, Claimant
WCB Case No. 90-15028
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of Referee Mills' order that set aside its denial of claimant's claim for her lower left extremity condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

Claimant sustained a right knee injury while working for the employer in 1986.

CONCLUSIONS OF LAW AND OPINION

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

On review, the insurer contends that claimant's condition should be analyzed as an occupational disease, rather than an injury. The insurer also argues that Dr. Baldwin is not persuasive because he relied upon claimant's opinion that her condition was work-related and because he could not state for certain that her condition was attributable to her work activity. Finally, the insurer contends that, because a preexisting degenerative condition is involved, claimant is required to show that work was the major cause of a worsening of the degenerative disease.

At the outset, we agree with the Referee's analysis of this case under both occupational disease and industrial injury theories. The Referee made

alternative findings and concluded that claimant's claim was compensable under either theory.

We disagree with the insurer's contention that Dr. Baldwin relied upon claimant's opinion in arriving at his own opinion regarding causation. Dr. Baldwin did testify that it was "not my decision (as to) when her symptoms arose." In that regard, Dr. Baldwin relied upon claimant's history. (Ex. 36). Under the circumstances, we find it reasonable for Dr. Baldwin to rely upon claimant's history pertaining to her symptoms, and we do not find that his reliance equates to a conclusion that he deferred to claimant's opinion that her condition was work-related.

The insurer also contends that Dr. Baldwin was unable to state with certainty that claimant's work caused her condition. However, Dr. Baldwin testified that if claimant had not been working, he suspected that she probably would not have developed her knee problem. Although he could not determine whether claimant's symptoms arose at the same time as the meniscal detachment, he continued to relate her condition to her "fairly strenuous" work activity.

Finally, the insurer contends that this case involves a preexisting degenerative condition. However, a July 1990 arthrogram of claimant's left knee showed a cyst, but an "otherwise normal left knee arthrogram." Additionally, Dr. Baldwin testified that claimant's "degenerative-type" of situation could have been occurring slowly or that it could have arisen from her work activity.

We are not persuaded that claimant has a preexisting degenerative condition for purposes of applying ORS 656.005(7)(a)(B). However, even if claimant did have a preexisting degenerative left knee condition, we would nonetheless find that the medical opinions establish that, under an industrial injury theory, the injury was the major contributing cause of claimant's disability and need for treatment. Bahman M. Nazari, 43 Van Natta 2368 (1991). Furthermore, under an occupational disease theory, we find that, if claimant had a degenerative left knee condition, her activity at work was the major contributing cause of a worsening of that condition. ORS 656.802(1)(c).

Because the insurer initiated the request for review and we have not disallowed or reduced compensation awarded to claimant, claimant is entitled to an assessed 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 attorney's services on review concerning the issue of compensability is $900. 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 2, 1991 is affirmed. For services on review concerning the issue of compensability, claimant's counsel is awarded an assessed attorney fee of $900, payable by the insurer.

In the Matter of the Compensation of
WAYNE WOOD, Claimant
WCB Case No. 90-20320
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Kevin Mannix, P.C., Defense Attorneys,

The insurer requests reconsideration of that portion of our June 9, 1992 Order on Review that reversed a Referee's order which upheld its denial of claimant's low back injury claim. On reconsideration, the insurer contends that claimant's low back claim is not compensable.

We concluded in our order that claimant's claim was compensably related to either a December 1989 work incident or an April 1990 work incident. In the process of reaching this conclusion, we held that it was the insurer's burden, resulting from application of ORS 656.262(6) to its "back-up" denial, to disprove compensability by clear and convincing evidence. The insurer contends that a December 1989 low back injury was not part of the accepted claim and subsequent back-up denial; therefore, the insurer argues, it is claimant's burden to prove compensability of this incident, rather than the insurer's burden to disprove compensability.

We disagree with the insurer's basic premise as to the nature of its acceptance and subsequent denial. We conclude, under the facts presented here, that for purposes of deciding the scope of the insurer's acceptance and denial, the determinative inquiry is the injury/condition claimed rather than the date of injury noted on the various claims documents. In this regard, claimant sought treatment and disability for a herniated L5-S1 disc. Claimant underwent surgery for this condition on May 5, 1990, prior to the insurer's July 27, 1990 acceptance. Moreover, the insurer's acceptance was expressly for a herniated L5-S1 disc. (Ex. 24). In sum, the insurer "officially" and "specifically" accepted a herniated disc, not an unspecified injury occurring on April 23, 1990. See Johnson v. Spectra Physics, 303 Or 49 (1987).

Our conclusion is supported by the underlying facts predating the insurer's acceptance. In both its back-up denial and its memorandum on reconsideration, the insurer contends that, following acceptance, the insurer learned that claimant's herniated disc preexisted the April 23, 1990 date of injury listed on the various claims documents in this matter, including claimant's "801" form and the insurer's notice of acceptance. In addition, the insurer contends that, subsequent to its acceptance of the claim, it became aware that claimant was suffering from back symptoms in late February and early March 1990 thereby indicating a chronic preexisting back condition of which it was previously unaware. (Somewhat paradoxically, the insurer acknowledges that it was aware of a December 1989 back strain episode). The insurer based its back-up denial in part on the basis of this "discovery" that claimant's condition preexisted the April 23, 1990 incident.

We do not agree with the insurer's contention that it did not become aware of claimant's "preexisting" condition until after it had accepted the claim. On April 23, 1990, Dr. Herscher completed a First Medical Report noting claimant's December 1989 back injury. (Ex. 11). On May 11, 1990, the insurer received a report from Dr. Freeman which noted the onset in December 1989 of symptoms similar to those claimant was experiencing in April 1990. (Ex. 14). On June 4, 1990, the insurer received a report from Dr. Herscher which noted that claimant was experiencing back problems in March 1990. (Ex. 21). Finally, on June 15, 1990, the insurer received a report from Dr. Franks indicating the claimant had "originally hurt his back while [at work]" in December 1989. (Ex. 16). In that pre-acceptance report, Dr. Franks expressly noted that a March 27, 1990 CT scan

had disclosed a herniated L5-S1 disc. (Id.) Therefore, the insurer had at least constructive knowledge that claimant's herniated disc predated the date of his injury claim by several weeks at least.

Accordingly, at the time of its July 27, 1990 acceptance, the insurer not only had knowledge of prior back problems in December 1989 and March 1990, but the insurer also had knowledge of the fact that claimant's herniated L5-S1 disc predated his April 23, 1990 claim. Therefore, we are unable to accept the insurer's statement in its "back-up" denial that it "discovered" that claimant had chronic preexisting back problems and "an already diagnosed L5-S1 disc herniation" while "processing this claim toward closure." Instead, it is apparent that the insurer had such knowledge prior to its acceptance of the claim.

Under these circumstances, we conclude that the insurer's focus on the date of injury as the dispositive factor here is inappropriate. Rather, we find that the dispositive factor is the condition claimed rather than the date of injury. Here, the condition claimed and accepted was a herniated L5-S1 disc. When the insurer attempted to "back-up" and deny that claim, it was incumbent on the insurer to establish noncompensability by "clear and convincing" evidence. ORS 656.262(6). This burden applied to whatever theory of compensability was raised by claimant. In opening remarks at hearing, claimant's counsel argued that claimant's back problems began as a consequence of his work activities and claimant also had a new incident on April 23, 1990. Claimant's counsel further contended that there was no question but that the back problems prior to April 23, 1990 were related to "at least one other work-related incident." Because claimant argued compensability resulting from both a December 1989 incident and an April 1990 incident, the insurer was required to disprove compensability as to either/both incidents. For the reasons stated in our order, we continue to conclude that the insurer has failed to sustain this burden.

Accordingly, our June 9, 1992 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our June 9, 1992 order effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD R. ZIPPI, Claimant
WCB Case Nos. 91-01680 & 90-21760
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Tooze, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

Kemper Insurance Company (Kemper) requests review of Referee Mongrain's order that: (1) set aside its denial of claimant's occupational disease claim for a foot condition; and (2) upheld the Hartford Insurance Company's (Hartford) denial of claimant's occupational disease claim for the same condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

On August 5, 1981, Kemper accepted claimant's July 23, 1981 claim for "excessive pain [in both feet] while standing on the job. Claimant's condition was subsequently identified as "flaccid planovalgus", or flat feet. Claimant received treatment, for which Kemper paid, up through October 17, 1990, when Kemper issued a denial of claimant's condition. Kemper now asserts that it is not disavowing its previous acceptance but that its denial applies only to claimant's current episodes of foot pain. Kemper is joined by Hartford in arguing that under the present statutes, claimant no longer can prove a compensable claim. Both carriers rely on ORS 656.005(7)(a)(B), which provides "where a work injury combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment." Kemper and Hartford point to medical evidence showing that the major contributing cause of claimant's symptoms is a preexisting congenital foot deformity rather than employment conditions.

It is well-established that carriers may challenge the compensability of a worker's current condition, notwithstanding a previous acceptance of an injury or disease, where the need for medical treatment is no longer attributable to the compensable injury. See ORS 656.245(1); Green Thumb, Inc. v. Basl, 106 Or App 98, 101 (1991). Similarly, we have held that under ORS 656.005(7)(a)(B), carriers may deny the compensability of a claimant's current condition when a compensable injury combines with a preexisting disease to cause a need for treatment and/or disability. See Bertha M. Gray, 44 Van Natta 810 (1992). We based this holding on the statute's language, which provides:

> "If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment." ORS 656.005(7)(c)(B).

The present claimant's condition preexisted his employment. (Exs. 1, 7, 13, 16). The record further establishes that claimant's job, because it requires prolonged standing on a hard surface, causes his preexisting condition to become symptomatic. Claimant's work, however, does not change or worsen the underlying condition. (Exs. 16, 17).

The Referee found, and we agree, that by accepting claimant's claim for excessive bilateral foot pain in 1981, Kemper also accepted claimant's underlying and preexisting flat feet condition. As did the Referee, we find Georgia-Pacific v. Piwowar, 305 Or 494 (1988) to be directly on point. In Piwowar, an insurer accepted a worker's claim for a "sore back," which later was determined to be a symptom of ankylosing spondylosis. The Court held that by accepting the symptoms of the underlying disease, the insurer was thereafter precluded from denying the compensability of the underlying condition "regardless of the cause." Here, as in Piwowar, the insurer accepted symptoms of claimant's underlying disease. It may not now deny the compensability of his preexisting condition, regardless of the cause.

Unlike the claimant in Bertha M. Gray, the present claimant's current need for treatment is not due to a combination of a compensable injury and a preexisting disease. Here, there has been an acceptance, as a matter of law, of claimant's flat foot condition, which becomes symptomatic by standing on the job. Inasmuch as the flat foot condition has been accepted as a compensable condition, it cannot constitute a preexisting disease or condition. See Rosalie

S. Drews, 44 Van Natta 36 (1992). Since there is no preexisting condition for claimant's compensable injury to combine with, we find ORS 656.005(7)(a)(B) inapplicable to this case. Kemper and Hartford cannot challenge compensability based on this statute.

We also agree with the Referee that Kemper's denial of claimant's "current" condition constitutes an invalid "backup" denial. As explained above, carriers may deny a request for payment of medical treatment if the treatment is not attributable to the industrial injury. Green Thumb, Inc. v. Basl, supra. However, such denials do not extend to the compensability of the industrial injury and treatment for the industrial injury continues to be compensable. See id. at 102.

When a carrier wishes to challenge the compensability of a previously accepted condition, it may revoke its acceptance and issue a backup denial under ORS 656.262(6). However, if this action is taken within two years of claim acceptance and the claimant requests a hearing, the carrier must prove by clear and convincing evidence that the claim is not compensable. Id. An insurer's backup denial issued more than two years after claim acceptance also is permissible so long as it is supported by a showing of fraud, misrepresentation or other illegal activity. Anthony G. Ford, 44 Van Natta 240 (1992).

Although Kemper claims to have denied only the compensability of claimant's current condition, we interpret the denial to be, in fact, an attempt to revoke its previous acceptance. As noted above, Kemper does not assert that claimant's current medical treatment is not attributable to his underlying condition. It does, however, challenge the compensability of a previously-accepted disease. We conclude that this challenge constitutes a backup denial. We, therefore, analyze its validity under ORS 656.262(6).

Kemper's denial issued more than two years after it accepted claimant's claim. It has offered no evidence of fraud, misrepresentation or other illegal activity. Therefore, we conclude that Kemper's backup denial is invalid.

Responsibility

Under ORS 656.308(1), responsibility for an occupational disease does not shift unless claimant suffers a "new compensable injury." See Donald C. Moon, 43 Van Natta 2595, 2596 n 1 (1991). Here, the medical evidence demonstrates that employment conditions did not cause, worsen or affect claimant's flat foot condition. (Exs. 16, 17). Therefore, we agree with the Referee that claimant did not sustain a "new compensable injury" and that responsibility remains with Kemper.

Attorney fee on Board Review

Claimant is entitled to an assessed attorney fee for services on Board review. 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 attorney's services on review is $500, to be paid by the Kemper. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), and the value of the interest involved and the complexity of the issues.

ORDER

The Referee's order dated August 2, 1991 is affirmed. For services on Board review, claimant is awarded a reasonable assessed attorney fee of $500, payable by Kemper Insurance.

WORKERS' COMPENSATION CASES

Decided in the Oregon Court of Appeals:

Albertson's, Inc. v. Dean (3/25/92) 1300
Benefiel v. Waremart, Inc. (4/22/92) 1319
Boeing Aircraft Co. v. Roy (3/11/92) 1283
Boeing Co. v. Viltrakis (4/22/92) 1310
Bohemia, Inc. v. McKillop (4/1/92) 1301
Buddenberg v. Southcoast Lumber (3/11/92) 1290
Castle & Cooke v. Alcantar (4/22/92) 1309
Davis v. R & R Truck Brokers (4/22/92) 1321
Depoe Bay Fish Co. v. Coon (5/27/92) 1340
EBI Insurance Co. v. Chandler (4/8/92) 1303
EBI Insurance Co. v. Witt (5/13/92) 1326
Gilkey v. SAIF (6/3/92) 1344
Higgins v. Schramm Plastics (4/22/92) 1324
Lacy v. SAIF (6/3/92) 1347
Liberty Northwest Ins. Corp. v. Griggs (3/11/92) 1286
Magana v. Wilbanks International (3/11/92) 1289
Marshall v. Cosgrave, Kester, Growe, Gidley (4/22/92) 1305
McCormac v. Cottage Crafts (5/20/92) 1333
Meda v. SAIF (4/22/92) 1318
Mosley v. Sacred Heart Hospital (5/27/92) 1337
Nelander v. Dept. of Insurance & Finance (4/22/92) 1312
Northwest Greentree, Inc. v. Cervantes-Ochoa (5/20/92) 1335
Pease v. National Council on Compensation Insurance (5/13/92) 1328
Quality Plastics v. Hamilton (3/25/92) 1297
Queener v. United Employers Ins. (6/3/92) 1346
Riley v. Inmate Injury Fund (4/22/92) 1314
SAIF v. Basham (3/4/92) 1282
SAIF v. Campbell (5/13/92) 1330
SAIF v. Crawley (5/13/92) 1332
SAIF v. Holmstrom (5/27/92) 1339
SAIF v. Langston (4/22/92) 1316
SAIF v. Wright (6/3/92) 1342
Sentrol, Inc. v. Bronson (4/22/92) 1304
Stone Container v. Fryman (3/4/92) 1283
Thomas v. A-1 Sandblasting and Steam Cleaning Co. (3/25/92) 1298
Tri-Met, Inc. v. Odighizuwa (3/18/92) 1292
Underwood v. Pendleton Grain Growers (3/25/92) 1295
Valencia v. Bailey Nurseries (5/13/92) 1329

Cite as 112 Or App 6 (1992) March 4, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Joseph E. Basham, Jr., Claimant.

SAIF CORPORATION and EUGENE PERSONNEL SERVICES, Petitioners,
v.
JOSEPH E. **BASHAM**, JR., Respondent.
(89-00968; CA A67795)

Judicial Review from Workers' Compensation Board.
On respondent's motion filed November 20, 1991.
Edward J. Harri, Salem, and Malagon, Moore & Johnson, Eugene, for the motion.
Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and David L. Runner, Assistant Attorney General, Salem, contra.
Before Rossman, Presiding Judge, and Riggs and Edmonds, Judges.
PER CURIAM
Reversed and remanded for reconsideration.

The Workers' Compensation Board's order for which judicial review is sought held claimant's claim compensable under the Board's decision in *Donna Aschbacher*, 41 Van Natta 1242 (1989), which we reversed. *Aetna Casualty Co. v. Aschbacher*, 107 Or App 494, 812 P2d 844, rev den 312 Or 150 (1991). Claimant has moved to remand this case to the Board "for further proceedings," meaning, apparently, for reconsideration in the light of this court's decision in Aschbacher and to consider whether the claim might be compensable under other theories advanced by claimant. SAIF has submitted a letter to the effect that it does not oppose claimant's motion, but that "the court should reverse the Board's order and remand the case to the Board for reconsideration."

ORS 183.482(7) and (8), made applicable to workers' compensation cases by ORS 656.298(6), delineate the actions that we may take on judicial review. The circumstances under which we may simply remand a case do not include an error of law of the type in *Aetna Casualty Co. v. Aschbacher, supra*, or this case.[1] Accordingly, we do not have authority to remand without reversing the Board. We treat claimant's motion as a concession that the Board erred in holding the claim compensable, and we accept the concession.

Reversed and remanded for reconsideration.

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[1] ORS 183.482(8)(a)(B) requires the court to remand if it finds that the agency has incorrectly interpreted a provision of law and that the correct interpretation compels a particular action. A correct interpretation of the provision of law involved here does not compel any particular action.

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Joann Fryman, Claimant.

STONE CONTAINER, Petitioner,
v.
JOANN **FRYMAN**, Respondent,
SOUTHWEST FORESTRY INDUSTRIES, Employer,
and KEMPER INSURANCE COMPANY, Insurer.
(88-10557, 88-10556, 88-10554, 88-05650; CA A66974)

Judicial Review from Workers' Compensation Board.
On respondent's request for remand filed November 4, 1991.
Karen M. Werner, Eugene, for the motion.
Adam T. Stamper and Cowling & Heysell, Medford, contra.
Before Rossman, Presiding Judge, and Riggs and Edmonds, Judges.
PER CURIAM
Reversed and remanded for reconsideration.

This case is before the court on employer's petition for judicial review of an order of the Workers' Compensation Board determining claimant's claim to be compensable. At the request of claimant, the case was held in abeyance pending the court's decision in a case presenting similar issues: *Aetna Casualty Co. v. Aschbacher*, 107 Or App 494, 812 P2d 84 (1991). By letters to the court, employer has requested a decision in its favor and claimant has requested that the case be remanded to the Board for reconsideration in light of the *Aschbacher* decision. We treat claimant's letter as a concession of error, and we accept the concession. *See SAIF v. Basham*, 112 Or App 6, ___ P2d ___ (1992).

Reversed and remanded for reconsideration.

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Robert E. Roy, Claimant.

BOEING AIRCRAFT COMPANY and AETNA CASUALTY COMPANY, Petitioners,
v.
ROBERT E. **ROY**, Respondent.
(89-07274; CA A66907)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 16, 1991.
Jeremy L. Fellows, Portland, argued the cause for petitioners. With him on the brief was Scheminske & Lyons, Portland.
Kevin Keaney, Portland, argued the cause for respondent. With him on the brief were Donald Atchison, Robert K. Udziela and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.
Before Richardson, Presiding Judge, and Joseph, Chief Judge, and Deits, Judge.
JOSEPH, C.J.
Affirmed.

Employer seeks review of a Workers' Compensation Board order holding that pain and numbness in claimant's shoulder, arm and hand are compensable conditions. It argues that the Board erred in setting aside the denial, because it was a partial denial of compensation involving 2 conditions from which claimant did not suffer. It also assigns error to the Board's determination that the condition is compensable, because claimant failed to establish a specific medical diagnosis for the cause of his pain and to its finding that the condition was the result of an on the job injury.

Claimant had an accident at work on January 18, 1989, while moving a heavy box of machine parts. Employer described the accident in the injury report:

> "As Robert reached down to straighten out parts basket to be parallel to operator's platform[,] his foot slipped off edge of platform, resulting in the twisting injury."

Claimant suffered some lower back and hip pain immediately and consulted the plant nurse, but he did not miss any work and did not consult a physician. As the back and hip pain gradually improved, he began to have pain in his neck and left shoulder. On February 5, 1989, he suffered sudden excruciating pain in his neck, left shoulder and arm, when he bent over to pick up a piece of paper in his bathroom at home. He went to see his family physician, Dr. Johansen.

On the first First Medical Report form, Johansen wrote as his diagnosis: "Strain left shoulde[r] (tendonitis)." A few days later, claimant went to a hospital emergency room for treatment of "right shoulder and arm pain with hand numbness." The hospital record shows that the emergency room physician diagnosed the problem as neuralgia and referred claimant to Dr. Cleary, an allergist, who concluded that the condition was "not in his field" and immediately referred claimant to a neurologist. Cleary nevertheless filled in the diagnosis section of the second First Medical Report form: "R[ule]/O[ut] L[eft] ulnar nerve injury L[eft] brachial plexus injury." Under remarks he added, "To see Dr. Robert Rosenbaum M.D." The Board found that Cleary did not intend those comments to be a diagnosis, but

> "reported to the carrier that he was referring claimant to Dr. Rosenbaum [a neurologist] *in order to rule out* a left ulnar nerve injury and a left brachial plexus injury." (Emphasis supplied.)

There is substantial evidence to support that.

In a letter dated February 21, 1989, Rosenbaum concluded, after his examination of claimant:

> "[T]he patient now has discomfort in the left shoulder into the left upper extremity. His symptoms and his weakness are primarily in an ulnar nerve distribution, however, in addition he has pain in his shoulder and a decreased left triceps reflex. Rather than an ulnar nerve lesion, I think that this represents a C8 nerve root lesion. Because the patient does have significant left hand weakness I have scheduled him for a MRI scan of the cervical spine."

The MRI report indicated that claimant had "narrowing of the left C7-T1 neuroforamen for the C8 root due to osteophyte formation arising from the body of T1." Johansen's progress report, dated March 21, 1989, interpreted the medical reports:

> "ACUTE PROBLEM: C: TENDONITIS LEFT SHOULDER. * * * [Claimant] had nerve conduction studies which showed some changes in his left arm and also a CT scan which showed some changes in his neck. That might cause nerve pressure. * * * Dr. Cleary and Dr. Rosenbaum felt that this was an industrial injury that was caused by an incident where he slipped while moving baskets of old parts on 1/18/89."

On February 15, 1989, claimant filed a claim for compensation for left arm and shoulder pain that caused time loss. On March 1, employer denied the claim:

> "We have concluded our investigation into the above captioned claim. Please be advised that we are denying your claim since our investigation indicates that the condition from which you suffer did not arise out of and in the scope of your employment.
>
> "That your left ulnar nerve and brachial plexus injuries are not causily [sic] related to the accident on January 18, 1989."

Employer argues that that letter only denied compensation for the 2 injury diagnoses specified in the second paragraph and was not a denial of the entire claim. It contends that claimant failed to prove that he suffered either of those injuries.

The Board's finding that the insurer intended the letter to be a complete denial is supported by substantial evidence in the record. The first paragraph clearly says that employer's investigation had been completed and implies that employer did not intend to consider the claim any further. The second paragraph suggests that employer had treated Cleary's note as a diagnosis. Even though the letter does not specifically mention tendonitis or neuralgia, it does not suggest that the decision was incomplete or that any element of the claim was still being considered. Moreover, claimant never received any other acceptance or denial.

In its second assignment of error, employer argues that the Board should have required claimant to prove a specific medical diagnosis to support the claim that his pain symptoms reflected a compensable injury. It relies on *Weyerhaeuser Co. v. Warrilow*, 96 Or App 34, 771 P2d 295, *rev den* 308 Or 184 (1989), in which we reversed the Board and reinstated the employer's partial denial of a claim for neck, shoulder, mid-back and left ankle pain. We held that, although the employer's letter was vague as to what conditions it had accepted, it was specific as to what it had denied and was, therefore, permissible as a partial denial.

That case does not stand for the proposition that employer advances here. The Board did not set aside a denial of responsibility for left ulnar nerve or brachial plexus injury; those denials were irrelevant, because claimant did not have those injuries and did not make a claim for them. The Board set aside a general denial of the claim.

Employer complains that it would be "completely unfair" if we affirm the Board, because it will be financially responsible if claimant's pain returns, "even if it is later conclusively determined that the pain is due to an otherwise noncompensable degenerative condition (like cervical osteophyte formations)."[1] It urges that claims that lack specificity "impale the employer on the horns of a dilemma," unfairly forcing it to risk failing to accept or deny the claim timely on the one hand or exposing itself to liability for a noncompensable condition on the other. ORS 656.262(10); *Georgia-Pacific v. Piwowar*, 305 Or 494, 753 P2d 948 (1988). Even if employer has correctly identified the legal effect of those hypothetical facts as a dilemma,[2] it has not raised an issue that we can address.[3]

Finally, employer argues that the record does not contain substantial evidence to support the Board's finding that claimant's pain and numbness were caused by his work. It returns to the theory that claimant had to prove a particular *diagnosis* in order to show by substantial evidence that the condition from which he suffers is related to the January 18 injury. It argues that that proof is required under *Johnsen v. Hamilton Electric*, 90 Or App 161, 751 P2d 246 (1988), in which we held that the claimant failed to prove that he was entitled to compensation, because he had no evidence that the abnormal marks on his lung were caused by any injury or disease. The claimant was seeking payment for diagnostic chest x-rays, not compensation for missed work or treatment of any condition that prevented him from performing his job. Without proof that he had an injury or disease, claimant could not prove that the lung marks were related to his work.

A claimant need not prove a specific diagnosis if he proves that his symptoms are attributable to his work. *Tripp v. Ridge Runner Timber Services*, 89 Or App 355, 749 P2d 586 (1988); *see Karen M. Partridge*, 39 Van Natta 137 (1987). Employer argues, however, that "[t]he only diagnosis for claimant's pain

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[1] We note that insurer sent the letter after the MRI revealed osteophyte formation, but it did not specify that diagnosis in its denial.

[2] ORS 656.262(6) provides, in part:

> "[I]f the insurer or self-insured employer accepts a claim in good faith but later obtains evidence that the claim is not compensable or evidence that the paying agent is not responsible for the claim, the insurer or self-insured employer, at any time up to two years from the date of claim acceptance, may revoke the claim acceptance and issue a formal notice of claim denial."

Moreover, an insurer may make a claim acceptance more specific than the claim is. *SAIF v. Abbott*, 107 Or App 53, 810 P2d 878 (1991).

[3] Employer's remedy, if any, lies with the legislature. *See SAIF v. Curry*, 297 Or 504, 511, 686 P2d 363 (1984).

symptoms which has not been ruled out by medical testing indicates that claimant's condition was caused by osteophyte formation in his cervical spine, a degenerative condition unrelated to the incident at work." The evidence shows that claimant has osteophyte formation in his cervical spine, but it does not show that that condition causes his pain. Moreover, neither tendonitis nor neuralgia were "ruled out by medical testing," as employer would have it. Tendonitis was, in fact, Johansen's first and final diagnosis, and that is consistent with the accident that occurred on January 18.

Employer contends that the Board concluded that claimant's pain was caused by his work only because the record contained no evidence to the contrary. The absence of evidence of some other cause, it argues, is not substantial evidence that work was the cause. Although absence of evidence of another cause might not alone constitute substantial evidence, it is evidence. *See, e.g., Tripp v. Ridge Runner Timber Services, supra.* In addition, the record contains Johansen's interpretation of the medical reports that claimant's pain was related to the January 18 accident. The facts that the initial injury was characterized as "twisting" claimant's whole body and that his neck pain gradually increased as his back pain gradually diminished also support the Board's conclusion that the condition was caused by his work. That evidence is substantial enough to support the Board's order.

Affirmed.

Cite as 112 Or App 44 (1992) March 11, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Michael A. Griggs, Claimant.

LIBERTY NORTHWEST INSURANCE CORPORATION and HAGEMAN BROTHERS CONSTRUCTION, Petitioners,
v.
MICHAEL A. **GRIGGS**, CALISTA CONSTRUCTION CO., CIGNA INSURANCE, ST. JOHNS CONSTRUCTION and SAIF CORPORATION, Respondents.
(WCB 88-04104, 88-03394, 88-03395; CA A61722)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 15, 1991.
Stafford J. Hazelett, Portland, argued the cause and filed the brief for petitioners.
Rick W. Roll, Tillamook, filed the brief for respondent Michael A. Griggs.
Jerald P. Keene, Portland, argued the cause for respondents Calista Construction Co. and CIGNA Insurance. With him on the brief was Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C., Portland.
Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, Jerome Lidz, Assistant Attorney General and Thomas E. Ewing, Assistant Attorney General, Salem, filed the brief for respondents St. Johns Construction and SAIF Corporation.
Before Richardson, Presiding Judge, and Deits and Edmonds, Judges.
DEITS, J.
Reversed and remanded for proceedings not inconsistent with this opinion.

After the Workers' Compensation Board (Board) issued its opinion in this case, Hageman Brothers Construction (employer) requested the Board to reconsider its order under ORS 656.295(5) in the light of newly developed evidence and to withdraw its order for purposes of reconsideration under ORS 183.482(6). Employer argues that the Board erred in denying the requests, in concluding that claimant, while employed by it, suffered a compensable injury in October, 1987, and in concluding that its denial of the claim was unreasonable. Employer finally argues that the Board erred in failing to order reimbursement to its carrier (Liberty) by claimant's other employers.

Claimant received an unscheduled permanent partial disability award for an injury to his low back that occurred in May, 1986, while he was working for Calista Construction Company (Calista). He began working as a carpenter for employer in August or September, 1987. Claimant asserts that he was injured twice while working for employer. According to his testimony, he stepped off a platform at the work site on October 22, 1987, and twisted his left ankle. He also testified that, on October 26, 1987, he

was injured when he jumped out of the way of a large piece of concrete pipe that fell from an overhead crane. He said that he jumped off a platform into a pit and was unconscious for several minutes. Although there were several other people on the platform, no one saw claimant jump or be injured. He testified that his back became sore that night and got worse each day thereafter until he was laid off on October 30, 1987, and that his back symptoms gradually worsened. He began working for St. Johns Construction Company (St. Johns) in early December but quit after two days because of back pain. He then sought medical treatment.

In December, 1987, claimant filed claims against employer and St. Johns, which both denied. He also filed an aggravation claim with Calista, which was also denied. On May 11, 1988, a hearing was held on the denials. Liberty, CIGNA and SAIF represented employer, Calista and St. Johns, respectively. At the hearing, employer argued that it had no knowledge that claimant had been injured or that a crane accident had occurred. It offered evidence, including claimant's criminal convictions, to attack his credibility. Some, but not all, of the evidence was admitted. The referee found that claimant was more credible than employer's representatives. He also noted that employer's own witnesses testified that a concrete object did fall from a crane and also that claimant had reported a foot injury. The referee found that the physician's reports supported claimant's description of the injury and concluded that claimant had suffered a new injury at employer. His order, issued on May 25, 1988, required employer to accept the claim and imposed a penalty for unreasonable denial. It also approved the denials of the other employers. On May 31, 1988, Liberty requested review of that order, and, on June 2, 1988, claimant filed a cross-request for review.

On March 24, 1989, a different referee issued an order approving a settlement[1] reached between claimant and employer during a determination order hearing in this case. The morning of the second day of that proceeding, the parties advised the referee of the settlement that they had reached during the overnight recess. Employer's attorney told the referee that, at the 1988 hearing before the other referee, claimant had not provided completely accurate information about his employment activities between the time that he worked at employer and St. Johns; he advised the referee that claimant had earlier denied that he had worked during that time but that there was evidence that he had done strenuous work without complaints of pain during that time period. The attorney stated that "the omission of that information satisfies the Bauman requirement for fraud and misrepresentation or other illegal acts"[2] and that, after the settlement was approved, employer would "be making [an] appropriate motion to the Workers' Compensation Board to dismiss the pending appeal [of the 1988] order." In the order approving the settlement, the referee explained:

> "Evidence was adduced at hearing * * * on March 15, 1989, to the effect that after claimant left [employer], he engaged in physical activity and labor that during testimony [at the 1988 hearing] he had denied. Evidence further indicated that during the time

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[1] The parties stipulated:

"1. The employer/insurer withdraws its Request for Hearing on the October 11, 1988 Determination Order, and said request shall be dismissed with prejudice.

"2. The claimant withdraws his Request for Hearing on the October 11, 1988 Determination Order, and said request shall be dismissed with prejudice.

"3. The claimant withdraws his Request for Hearing concerning any medical services to which he might be entitled under the accepted claim status and his request for penalties and fees for any claim processing errors, and said Requests for Hearing shall be dismissed with prejudice.

"4. The denial of the compensability of claimant's claim issued by counsel for the employer/insurer on March 16, 1989 will not be appealed by claimant and will remain in full force and effect.

"5. The employer/insurer retains it rights to whatever civil legal recourse it may have against claimant outside the Workers' Compensation System of the State of Oregon."

[2] *Bauman v. SAIF*, 295 Or 788, 794, 670 P2d 1027 (1983), held

"If * * * the insurer officially notifies the claimant that the claim has been accepted, the insurer may not, after the 60 days have elapsed, deny the compensability of the claim unless there is a showing of fraud, misrepresentation or other illegal activity."

claimant's claim was in denied status he received money for his labor that he did not report to the insurer prior to its paying disability compensation to claimant under the terms of [the 1988] Opinion & Order."

On March 30, 1989, Liberty moved to withdraw its request for review of the 1988 order holding employer responsible for claimant's injury. It gave as reasons that

"the underlying claim of compensable injury against [employer] has been finally found not compensable as a result of litigation regarding a retroactive denial of the claim from the beginning."

The motion attached a copy of the 1989 order after the settlement and requested the Board to take administrative notice of that order and record. Despite that motion, claimant continued to seek affirmance of the 1988 order on his cross-request for review, and the Board affirmed and adopted it. The Board noted in its order that employer had withdrawn its request for review but had sought reimbursement if another employer was found responsible for the claim. The Board, however, found that, *in view of employer's withdrawal*, the request for reimbursement was moot and "offer[ed] no comment concerning the validity of [the 1989] order."

A week after the Board had issued its order, employer moved for reconsideration. It asked the Board to take administrative notice of "admissions made by claimant" in the settlement hearing and to consider evidence unobtainable at the time of that hearing. The Board issued an order denying reconsideration, stating as its reason:

"Former [Board] Chairman Johnson, along [Board] Member Ferris, signed the Board's majority opinion in the July 19, 1989 Order on Review. Inasmuch as Mr. Johnson is no longer on the Board, the Board consists of two members. The remaining members cannot reach agreement concerning the Motion for Reconsideration."

Employer again requested the Board to reconsider and asked it to withdraw its order for reconsideration under ORS 183.482(6). The Board concluded that it lacked jurisdiction to reconsider its final order under ORS 656.292(5), because a petition for review of the order had been filed with this court on August 16, 1989. It also refused to withdraw its order for reconsideration under ORS 183.482(6).

ORS 656.295(5) provides that,

"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 decision as to whether the case ought to be remanded under that provision is within the Board's discretion. A Board rule provides guidance for the exercise of its discretion:

"If the motion for reconsideration is accompanied by additional evidence not otherwise in the record, the additional evidence will only be considered if the Board finds that: (a) the record, without the additional evidence, has been improperly, incompletely or otherwise insufficiently developed; *and* (b) the additional evidence *was unobtainable with due diligence by the moving party prior to its submission to the Board.* OAR 438-12-065(3). (Emphasis supplied.)

The problem here is that the Board did not make any findings regarding the motion for reconsideration or explain its denial, other than to say that there were only two members on the Board and that they could not agree. We are unable to review an agency's action without the agency first making a decision. In reviewing the Board's exercise of discretion here, we need to know whether the Board concluded that, as employer alleges, claimant committed perjury at the earlier hearing and whether evidence of that was "unobtainable with due diligence by the moving party prior to its submission to the Board." The Board has an obligation to express the results of its evaluation of a party's factual and legal assertions in the first instance. Accordingly, it is necessary to remand the case to the Board.

A number of employer's assignments of error concern whether the Board properly found claimant's injury to be compensable and properly assigned responsibility for the injury to it. In the light of our disposition in this case, however, we need not address them.

Reversed and remanded for proceedings not inconsistent with this opinion.

Cite as 112 Or App 134 (1992) March 11, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Ernesto Magana, Claimant.

ERNESTO **MAGANA**, Petitioner,
v.
WILBANKS INTERNATIONAL, Respondent.
(88-10463; CA A68727)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 18, 1991.
Ronald A. Fontana, Portland, argued the cause and filed the brief for petitioner.
Karen O'Kasey, Portland, argued the cause for respondent. On the brief were Janet M. Schroer and Schwabe, Williamson & Wyatt, Portland.
Before Richardson, Presiding Judge, and Deits and Durham, Judges.
DURHAM, J.
Reversed and remanded for reconsideration.

Claimant seeks review of a Worker's Compensation Board order denying an occupational disease claim. We remand for reconsideration.

Claimant suffers from end-stage renal disease (ESRD), a kidney condition. Claimant alleged that his disease results from a 1987 on-the-job exposure to chemical vapors. Respondent denied the claim, and the Board upheld the denial.

At the time of claimant's disability, ORS 656.802(1)(a) defined an occupational disease as

> "[a]ny disease or infection arising out of and in the course of employment * * * to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein * * *."

Claimant must prove by a preponderance of the evidence that his work exposure to chemicals was the major contributing cause of his need to miss work and obtain medical services. *Dethlefs v. Hyster Co.*, 295 Or 298, 310, 667 P2d 487 (1983); *SAIF v. Scott*, 111 Or App 99, 101, ___ P2d ___ (1992).

The Board order stated:

> "Because claimant has not eliminated all other explanations, we conclude that claimant has failed to establish a compensable occupa-tional disease claim."

That is the wrong test. Claimant need not eliminate all other possible explanations of causation. ORS 656.266.[1]

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[1] ORS 656.266 provides:

"The burden of proving that an injury or occupational disease is compensable and of proving the nature and extent of any disability resulting therefrom is upon the worker. The worker cannot carry the burden of proving that an injury or occupational disease is compensable merely by disproving other possible explanations of how the injury or disease occurred."

Employer argues that we should treat the Board's statement as surplusage, because the referee applied the correct test and the Board order says: "The Board affirms and adopts the order of the Referee * * *." ORS 183.482(7) provides, in part:

> "The court shall remand the order for further agency action if it finds that either the fairness of the proceedings or the correctness of the action may have been impaired by a material error in procedure or a failure to follow prescribed procedure."

Conflicting inferences arise from the final order regarding the issue of causation. We cannot disregard as surplusage the Board's explicit conclusion that claimant did not prevail because he did not prove a fact that, by law, he does not have the burden to prove. In order to conduct meaningful appellate review, we must be able to discern from the order a clear explanation of why the Board's findings led to its conclusion. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988).[2] Although the Board can adopt a referee's order in whole or in part, the final order must be sufficiently clear that we are not forced to speculate about the Board's reasoning. Because of the ambiguity, the Board must reconsider and explain its conclusion regarding causation.

Reversed and remanded for reconsideration.

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[2] The requirement was explained in *Home Plate, Inc. v. OLCC*, 20 Or App 188, 190, 530 P2d 862 (1975):

> "If there is to be any meaningful judicial scrutiny of the activities of an administrative agency--not for the purpose of substituting judicial judgment for administrative judgment but for the purpose of requiring the administrative agency to demonstrate that it has applied the criteria prescribed by statute and by its own regulations and has not acted arbitrarily or on an ad hoc basis--we must require that its order clearly and precisely state what it found to be the facts and fully explain why those facts lead it to the decision it makes."

Cite as 112 Or App 148 (1992) March 11, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Ronald R. Buddenberg, Claimant.

RONALD R. **BUDDENBERG**, Petitioner,
v.
SOUTHCOAST LUMBER and SAIF CORPORATION, Respondents.
(89-19242; CA A68896)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 18, 1991.
Edward J. Harri, Salem, argued the cause for petitioner. With him on the brief were Jon C. Correll and Malagon, Moore & Johnson, Eugene.
Katherine H. Waldo, Assistant Attorney General, Salem, argued the cause for respondents. With her on the brief were Dave Frohnmayer, Attorney General, and
Virginia L. Linder, Solicitor General, Salem.
Before Richardson, Presiding Judge, and Deits and Durham, Judges.

DURHAM, J.
Affirmed.

Claimant seeks review of an order of the Workers' Compensation Board denying him increased permanent partial disability (PPD) benefits because of aggravation of a compensable injury. The issue is whether the aggravation claim is governed by the "guidelines"[1] in effect at the time of the last arrangement of compensation on May 6, 1987, or by the "standards"[2] in effect on September 18, 1989, the date of the determination order that rated the extent of disability for the worsened condition. We hold that the Board correctly applied the standards and affirm.

Claimant's feet were injured on June 6, 1981. His claim was closed on August 4, 1982. Under the guidelines then in effect, he was awarded 60% scheduled PPD for each foot. The claim was reopened four times, but the PPD award was maintained at 60% through the last arrangement of compensation on May 6, 1987.

In 1987, the legislature substantially amended the workers' compensation laws, and one of its goals was the reduction of costs. *Aetna Casualty Co. v. Aschbacher*, 107 Or App 494, 500, 812 P2d 844, *rev den* 312 Or 150 (1991). ORS 656.283(7) was amended by Or Laws 1987, ch 844, 11, to include the underscored language:

> "Except as otherwise provided in this section and rules of procedure established by the board, the referee is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, and may conduct the hearing in any manner that will achieve substantial justice. *The referee shall apply to the hearing of the claim such standards for evaluation of disability as may be adopted by the director pursuant to ORS 656.726. Nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present evidence at hearing and to establish by clear and convincing evidence that the degree of permanent disability suffered by the claimant is more or less than the entitlement indicated by the standards adopted by the director under ORS 656.726.*" (Emphasis supplied.)

Effective July 1, 1988, the director promulgated new standards for the evaluation of a worker's permanent disability pursuant to ORS 656.726(3)(f).[3] *See* OAR 436-35-001 *et seq*. They were intended "to reflect the criteria for rating outlined in legislation adopted by the 1987 Legislature * * *." OAR 436-35-002. The standards replaced the guidelines and "applied to all claims closed after July 1, 1988." OAR 436-35-003.

After surgery in November, 1988, claimant claimed that his condition had worsened. He became medically stationary on August 21, 1989. On September 18, 1989, a determination order awarded him temporary total disability benefits but no additional PPD. The Board ruled that the disability had been correctly evaluated under the 1989 standards at 28% and that clear and convincing evidence adduced at the hearing proved that his disability exceeded 28%, but did not exceed the 60% previously granted. It awarded no PPD increase.

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[1] *See former* OAR 436-65-500 *et seq*.

[2] *See* OAR 436-35-001 *et seq*.

[3] ORS 656.726(3) provides:

"The director [of the Department of Insurance and Finance] hereby is charged with duties of administration, regulation and enforcement of ORS 654.001 to 654.295, 654.750 to 654.780 and this chapter. To that end the director may:

"* * * * *

"(f) Provide standards for the evaluation of disabilities. The following provisions apply to the standards:

"(A) 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.

"(B) Impairment is established by a preponderance of medical evidence based upon objective findings.

"(C) When, upon reconsideration of a determination order or notice of closure pursuant to ORS 656.268, it is found that the worker's disability is not addressed by the standards adopted pursuant to this paragraph, notwithstanding ORS 656.268, the director shall stay further proceedings on the reconsideration of the claim and shall adopt temporary rules amending the standards to accommodate the worker's impairment. When the director adopts temporary rules amending the standards, the director shall submit those temporary rules to the Workers' Compensation Management-Labor Advisory Committee for review at their [sic] next meeting."

Claimant argues that, because his condition has worsened from its 1987 status, he is entitled to additional PPD benefits under ORS 656.273(1).[4]

We decline claimant's invitation to construe ORS 656.273(1) to create an unqualified right to additional compensation for a worsened condition, because that would require us to ignore the 1987 amendment. Our task is to interpret statutes to give effect to the legislature's intention. *Aetna Casualty Co. v. Aschbacher, supra,* 107 Or App at 499. The 1987 amendment to ORS 656.283(7) required the Board to evaluate aggravation claims under the director's standards, which in this case are less generous than the former guidelines. A worker is entitled to additional compensation under ORS 656.273(1) only if the worsened condition increases the extent of disability as defined in the standards.

Claimant argues that the "Board's method is unprecedented, and the ramifications [are] far-reaching." However, in *Wardell v. Smurfit Newsprint,* 107 Or App 358, 812 P2d 21 (1991), we held that the Board correctly decided a claim for increased disability compensation by evaluating a worsened condition under standards in effect when the alleged worsening occurred. The Board analyzed this claim similarly. *See also Barrett v. Union Oil Distributors,* 60 Or App 483, 488, 654 P2d 668 (1982), *rev den* 194 Or 569 (1983). If the Board's analysis produces undesirable consequences, the solution must come from the legislature.

Affirmed.

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[4] ORS 656.273(1) provides, in part:

"After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury."

Cite as 112 Or App 159 (1992) March 18, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Peter O. Odighizuwa, Claimant.

TRI-MET, INC., Petitioner,
v.
PETER O. **ODIGHIZUWA**, Respondent.
(89-11253, 89-11254; CA A68812)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 11, 1991.
Jerald P. Keene, Portland, argued the cause for petitioner. With him on the brief was Roberts, Reinisch, Mackenzie, Healey & Wilson, P.C., Portland.
Karen Stolzberg, Portland, argued the cause for respondent. With her on the brief was Goldberg & Mechanic, Portland.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
EDMONDS, J.
Reversed and remanded for reconsideration.

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); ORS 656.382(1).[1] It argues that the Board erred as a matter of law. We reverse.

Claimant, a bus driver, sustained injuries in a collision between the bus that he was driving and a car driven by another employee of employer that was chasing the bus. There are conflicting eyewitness accounts of the events preceding the collision. Employer argued that, before the collision occurred, claimant had been relieved of his duties as a result of a conflict with another employee and had been directed not to drive the bus to the bus barn. Claimant argued that he was acting within the scope of his employment when the collision occurred. Employer denied compensability[2] on the basis of

the version of its witnesses. The referee found claimant credible and set aside the denial. Employer sought review, and claimant requested penalties and attorney fees for an unreasonable denial.

The Board affirmed the order setting aside the denial and held that employer's denial was unreasonable. It said:

> "The standard for determining an unreasonable denial is whether the employer had a legitimate doubt as to its liability. Unreasonableness and 'legitimate doubt' are to be considered in light of all the evidence available to the employer at the time. * * *
>
> "* * * * *
>
> "Here, the employer knew that claimant's bus had been involved in an accident with another of the employer's vehicles. Moreover, the employer was aware that claimant had suffered an injury as a result of the accident. Inasmuch as the employer had knowledge of the accident, it had no basis for questioning the compensability of the injury.
>
> "Accordingly, we conclude that at the time the employer issued its denial, the medical and legal information available to it did not raise a legitimate doubt as to the compensability of claimant's right knee, right hip, and low back injury. Therefore, we find that the issuance of the denial was unreasonable. Penalties and related attorney fees will be assessed. ORS 656.262(10); 656.382(1)." (Citations omitted.)

On reconsideration, the Board adhered to its order with this clarification:

> "The gist of this case is that under claimant's version of the events in question, he sustained a compensable injury; under his supervisors' version of the events in question, the injury is not compensable. The Referee, in his order, acknowledged that the case had to be resolved based on credibility. He specifically found claimant credible based on claimant's demeanor. In contrast, he found the supervisors not credible. In other words, he found that the supervisors were lying and claimant was telling the truth.
>
> "The denial was based on the supervisors' version of the facts. Because the supervisors were not telling the truth, there was no reasonable basis for the denial. As the Court of Appeals recently said of an attorney who was the employer's agent:

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[1] ORS 656.262(10) provides, in part:

"(a) 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."

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."

[2] ORS 656.005(7) provides, in part:

"(a) 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, if it is established by medical evidence supported by objective findings, subject to the following limitations:

"* * * * *

"(b) '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."

"'Employer contends that it had a legitimate doubt, because it relied on the advice of counsel. We disagree. Employer's attorney is its agent, and employer, as principal, cannot hide behind the incorrect advice of its agent.' *International Paper Company v. Huntley*[, 106 Or App 107, 806 P2d 188 (1991)].

"Similarly, the employer must be charged with the actions of its agents who were claimant's supervisors and who, presumably, knew that the claim was compensable."

In rendering its opinions, the Board adopted the referee's findings of fact and the reasoning on the issue of compensability. The referee said:

"By contrast, I am not satisfied that employer's witnesses could have seen or heard many of the things to which they testified because of the activities in which they were engaged at the time or their distance from the scene. I do not find the testimony of Bishop, Radford, light rail supervisor Frailey, or road supervisor Pool, trustworthy concerning the events at the time. Further, the Tri-Met supervisors had no authority other than what they took upon themselves to chase the bus after it left the terminal. The inconsistencies in their testimony and their demeanor while testifying undercut the credibility of their testimony. Supervisor Renner's report contains various inaccuracies and is based almost exclusively upon the conclusions and statements of the supervisors involved."

Employer argues that the Board erred in assessing penalties and attorney fees for an unreasonable denial when, at the time of the denial, reasonable doubt existed as to the credibility of witnesses and compensability turned on the resolution of the credibility issues. Employer also contends that the knowledge by its supervisors is not imputable to it for the purposes of evaluating the validity of a claim. Claimant argues that employer did not have a reasonable basis for denial of the claim, because the employer depended on statements of employees who were determined by the referee not to be credible.

In *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591, 763 P2d 408 (1988), we said, regarding whether a denial is unreasonable:

"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 * * * [the employer] had a legitimate doubt as to its liability. If so, the denial was not unreasonable. 'Unreasonableness' and 'legitimate doubt' are to be considered in the light of all the evidence available to the insurer." (Citations omitted.)

The proper focus in this case is on the evidence available to employer at the time of the denial.[3] *Ginter v. Woodburn United Methodist Church*, 62 Or App 118, 122, 659 P2d 434 (1983).

In its order on reconsideration, the Board held that the denial was based on the supervisors' version of the facts and that their knowledge of the true facts was imputable to employer. Therefore, employer's denial was unreasonable. An agent's knowledge may be imputable to the principal, even if the agent does not communicate the information to the principal. However, the knowledge of an agent is imputable only if it is about matters within the agent's authority as agent. *Hogan v. Alum. Lock Shingle Corp.*, 214 Or 218, 228, 329 P2d 271 (1958); *Phillips v. Colfax Company, Inc.*, 195 Or 285, 300, 243 P2d 276, 245 P2d 898 (1952).[4]

The Board adopted the referee's conclusion that the supervisors had no authority to chase the bus after it left the terminal. However, the Board made no findings about whether the knowledge of supervisors Pool, Frailey or Renner could be imputed to employer on the basis of their authority. Also, the Board's reliance on *International Paper Co. v. Huntley*, 106 Or App 107, 806 P2d 188 (1991), is

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[3] An insurer may reasonably deny a claim but later obtain information that makes continuation of the denial unreasonable. *See Brown v. Argonaut Insurance Company, supra*, 93 Or App at 592. Claimant does not contend that employer here ever had obtained that sort of information.

misplaced. In that case, the employer contended that it had a legitimate doubt, because it had relied on the advice of counsel. We held that the employer could not hide behind the incorrect advice of its agent. This case does not involve reliance on the advice of counsel. Rather, it involves the imputation of knowledge by the supervisors to the principal on the issue of the reasonableness of a denial.

We conclude that the Board erred when it imputed the knowledge of the supervisors to employer without determining the scope of their authority. The Board is required to make findings on that issue in order to make a determination of whether employer had a legitimate doubt about its liability. *See SAIF v. Barajas*, 107 Or App 73, 810 P2d 1316 (1991).

Reversed and remanded for reconsideration.

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[4] In *Colvin v. Industrial Indemnity*, 301 Or 743, 725 P2d 356 (1986), the court held that knowledge of a claimant's injury may be imputed to an employer on the basis of apparent authority, if the employee who received the information had supervisory authority over the claimant. Colvin dealt only with the issue of whether a supervisor's knowledge should be imputed to an employer for purposes of a timely notice of a claim. Here, the issue is whether the supervisors' knowledge should be imputed to employer for the purpose of deciding whether employer had a reasonable basis for denying the claim.

Cite as 112 Or App 170 (1992) March 25, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Dennis P. Underwood, Claimant.

DENNIS P. **UNDERWOOD**, Petitioner,
v.
PENDLETON GRAIN GROWERS and SAIF CORPORATION, Respondents.
(90-05925; CA A68728)

Judicial Review from the Workers' Compensation Board.
Argued and submitted November 8, 1991.
Kevin N. Keaney, Portland, argued the cause for petitioner. With him on the brief were Lawrence Baron, Robert K. Udziela and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.
Michael O. Whitty, 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 seeks review of an order of the Workers' Compensation Board determining that his injury did not occur in the course of his employment and is not compensable. We affirm.

Claimant sold tires in eastern Oregon. He worked in employer's Pendleton store and lived in Milton-Freewater, approximately 30 miles away. His job duties included selling, repairing and periodically transporting tires between employer's stores in Pendleton and Milton-Freewater, and his sales route included the area between the two towns. He had wide discretion regarding when and where to contact customers, and he was sometimes called away from home after hours to make service calls. He was occasionally asked to take tires home in his own truck and deliver them to the Milton-Freewater store the next morning. He had sought and received reimbursement for mileage on at least one occasion.

On January 22, 1990, employer asked claimant to drive a co-worker home, transport a load of tires to the store in Milton-Freewater and call on customers on his sales route. En route, claimant and his co-worker stopped at a store and bought a six-pack of beer, which they drank on the way. They also detoured to Weston, where they visited two taverns, played pool and each drank approximately ten glasses of beer between 1:20 p.m. and 4 p.m. Claimant then dropped off the co-worker, who entered

his residence and attempted to eat but immediately passed out.[1] Travelling in the direction of his home, claimant drove by the Milton-Freewater store without stopping. His truck suddenly veered across four lanes of traffic and collided head-on with a truck. He suffered a closed head injury, temporarily went into a coma and now has permanent nerve damage. Tests showed that, at the time of the accident, claimant had an "elevated" level of alcohol and barbiturates in his blood. No evidence was presented regarding the actual percentage of claimant's blood alcohol, the effects of combining alcohol with barbiturates or the likely effect of the combination on claimant's physical and mental faculties.

Claimant argues that, given the use of his personal vehicle for the employer's benefit, his trips to and from work were within the course of his employment. He also contends that, because of the latitude that he enjoyed in deciding when and where to call on sales customers, he could detour from and return to his employment in the course of a normal work day. *See Fowers v. SAIF*, 17 Or App 189, 521 P2d 363, *rev den* (1974).[2] Finally, he argues that, because he was using his truck to carry out the employer's business on the day of the accident, his injuries are compensable. He acknowledges that he deviated from his employment from the time that he started to drink, but contends that he returned to the course of his employment when he left the second tavern.

The referee agreed and further concluded that claimant's detour to Weston had not substantially increased the risk of his homeward journey. The referee based that conclusion on the fact that claimant is "an alcoholic who was able to hold his liquor [and thus] was not intoxicated at the time of the collision." The Board reversed, holding that

> "claimant's injury occurred after a nonbusiness delay of at least four and a half hours, during which time he consumed a substantial amount of alcohol. We find that those actions, coupled with the employer's enforced policy that specifically prohibited the consumption of alcohol while working,[3] removed him from the course of employment."

We agree with the Board. It is undisputed that claimant drank a large quantity of alcohol and ingested bartiturates, then drove home. Due to the length of his deviation and the nature of his acts, which were completely unrelated to his employment and which considerably increased the hazards associated with driving, and given that he was prohibited from carrying out the employer's business after consuming alcohol or drugs, we conclude that claimant had abandoned his job for that work day. At the time of the injury, he was not on his way home from work; he was on his way home from a tavern. Because there was no causal connection between his trip home and his employment, claimant did not suffer a compensable injury. *See Burge v. SAIF*, 108 Or App 145, 148, 813 P2d 81 (1991); *O'Connell v. SAIF*, 19 Or App 735, 738, 528 P2d 1064 (1974).

Affirmed.

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[1] The referee found that the co-worker's reaction to the alcohol he had consumed was "unusually potent." Both claimant and the co-worker claimed that, although they did not voluntarily take any illicit drugs that day, they may have been "slipped a 'mickey'" at one of the taverns they visited. The referee concluded that, regardless of how claimant took the drug, its introduction into his system was a consequence of his personal activities.

[2] In *Fowers v. SAIF, supra*, we held that an employee's two-hour drinking interval did not constitute an abandonment of his employment, because the employee had flexibility in how and when to accomplish his job duties. The employee in that case was not prohibited from drinking during the workday.

[3] Employer's policy forbid employees from reporting for duty or performing work while under the influence of any drug, alcoholic beverage or intoxicant. Employees who failed to abide by the policy were subject to discipline, including termination. The Board found that claimant knew "he could be fired if he called upon a customer [while] under the influence' of intoxicants.

Cite as 112 Or App 175 (1992) March 25, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of the Beneficiaries of Linda S. Deacon, Deceased.

QUALITY PLASTICS and LIBERTY NORTHWEST INSURANCE CORPORATION, Petitioners,
v.
JAMES M. **HAMILTON**, Surviving Spouse; and CORWIN F. BOWEN, III, Custodial Parent of CORWIN F. BOWEN, IV, BRIAN S. BOWEN and SHAWN BOWEN, Minor Children, Respondents.
(88-12258 and 88-21455; CA A69730)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 8, 1991.
Jerry K. Brown, McMinnville, argued the cause and filed the brief for petitioners. With him on the brief was Cummins, Brown, Goodman, Fish & Peterson, P.C., McMinnville.
Nick Chaivoe, Portland, argued the cause for respondent Bowen. James S. Coon, Portland, argued the cause for respondent Hamilton. With them on the brief was
Imperati, Barnett, Sherwood & Coon, Portland.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
ROSSMAN, J.
Affirmed.

The issue in this workers' compensation case is whether decedent's fatal car accident was a consequence of her earlier compensable injury. Both the referee and the Workers' Compensation Board held that it was, and we affirm.

Decedent was injured in the course of her employment. While still under a doctor's care for conditions resulting from that injury, she embarked on a trip that was to have included two personal errands and, then, an appointment with her treating physician. She left her home, two miles south of McMinnville, drove northeast for approximately 20 miles, stopped near Newberg to pick up her paycheck at employer's place of business, then drove several miles to Carlton, where she picked up a meat order for her family. At that point, she called one of her sons to inform him that she was on her way to the doctor's office and would be home after the appointment. She began traveling directly toward the doctor's office in McMinnville but was killed in a motor vehicle accident while she was *en route*.

It is undisputed that decedent's need to obtain medical treatment was a compensable consequence of her original injury. The only question is whether the two personal errands before driving to the doctor's office broke the link between her original and subsequent injuries to the extent that compensation should be denied.

A subsequent injury is compensable if it is the direct and natural result of a compensable prior injury. *Firkus v. Alder Cr. Lbr.*, 48 Or App 251, 254, 617 P2d 620 (1980), *rev den* 290 Or 302 (1981); *see also Williams v. Gates, McDonald & Co.*, 300 Or 278, 709 P2d 712 (1985). Injuries that occur during a trip to a physician for treatment of a compensable injury are compensable. *Fenton v. SAIF*, 87 Or App 78, 83, 741 P2d 517, *rev den* 304 Or 311 (1987).

Substantial evidence supports the Board's finding that the personal segment of decedent's trip had ended and that "the basic purpose of the activity in which decedent was killed was to get to her doctor's office in time for an appointment to treat her compensable injury." The Board did not err in concluding that there was a sufficient relationship between the original injury and the activity that gave rise to the subsequent injury to make the latter compensable.

Affirmed.

Cite as 112 Or App 185 (1992) March 25, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of the Beneficiaries of Donald E. Thomas, Deceased, Claimant.

MARY L. **THOMAS**, Beneficiary of Donald E. Thomas, Deceased, Claimant, Petitioner,
v.
A-1 SANDBLASTING AND STEAM CLEANING CO., ROSS BROTHERS CONSTRUCTION COMPANY and SAIF CORPORATION, Respondents.
(87-17184, 88-02638; CA A66235)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 17, 1991.
Donald O. Tarlow, Newberg, argued the cause for petitioner. With him on the brief was Brown, Tarlow & Berry, P.C., Newberg.
David L. Runner, Assistant Attorney General, Salem, argued the cause for respondents A-1 Sandblasting and Steam Cleaning Co. and SAIF Corporation. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Jerald P. Keene, Portland, argued the cause for respondents Ross Brothers Construction Company and SAIF Corporation. With him on the brief was Roberts,
Reinisch, MacKenzie, Healey & Wilson, P.C., Portland.
Before Richardson, Presiding Judge, and Joseph, Chief Judge,* and Deits, Judge.
DEITS, J.
Reversed; referee's order reinstated.
*Joseph, C.J., *vice* Newman, J., deceased.

In this workers' compensation case, petitioner is the beneficiary of a deceased worker (decedent), who died while working under a subcontract between Ross Brothers Construction Company (Ross) and A-1 Sandblasting and Steam Cleaning Co. (A-1). SAIF insures both companies. The referee set aside SAIF's denial on behalf of A-1. The Workers' Compensation Board reversed, finding that Ross is the responsible employer and holding that petitioner is not entitled to Oregon benefits. Compensability is not disputed. The issues on review are whether A-1 or Ross was decedent's employer at the time of his death in California and, only if Ross was his employer, whether petitioner is entitled to benefits under ORS 656.126(1) by reason of decedent's death while working temporarily out-of-state. Because we hold that A-1 is the responsible employer, we reverse.

For approximately 23 years Ross, a general contractor in Oregon, has subcontracted with A-1, an Oregon business, to do most of Ross' painting work. Ross is licensed to do business in California and had a contract there to disassemble a bridge, remove it to a maintenance yard and clean and paint it. In August, 1987, Ross had moved the bridge to the maintenance yard, but it still needed to be cleaned and painted. Ross contacted the president of A-1 and requested that A-1 subcontract to paint the bridge. However, because A-1 was not licensed in California, they agreed that A-1 would do the project, but Ross would put A-1's employees on its payroll and pay them directly. A-1 would bill Ross for the cost of transportation, equipment rental and supplies, plus 10 percent.

Ross provided A-1 the specifications for the project. A-1 then obtained all of the necessary equipment and supplies and worked with the State of California to obtain approval of the paint. One of A-1's officers, Cornett, arranged for decedent to work with him on the California job. Decedent had been employed by A-1 for at least 10 years. During the previous three or four years, he had not worked for any other employer, although he had done minor free-lance work when A-1 did not have sufficient work. When he was not working, he drew unemployment compensation chargeable against A-1. Decedent had never worked for Ross and never applied to work for it. His first contact with Ross was enroute to California when, at A-1's direction, he and Cornett delivered their W-4 forms and a copy of the union pay scale to the Ross offices. A Ross employee then joined them to work on the project.

At the job site, decedent and Cornett worked without supervision and made most decisions jointly. Cornett kept the records, made all necessary contacts with A-1, decided what hours they would work and reported hours worked to Ross. The Ross employee, who was sent to make sure that job

costs and time worked were reported accurately, apparently worked under the direction of A-1's employees. While working on the project, decedent suffered a fatal heart attack.

Claimant, as decedent's beneficiary, filed for Oregon workers' compensation death benefits. At a hearing on compensability, the referee found that A-1 was decedent's employer. He set aside SAIF's denial on behalf of A-1 and upheld SAIF's denial on behalf of Ross. On review, the Board adopted the referee's findings of fact, with one minor addition. It concluded, however, that decedent was an employee of Ross under the loaned-servant doctrine and that he was a California worker at the time of his death. Therefore, claimant was not entitled to Oregon workers' compensation benefits.

Claimant argues that the Board erred in applying the loaned-servant doctrine to this case. Alternatively, she contends that, assuming the doctrine is applicable here, the Board misapplied it. In *Multnomah County v. Hunter*, 54 Or App 718, 721, 635 P2d 1371 (1981), we explained the applicability of the loaned-servant doctrine:

> "The [loaned-servant] doctrine applies where an employe in an existing employment relationship is loaned by the original employer to a special employer."

Here, it is undisputed that A-1 was decedent's general employer. Because of the California license problems, A-1 agreed to allow Ross to put decedent on its payroll as its employee. We conclude that Ross was a special employer and, therefore, the loaned-servant doctrine applies. *Newport Seafood v. Shine*, 71 Or App 119, 123, 691 P2d 132 (1984).

After it is determined that a general employer has loaned an employee to another employer, it is necessary to decide which is responsible for the injury. As stated in 1C Larson *Workmen's Compensation Law* 8-317, 48.00 (1991):

> "When a general employer lends an employee to a special employer, the special employer becomes liable for workmen's compensation only if
>
> "(a)the employee has made a contract of hire, express or implied, with the special employer;
>
> "(b)the work being done is essentially that of the special employer; and
>
> "(c)the special employer has the right to control the details of the work."

It is unnecessary for us to decide whether there was an implied contract of hire between decedent and Ross, or whether the work being done was essentially that of the "special employer," Ross, because we conclude that, under the Board's findings, the third criteria was not satisfied. The Board adopted the referee's findings:

> "A-1 sent to California two skilled individuals who were capable of working within the contract parameters without much upper-level supervision. [Cornett] was serving as a corporate officer. Though he tended to physically do the more menial, less-skilled, tasks while [on the project], he was, in fact, the person who physically communicated with [decedent] and arranged for him to work in California on the bridge project. [Cornett and decedent] worked together on all decisions, though [Cornett] is the one who decided when they would go to work in the morning, he kept track of all the hours worked by all three workers, maintained custody of the job specifications, and kept a diary of the job."

The order also reveals that decedent performed his job in his usual manner. A-1 instructed him to report initially to A-1 offices to pick up and transport the supplies and equipment necessary for the job. A-1 supplied everything that he needed to complete the project. Cornett made all decisions about work hours, and he and decedent jointly decided the details of how to perform the work. The part of the project that Ross did itself was complete, and none of its supervisory personnel were still on the site. Although Cornett reported to Ross about hours worked for payroll purposes and other minor

details, he also maintained regular contact with A-1 while on the project. However, there were no findings that the one Ross employee who accompanied the painters "to be sure that they were working" had any supervisory function.[1] A-1 maintained its usual extent of control over the details of decedent's work, even though he had been "loaned" to Ross. We hold that A-1, as the general employer of decedent, remained liable for worker's compensation benefits during the time that decedent was "loaned" to Ross.

Reversed; referee's order reinstated.

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[1] The employee sent to the project by Ross was the 20-year-old nephew of one of the owners. He was not skilled and made none of the decisions. The Board found that he was sent to make sure that "they were working and not sitting on their butts."

Cite as 112 Or App 215 (1992) March 25, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Jamie N. Dean, Claimant.

ALBERTSON'S, INC., Petitioner - Cross-Respondent,
v.
JAMIE N. **DEAN**, Respondent - Cross-Petitioner.
(88-14751; CA A67590)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 18, 1992.
Neil W. Jones, Portland, argued the cause for petitioner - cross-respondent. With him on the brief was Mitchell, Lang & Smith, Portland.
Judy L. Johnson, Portland, argued the cause for respondent - cross-petitioner. With her on the brief was Sherwood & Coon, P.C., Portland.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

PER CURIAM
Affirmed on petition; remanded on cross-petition for correction of date error.

Employer seeks review of an order of the Workers' Compensation Board holding that claimant is permanently and totally disabled. There is substantial evidence to support the Board's decision, and we affirm it.

Claimant has pointed out in his cross-petition that the Board's order incorrectly notes that the referee's order being affirmed is the order dated July 14, 1989. In fact, the referee issued a second amended order on August 7, 1989, and that is the order from which employer appealed to the Board. The Board's order should be modified to reflect that the referee's order being affirmed is the order of August 7, 1989.

Affirmed on petition; remanded on cross-petition for correction of date error.

Cite as 112 Or App 261 (1992) April 1, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Karen S. McKillop, Claimant.

BOHEMIA INC. and LIBERTY NORTHWEST INSURANCE CORPORATION, Petitioners,
v.
KAREN S. **McKILLOP**, CROWN INDUSTRIES, OLYMPIC ADVERTISING and SAIF CORPORATION, Respondents.
(89-00905, 89-00906, 89-08897; CA A68769)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 3, 1992.
David O. Wilson, Eugene, argued the cause for petitioners. With him on the brief was Employers Defense Counsel, Eugene.
Karen M. Werner, Eugene, argued the cause for respondent Karen S. McKillop. With her on the brief were Thomas Carey and Coons, Cole & Carey, Eugene.
Darrell E. Bewley, Salem, waived appearance for respondent Crown Industries.
Steve Cotton, Special Assistant Attorney General, Salem, waived appearance for respondents Olympic Advertising and SAIF Corporation.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
EDMONDS, J.
Affirmed.

Bohemia, Inc. (employer) seeks review of an order of the Workers' Compensation Board that held that claimant's claim was filed timely. We affirm.[1]

In October, 1986, while employed at Crown Industries (Crown), claimant began to suffer pain in her elbows. In June, 1987, she was diagnosed as suffering bilateral "tennis elbow syndrome," and a doctor confirmed that the condition was related to her employment. In October, 1987, she began working for employer. In February, 1988, a doctor authorized time loss in connection with her elbow syndrome. In April, 1988, a doctor determined that claimant was suffering from carpal tunnel syndrome and confirmed her inability to work since February, 1988. Claimant filed a claim against employer in November, 1988, which was denied, in part, because it was not timely. The Board held that the claim against employer was not time-barred under ORS 656.807(1), because claimant first became disabled in February, 1988.

Employer argues that, because claimant filed the claim more than one year after she was informed that she was suffering from an occupational disease, the Board erred as a matter of law in concluding that her claim was timely. ORS 656.807(1) provides:

> "All occupational disease claims shall be void unless a claim is filed with the insurer or self-insured employer by *whichever is the later of the following dates*:
>
> "(a) One year from the date the worker first discovered, or in the exercise of reasonable care should have discovered, the occupational disease; or
>
> "(b) One year from the date the claimant becomes disabled or is informed by a physician that the claimant is suffering from an occupational disease." (Emphasis supplied.)

Employer asserts that the statute requires the Board to determine the earlier of the two possible dates in subparagraph (a), and compare it with the earlier of the two possible dates in subparagraph (b). The claim must, it argues, be filed within one year after the latest of the dates thus determined. Employer contends that the earlier dates must be considered, because any other construction would relieve

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[1] SAIF and Crown Industries waived appearance in this proceeding.

workers of the duty to exercise reasonable care in the discovery of their occupational diseases.[2] According to employer, claimant "discovered" that she was suffering from an occupational disease in December, 1986, or January, 1987. In June, 1987, she was informed by a doctor that her elbow problems were caused by her work. Therefore, the "later" of those dates would be June, 1987, and, because she did not file a claim with employer until November, 1988, her claim was untimely.

Claimant argues that "the later of the following dates" modifies each clause within subparagraphs (a) and (b) and, therefore, the relevant date is the *later* of the dates in each subparagraph. Thus, because claimant became disabled in February, 1988, her claim was filed timely.

Reading all of ORS 656.807(1) does not support employer's argument that we should first compare the dates in each subparagraph to determine which is earlier. Even if we assume that the statute is ambiguous, the legislative history refutes employer's argument. ORS 656.807 was amended in 1987. Or Laws 1987, ch 713, 6. One of the purposes of the amendment was to extend the Statute of Limitations in recognition of the latency periods associated with some occupational diseases.[3] The initial draft of the bill was prepared by the House Task Force on Occupational Disease. One of the earlier drafts contained the phrase "whichever is earlier," but that language was rejected. It was replaced with the current language "whichever is the later of the following dates."[4] The amendments to ORS 656.807(1) that were recommended by the Task Force were enacted by the legislature without any changes.

Although the two provisions of subparagraph (a) itself cannot be construed together in the light of the whole subsection (1), it does not reasonably follow that the legislature meant "the earlier date" when it expressly said "the later of the following dates." It is more likely that the legislature intended that the dates in subparagraph (a) are alternative dates to be compared with the dates in subparagraph (b) to determine the later date. We reject employer's argument. We agree with the Board that claimant's claim was filed timely.

Employer's other arguments do not require discussion.

Affirmed.

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[2] Obviously, the date that a worker should have discovered an occupational disease can never be *after* the date that the worker actually discovered the disease. *See Note*: "Development in the Law: Workers' Compensation Law," 24 Will L Rev 341, 374-75 (1988)

[3] *See* Minutes, House Task Force on Occupational Disease, October 8, 1986, p 19; Exhibit G, House Task Force On Occupational Disease, October 8, 1986; Minutes, House Committee on Labor, March 25, 1987, pp 1,3; Tape recording, House Committee on Labor, March 25, 1987, tape 70, side A and tape 69, side R; Exhibit F, House Committee on Labor, March 25, 1987; Minutes, Senate Committee on Labor, April 23, 1987, pp 2,4; Tape recording, Senate Committee on Labor, April 23, 1987, tape 120, side B; Exhibits B and D, Senate Committee on Labor, April 23, 1987.

[4] *See* Minutes, House Task Force on Occupational Disease, October 8, 1986, p 28; Tape recording, House Task Force on Occupational Disease, October 8, 1986, tape 30; Minutes, House Committee on Labor, March 6, 1987, p 5; Tape recording, House Committee on Labor, March 6, 1987, tape 48, side B.

Cite as 112 Or App 275 (1992) April 8, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of C. Bernice Chandler, Claimant.

EBI INSURANCE COMPANY and ST. CHARLES MEDICAL CENTER, Petitioners - Cross-Respondents,
v.
C. BERNICE **CHANDLER**, Respondent - Cross-Petitioner.
(89-26231; CA A69713)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 12, 1992.
Craig A. Staples, Portland, argued the cause for petitioners - cross-respondents. With him on the briefs was Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C., Portland.
Dan Steelhammer, Bend, argued the cause for respondent - cross-petitioner. With him on the brief was Brothers, Drew & Steelhammer, Bend.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
BUTTLER, P.J.
Affirmed on petition and on cross-petition.

In this workers' compensation case, employer seeks review of an order of the Board holding that claimant's request for hearing on a determination order for her claim for injury to her neck, shoulder, back and leg was timely filed. Claimant cross-petitions, seeking review of the Board's determination of the extent of disability. There is substantial evidence to support the Board's determination of the extent of disability. We write only to address the issue of the timeliness of the request for hearing.

At the relevant time, ORS 656.319(4) provided that a request for hearing must be filed within 180 days after the date of mailing the determination order. The term "filed" is not defined in the statutes. In OAR 438-05-046(1)(a), the Board has defined it to mean

> "the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing."

Here, claimant mailed her request for hearing on the 180th day. It was not received until the 182nd day. The Board held, relying on its administrative rule, that the filing was timely. Employer contends that there is controlling case law interpreting ORS 656.319 that holds that a request for hearing is filed only when received, *Norton v. Compensation Department*, 252 Or 75, 78, 448 P2d 382 (1968), and that, therefore, the Board's rule interpreting the statute differently is invalid. Employer did not challenge the substantive validity of the rule at the Board level; therefore, we will not consider the argument for the first time on judicial review. *Northwest Advancement v. Wage and Hour Comm.*, 96 Or App 146, 772 P2d 934, *rev den* 308 Or 315 (1989), *cert den* ___ US ___, 110 S Ct 2590, 110 L Ed 2d 271 (1990). Employer does not contend that the rule was not properly promulgated or adopted. Under the express terms of the rule, the request for hearing was timely filed.

Affirmed on petition and on cross-petition.

Cite as 112 Or App 354 (1992) April 22, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Anita J. Bronson (Stratton), Claimant.

SENTROL, INC., Petitioner,
v.
ANITA J. **BRONSON** (STRATTON), FORD INDUSTRIES, INC., and INDUSTRIAL INDEMNITY, Respondents.

In the Matter of the Compensation of Anita J. Bronson-Stratton, Claimant.

ANITA J. **BRONSON-STRATTON**, Petitioner,
v.
SENTROL, INC., Respondent.
(WCB 88-00828, 87-15926 & 88-12537; CA A64366 (Control); A65404)
(Cases Consolidated)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 17, 1991.
Jerald P. Keene, Portland, argued the cause for petitioner/respondent Sentrol, Inc. With him on the briefs was Roberts, Reinisch, Mackenzie, Healey & Wilson, P.C., Portland.
Robert Wollheim, Portland, argued the cause for respondent/petitioner Anita J. Bronson-Stratton. With him on the brief was Welch, Bruun and Green, Portland.
Todd C. Ainsworth, Portland, argued the cause and filed the brief for respondents Ford Industries, Inc., and Industrial Indemnity.
Before Richardson, Presiding Judge, and Joseph, Chief Judge,* and Deits, Judge.
RICHARDSON, P.J.
CA A64366 affirmed; in CA A65404, attorney fees denial reversed and remanded for reconsideration and otherwise affirmed.
*Joseph, C.J., *vice* Newman, J., deceased.

Petitions for judicial review by Sentrol, Inc. (employer) and by claimant were consolidated for review. In employer's case, the Workers' Compensation Board held that employer was responsible for claimant's condition, because it was a new injury and not an aggravation. In claimant's case, the Board denied compensation for chiropractic treatments and held that she was not entitled to attorney fees.

Claimant sustained a compensable back injury in 1979 while employed by Ford Industries, Inc., which was insured by Industrial Indemnity. She ultimately was awarded 10 percent unscheduled disability on an "Own Motion Claim" in 1987. In May or June, 1987, claimant began to work for employer. She filed a claim against employer and Ford Industries, Inc., for increased back pain resulting from lifting a box of parts while at work for employer. Both denied responsibility; compensability was conceded. The Board concluded that the incident while claimant was working for employer independently contributed to the worsening of her back condition. Employer argues that there was not substantial evidence to support findings that are the necessary predicate for that conclusion. There was conflicting medical evidence on the issue of responsibility. We are not persuaded that the Board misinterpreted it, as employer contends. There was substantial evidence to support the findings.

In a separate order, the Board held that the chiropractic treatments that claimant had received after her injury at employer were not reasonable and necessary, and so it upheld employer's denial. Claimant argues that there was not substantial evidence to support the Board's order, principally because the Board did not explain why it disregarded the referee's conclusion that claimant was credible. The Board depended on an analysis of several physicians' opinions that chiropractic treatment was not indicated and might be counter-productive. There was substantial evidence to support the facts found by the Board, and it was not required to explain its reasons for disregarding the referee's opinion on credibility. *Erck v. Brown Oldsmobile*, 311 Or 519, 815 P2d 1251 (1991).

Claimant sought attorney fees under ORS 656.386(1) for overturning employer's denial of her request for it to pay for a weight loss program prescribed by her chiropractor. Before the hearing on the denial, employer authorized the program. The Board denied attorney fees on the basis of its opinion in *Duane L. Jones*, 42 Van Natta 875. It concluded that there had to be a hearing and a ruling by the referee in order for claimant to be entitled to attorney fees. We held in *Jones v. OSCI*, 108 Or App 230, 814 P2d 558 (1991), that, under the 1991 amendment of ORS 656.386(1), a hearing and ruling is not a predicate to an award of attorney fees for prevailing on a denied claim. The Board erred by denying fees on that rationale. On remand, the Board should consider whether attorney fees are authorized by ORS 656.386. *See Short v. SAIF*, 305 Or 541, 754 P2d 575 (1988); *Shoulders v. SAIF*, 300 Or 606, 716 P2d 751 (1986).

CA A64366 affirmed; in CA A65404, attorney fees denial reversed and remanded for reconsideration and otherwise affirmed.

Cite as 112 Or App 384 (1992) April 22, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON

JEURINE **MARSHALL**, Appellant,

v.

COSGRAVE, KESTER, CROWE, GIDLEY and LAGESEN, AUSTIN W. CROWE, JR. and MICHAEL C. LEWTON (all partners individually named), Respondents.

(89-12-07157; CA A67599)

Appeal from Circuit Court, Multnomah County.
Morton A. Winkel, Judge pro tempore.
Argued and submitted February 28, 1992.
Kevin Keaney, Portland, argued the cause for appellant. With him on the brief were Robert K. Udziela and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.
Deborah L. Sather, Portland, argued the cause for respondents. With her on the brief was Cooney, Moscato & Crew, P.C., Portland.
Before Richardson, Presiding Judge, and Deits and Durham, Judges.
RICHARDSON, P.J.
Reversed and remanded.

Plaintiff brought this legal malpractice action against defendants, contending that they negligently failed to perfect a petition for judicial review to this court from a Workers' Compensation Board order holding that plaintiff's injuries in an automobile accident did not arise out of and in the course of her employment and, therefore, that her claim was properly denied. The trial court granted a summary judgment for defendants on the ground that, had review been had, we would have affirmed the Board as a matter of law. Plaintiff appeals, and assigns error to the granting of defendants' motion.[1] We reverse.

We take the facts as found by the Board:

> "Claimant is a media specialist for the self-insured employer, a school district. In addition to her work as a media specialist, she worked as an adult advisor to a group of students in a special advisory program. Her usual work hours are from 7:20 a.m. to 3:30 p.m., although she is not required to stay at school after 2:45 p.m. On September 21, 1987, claimant decided that she would bring some cupcakes to school the next morning in connection with meeting some of the goals of the advisory program. She sought and received approval of her plan from the counsellor in charge of the advisory program.

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[1] She does not assign error to the denial of her "cross-motion" for summary judgment.

"Claimant's school is located in southeast Portland. Claimant resides in west Portland. Her usual route to and from work causes her to cross the Sellwood Bridge over the Willamette River. Claim-ant intended to purchase the cupcakes at a market on the west side of the Sellwood Bridge in her neighborhood. She checked out of the school at approximately 3 p.m. on September 21, 1987. She had a personal appointment at 4 p.m. on the west side of the Willamette River. She intended to drive to the market, pick up the cupcakes, then drive to her personal appointment, then drive home. While crossing the Sellwood Bridge on her way to the market she was involved in a head-on motor vehicle accident and received serious injuries. Later that evening, one of claimant's daughters, at claimant's request, called a teacher friend of claimant's and asked the friend if she would pick up a 'treat' and take it to school the next morning. The friend did so. Neither the counsellor in charge of the advisory program nor the school principal would have ordered anyone to obtain a 'treat' in lieu of the cupcakes claimant was unable to pick up."

In the opinion portion of its order, the Board explained that the counselor and the principal did not have the authority to direct anyone to pick up the treats.[2]

The Board majority applied the "dual purpose" exception to the "going and coming" rule. We gave a general explanation of that exception in *Hendrickson v. Lewis*, 94 Or App 5, 8, 764 P2d 577 (1988):

"An employe's injuries are generally not covered by workers' compensation if they are sustained while going to or coming from work. *Heide/Parker v. T.C.I. Incorporated*, 264 Or 535, 539, 506 P2d 486 (1973); *Walker v. SAIF*, 28 Or App 127, 129, 558 P2d 1270 (1977). The general principle, however, is subject to a number of exceptions. When a trip to or from work is combined with a business-related purpose, an injury incurred during the trip may be compensable."

The Board considered two issues to be decisive against plaintiff's compensation claim: First, she would have been at approximately the same place at the time that the accident occurred, regardless of whether she had been on her way to pick up the cupcakes or had been on her personal business; and, second, the employer would not have ordered another person to pick up the cupcakes if plaintiff had been unable to do so herself or arrange for someone else to do it. The dissenting board member stated, in part:

"My disagreement with the majority opinion centers around its statement that '[t]he question is whether the employer would have *directed* someone to make the trip for that purpose.' The majority's formulation of the exception is far too restrictive. As applied here, it has the unwarranted effect of precluding recovery simply because claimant exercised discretion in the performance of her job duties.

"* * * * *

"The relevant question is not whether the employer would have directed someone to make the trip, but rather whether the purpose of the trip was such that someone would have undertaken it if claimant had not been able to handle it in combination with her homeward journey. 1 Larson, *Workers' Compensation Law*, sec. 18.21 (1985). Stated

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[2] Defendants recite in their statement of facts:

"As the school counselor in charge of the group program, Ms. Mooney concurred with plaintiff's idea to provide treats for the group meeting. However, Ms. Mooney testified that if plaintiff had been unable to pick up the treats, she would have asked someone else to do this out of professional courtesy. However, she would not have had the authority to order anyone else to pick up those treats.

"Similarly, John Beck, principal of Sellwood Middle School, supported the decision to provide cupcakes to the group and considered plaintiff's trip to buy the cupcakes to be school-related. However, if plaintiff had been unable to pick up the treats, Mr. Beck did not have the authority to dispatch anyone else to pick up the treats."

> otherwise, the relevant inquiry is whether the business purpose of the trip was important enough that claimant, or another employee, would have made the trip in the absence of the personal motive." (Emphasis in original.)

We agree with the dissent.

Plaintiff argues that, had we reviewed the Board's decision, we would have reversed it. Defendants disagree. They argue, first, that our review would have been for substantial evidence and that there was sufficient evidence in the whole record to support the Board's findings. That is correct but, as plaintiff answers, it has little to do with anything. The facts are not disputed; the question is how the law applies to them.

We do not agree with the Board that the fact that plaintiff would have been at the accident scene at the same time, whether on her employer's business or on her own, takes her out of the dual purpose exception, in the light of the fact that she was on her way to the job-related part of her planned activities at the time of the accident. *See Munson v. State Ind. Acc. Comm.*, 142 Or 252, 20 P2d 229 (1933); *Bebout v. SAIF*, 22 Or App 1, 537 P2d 563, *aff'd* 273 Or 487, 541 P2d 1293 (1975); *see also Rosencrantz v. Insurance Service*, 2 Or App 225, 467 P2d 664 (1970). This case differs from *Hendrickson v. Lewis, supra*, and *Gumbrecht v. SAIF*, 21 Or App 389, 534 P2d 1189 (1975), where the employees had completed their job-related tasks before they were injured.

The closer question is whether the fact that the employer would not have ordered someone to complete the mission if plaintiff had not would have defeated her workers' compensation claim. In *Rosencrantz v. Insurance Service, supra*, and again in *Gumbrecht v. SAIF, supra*, we quoted from 1 Larson, *Workmen's Compensation Law* 294.5-294.10, 18.12 (1968):

> "The basic dual-purpose rule, accepted by the great majority of jurisdictions, may be summarized as follows: when a trip serves both business and personal purposes, it is a personal trip if the trip would have been made in spite of the failure or absence of the business purpose and would have been dropped in the event of failure of the private purpose, though the business errand remained undone; it is a business trip if a trip of this kind would have been made in spite of the failure or absence of the private purpose, because the service to be performed for the employer would have caused the journey to be made by someone even if it had not coincided with the employee's personal journey."

From that common starting point, *Gumbrecht* and *Rosencrantz* went on to quote different additional passages from Larson that suggest different answers to the question. The passage quoted in *Gumbrecht* states:

> "In all such cases, we start with a personal motive--that of getting home--which would have caused the employee to take the trip in any case. *The question then becomes: was the business mission of such character or importance that it would have necessitated a trip by someone if this employee had not been able to handle it in combination with his homeward journey?*
>
> "In some cases it has been possible to answer this question 'yes,' with the result that while covering his usual route toward his home the employee has been deemed, for this particular occasion, to remain in the course of his employment." 1 Larson, *supra*, 4-169-4-170, 18.21. (Emphasis supplied.)

In *Rosencrantz*, we quoted from 1 Larson, *supra*, 294.10-294.11, 18.13:

> "It is inaccurate and misleading to call this test, as sometimes has been done, the 'dominant purpose' test, or to paraphrase it by saying that the trip is a business trip if the 'primary' purpose is business. Judge Cardozo used no such language. He said it was sufficient if the business motive was a concurrent cause of the trip. He then defined 'concurrent cause' by saying that it meant a cause which would have occasioned the making of the trip even if the private mission had been canceled. One detail must be stressed to make this rule complete: it is not necessary, under this formula, that, on

> failure of the personal motive, the business trip would have been taken by this particular employee at this particular time. It is enough that someone sometime would have had to take the trip to carry out the business mission. Perhaps another employee would have done it; perhaps another time would have been chosen; but if a special trip would have had to be made for this purpose, and if the employer got this necessary item of travel accomplished by combining it with this employee's personal trip, it is accurate to say that it was a concurrent cause of the trip, rather than an incidental appendage or afterthought."

The second quotation in *Gumbrecht* can be read to mean that a subsequent "substituted performance" by another employee is an indispensable part of the injured employee's showing that his earlier trip had the requisite dual purpose and was therefore in the course and scope of his employment. However, the second passage quoted in *Rosencrantz* places the substituted performance concept in a broader context; it indicates that the overriding inquiry is whether the business aspect of the trip was significant enough to have necessitated it, independently of the employee's personal purpose, and that the employer's later directive to another employee to complete the mission is one possible basis, but not the exclusive one, for determining that the injured employee's journey had a significant business purpose. We conclude that the understanding of the rule reflected in *Rosencrantz* is the better one. The *Gumbrecht* solution would unduly restrict the ways by which the existence and significance of the business purpose can be determined, and it substitutes an after-the-fact event or contrivance for what necessarily must be determined in the light of what the injured employee was doing at the time of the trip.[3]

In any event, neither of the possible understandings of the substituted performance rubric goes as far as the Board went here. We note, first, that the business mission *was* accomplished by plaintiff's arranging for a friend to pick up the treats. More to the point, neither of plaintiff's superiors had the *authority* to order another employee to complete the business mission, although both regarded it as "school-related" and significant. *See* n 2, *supra*. Under these circumstances, the fact that no one would have been directed to complete the errand is irrelevant. It relates only to the organizational or command structure of the employer's business and has nothing to do with whether the errand itself had a significant business purpose. Every other consideration militates in favor of the conclusion that, at the time of the accident, plaintiff was engaged in a significant work-related activity and was acting within the course of her employment. If the case had been brought to us, we would have reversed and remanded the order and instructed the Board to allow plaintiff's claim.

It follows that, if defendants were negligent, their negligence caused harm. Defendants do not concede that they were negligent. As noted earlier, note 1, *supra*, plaintiff assigns error only to the granting of defendants' motion for summary judgment and not to the denial of her own. The question of negligence was not decided by the trial court, and we cannot decide it now, at least under the assignment of error that plaintiff makes. A remand is necessary to consider the issues of negligence and, if it arises, damages. We do not foreclose the possibility that plaintiff may renew her motion for summary judgment on liability in the proceedings on remand.

Reversed and remanded.

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[3] *Brown v. SAIF*, 43 Or App 447, 602 P2d 1151 (1979), *rev den* 288 Or 335 (1980), is not contrary to our conclusion. We based our holding that the dual purpose exception did not apply there, in part on the fact that no other employee would have been sent to complete the business mission, if the claimant's deceased had not performed it. However, the principal basis for the holding was that the supposed business purpose was incidental to the decedent's personal motives in connection with the trip.

Cite as 112 Or App 392 (1992) April 22, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of John J. Alcantar, Claimant.

CASTLE & COOKE, Petitioner,
v.
JOHN J. **ALCANTAR**, OAK GROVE FOODS, UNITED FOODS, INC., UNITED STATES FIDELITY & GUARANTY COMPANY, Respondents.
(WCB 87-18551, 87-01266 and 88-01581; CA A64740)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 1, 1991.
Craig A. Staples, Portland, argued the cause for petitioner. With him on the brief was Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C., Portland.
No appearance for respondent John J. Alcantar.
Jay W. Beattie, Portland, argued the cause for respondent Oak Grove Foods. With him on the brief was Lindsay, Hart, Neil & Weigler, Portland.
Daryll E. Klein, Milwaukie, waived appearance for respondents United Foods, Inc., and United States Fidelity & Guaranty Company.
Before Richardson, Presiding Judge, and Joseph, Chief Judge,* and Deits, Judge.
RICHARDSON, P.J.
Reversed and remanded for reconsideration.
*Joseph, C.J., vice Newman, J., deceased.

Petitioner seeks review of the Workers' Compensation Board order holding that petitioner is responsible for claimant's back condition from November, 1986, until October 23, 1987.[1] It argues that the Board erred by holding that it had waived its right to assert a "causation defense" by contesting responsibility only. We reverse.

Claimant injured his back in 1982, while employed by petitioner as a mushroom picker. Petitioner was self-insured for workers' compensation and accepted the claim, which was closed as nondisabling. Subsequently, the business changed owners three times.[2] Claimant again developed back problems associated with his work in 1986 when Oak Grove Foods (Oak Grove) was the employer. He filed an aggravation claim with petitioner, which denied the claim:

> "Information in our files indicates to us that your current condition is a result of present work activity * * *.
>
> "Therefore, [we] must respectfully deny your claim for aggravation, as your present complaints are not a result of your July 13, 1982 claim."

Claimant later filed a new injury claim with Oak Grove and it denied both responsibility and compensability.

The referee found that petitioner was responsible, because the 1982 injury was a material contributing cause of claimant's condition. The Board concluded that the injury in 1982 was not a material contributing cause of claimant's present back disability and that his work activities for Oak Grove had independently contributed to his condition.

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[1] United Foods, Inc., insured by United States Fidelity & Guaranty Company, was found to be responsible for claimant's condition after October 23, 1987. It does not challenge that ruling.

[2] Claimant, at all times relevant to this review, worked in the same place for different employers. It was owned by petitioner in 1982. In 1985, it was owned by Mushroom King, and, in 1986, it was owned by Oak Grove Foods. By October, 1987, the business had been sold to United Foods, Inc. See n 1, *supra*.

The Board granted Oak Grove's request for reconsideration and, in its first order on reconsideration, held that petitioner was barred from asserting a "causation defense," because it had acquiesced in an order designating a paying agent under ORS 656.307. The Board concluded that petitioner, not Oak Grove, was responsible for claimant's disability. It later granted petitioner's motion for reconsideration. It agreed that there had been no order under ORS 656.307, but held that petitioner had "waived its compensability defense of causal connection because it did not raise [it]." It affirmed the first order on reconsideration, as modified, that petitioner was responsible.

The Board's rationale appears to be that a causal connection between a previously accepted claim and a present condition relates only to whether a claim is compensable. A claim is compensable if the injury arises out of and in the course of claimant's employment. However, even if a condition is compensable, there can still be questions of causation to sort out as to which employer or insurer is responsible. We agree with petitioner's argument:

> "The Board's determination that [petitioner] waived its causation defense stemmed solely from its belief that causation may be argued only in the context of a compensability denial. The Board is wrong; a responsibility denial may also be defended on the basis of causation."

A concession of compensability only admits that a claimant's condition resulted from a work exposure. It does not operate to waive an employer's right to argue that the disability is not related to a work exposure in its employment. The Board erred by foreclosing the issue of causation.

Oak Grove argues that, even if it was not waived, the defense was in fact litigated and the referee and the Board found that there was a causal connection between claimant's condition and the 1982 injury. Although the Board may have made that determination, it is difficult to tell whether it was made on the facts or on the rationale that petitioner was foreclosed from contesting it. The Board's error of law infected its findings of fact and its conclusion.

Reversed and remanded for reconsideration.

Cite as 112 Or App 396 (1992) April 22, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of George A. Viltrakis, Claimant.

BOEING COMPANY and AETNA CASUALTY COMPANY, Petitioners,
v.
GEORGE A. **VILTRAKIS**, Respondent.
(89-24484; CA A70217)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 18, 1992.
Jeremy L. Fellows, Portland, argued the cause for petitioners. With him on the brief was Scheminske & Lyons, Portland.
Floyd H. Shebley, Portland, argued the cause for respondent. With him on the brief was Westmoreland & Shebley, Portland.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
BUTTLER, P.J.
Affirmed.

Employer seeks review of an order of the Workers' Compensation Board holding that claimant is entitled to treatment for the effects of stress allegedly caused by a compensable injury. We conclude that the Board applied the correct legal analysis and that its finding that the need for treatment is related to claimant's compensable injury and is, therefore, compensable is supported by substantial evidence.

Claimant injured his knee while working for employer, which accepted the claim and paid benefits for temporary disability and permanent partial disability. Claimant's doctor permanently restricted him from working more than 8 hours per day, 5 days per week. Later, claimant filed a claim seeking benefits for treatment of the effects of stress allegedly caused by his fear that he would be laid off because of his inability to work overtime because of the knee injury. Employer denied the claim; the referee upheld the denial, but the Board reversed.

Noting that claimant is seeking only medical benefits allegedly related to his compensable injury, the Board reasoned that he is not subject to ORS 656.802(2)[1] for establishing the compensability of a mental disorder, but needs only to prove that his need for treatment is a natural consequence of the injury. *Williams v. Gates, McDonald & Co.*, 300 Or 278, 281, 709 P2d 712 (1985). The Board held that claimant met that burden.

Employer first contends that the Board erroneously characterized the claim as something other than a claim for a mental disorder under ORS 656.802. On his Form 801, claimant indicated that he sought benefits for an occupational disease; he made the same notation on his specification of issues for hearing. The Board noted correctly, however, that claimant did not seek to establish at the hearing or before the Board that his condition that results from stress is independently compensable as an occupational disease; neither does he seek to establish that he has a mental disorder. He seeks only medical services for the effects of stress that he alleges are a consequence of the original compensable injury. We agree with the Board that his claim is properly characterized as one for benefits for the "natural consequences" of a compensable injury, rather than as an independent claim for an occupational disease.

Employer also contends that the claim is barred, because it was not brought within the time allowed by ORS 656.807(1). In view of our holding that the claim is not for an occupational disease brought pursuant to ORS 656.802, the contention is without merit.

Finally, employer contends that, whether or not the claim is for an occupational disease or for the consequences of a compensable injury, the standards of ORS 656.802(2) are applicable and require that claimant show by clear and convincing evidence that he suffers from a mental disorder, the major contributing cause of which is his employment. ORS 656.802(2) states:

> "(2) *Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter*:
>
> "(a) Unless the employment conditions producing the mental disorder exist in a real and objective sense.
>
> "* * * * *
>
> "(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." (Emphasis supplied.)

Employer focuses on the emphasized language as support for its conclusion that the provisions of ORS 656.802(2) apply any time that a person seeks compensation for the effects of work-related stress. We held in *American Nursing v. Yost*, 108 Or App 243, 815 P2d 708 (1991), and *Nordstrom, Inc. v. Gaul*, 108 Or App 237, 815 P2d 710 (1991), that, when a claimant merely seeks to recover benefits for the consequences of a compensable injury, but does not seek to establish independently the compensability of a mental disorder, the provisions of ORS 656.802 do not apply. *See Jeld-Wen, Inc. v. Page*, 73 Or App 136, 398 P2d 61 (1985); *Grace v. SAIF*, 76 Or App 511, 709 P2d 1146 (1985). If the condition is compensable, it is because it is related to the compensable injury, not because it is independently work-connected. The compensable injury provides the necessary work connection. To establish entitlement to benefits for treatment of symptoms of stress that were brought about by a compensable injury, a

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[1] ORS 656.802(2) was renumbered ORS 656.802(3) in 1990. Or Laws 1990, ch 2, 43.

claimant need only show that the compensable injury is a material contributing cause of the condition requiring treatment.[2]

There is substantial evidence to support the Board's determination that claimant's compensable injury is a material contributing cause of his need for treatment of the effects of stress.

Affirmed.

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[2] We note that ORS 656.005(7)(a)(A) was enacted in 1990:

"(A) No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition." Or Laws 1990, ch 2, 3.

It is not applicable here, because the hearing was convened before July 1, 1990. Or Laws 1990, ch 2, 54(2).

Cite as 112 Or App 419 (1992) April 22, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Complying Status of Joseph C. Nelander, dba NCE Potlatch Builders.

JOSEPH C. **NELANDER**, dba NCE Potlatch Builders, Petitioner,
v.
DEPARTMENT OF INSURANCE AND FINANCE and TOBY ROSSMAN, Respondents.
(90-18102, 91-00752; CA A70707)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 12, 1992.
Alison K. Greene, Portland, argued the cause for petitioner. On the brief were Montgomery W. Cobb and Tooze Shenker Holloway & Duden, Portland.
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.
No appearance for respondent Toby Rossman.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
BUTTLER, P.J.
Affirmed.

Employer seeks review of an order of the Department of Insurance and Finance (DIF) holding that it is a noncomplying employer.

The facts are undisputed. Employer is a construction contractor that, before August, 1990, was located in Washington. It subcontracted for Allweather Construction Co. (Allweather) to do roofing on an apartment complex in Wilsonville, Oregon. The work was in the normal course of employer's business. Rossman was employed by Allweather and sustained a compensable injury while working on the apartment complex. Allweather had no workers' compensation insurance. Employer had workers' compensation insurance coverage in Washington, but not in Oregon.

The department determined that employer was noncomplying and issued an order of noncompliance. Employer argues that, despite the fact that it had no workers' compensation insurance coverage in Oregon, it is not a noncomplying employer, because it had no employees in Oregon and, therefore, under ORS 656.052, it is not a subject employer. ORS 656.052 provides, in part:

"(1) No person shall engage as a subject employer unless and until the person has provided coverage pursuant to ORS 656.017 for subject workers the person employs.

"(2) Whenever the director has reason to believe that any person has violated subsection (1) of this section, the director shall serve upon the person a proposed order declaring the person to be a noncomplying employer and containing the amount, if any, of civil penalty to be assessed pursuant to ORS 656.735(1)."

Although employer does not come within that statute, because he did not employ any subject workers, that statute does not provide the only basis on which an employer may be determined to be noncomplying. DIF held that employer must be treated as noncomplying under the provisions of ORS 656.029(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 an individual who performs labor under the contract incurs a compensable injury and no workers' compensation insurance is provided 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."

That section imposes the responsibility for providing workers' compensation coverage on the person who awards a contract involving the performance of labor, unless the individual providing the labor under the contract provides such coverage before the contract commences. If the person responsible for providing coverage does not do so, that person is treated as a noncomplying employer.

Because Allweather did not provide coverage for Rossman before the contract commenced, employer was the person responsible for providing coverage and, because it did not do so, it must be treated as a noncomplying employer. Contrary to employer's contention, we will not read into ORS 656.029 the requirement that the entity that awards the contract be an employer subject to ORS Chapter 656.[1]

We do not address employer's contentions concerning the applicability of the penalty provisions of ORS 656.052 and ORS 656.735, because the order does not impose a penalty. That issue is not before us.

Affirmed.

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[1] Before the statute was amended in 1985, it provided, in part:

"(1) If any person engaged in a business and subject to this chapter as an employer lets a contract involving the performance of labor and such labor is performed by the person to whom the contract was let, with assistance of others, all persons engaged in the performance of the contract are deemed subject workers of the person letting the contract."

Cite as 112 Or App 423 (1992) April 22, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Kenneth G. Riley, Claimant.

KENNETH G. **RILEY**, Petitioner,
v.
INMATE INJURY FUND and OREGON STATE PENITENTIARY, Respondents.
(90-08078; CA A70657)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 12, 1992.
Donald E. Beer, Portland, argued the cause for petitioner. With him on the brief was Popick & Merkel, Portland.
Julie K. Bolt, Special Assistant Attorney General, Salem, argued the cause for respondents. With her on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
BUTTLER, P.J.
Reversed and remanded with instructions to pay claim for medical expenses.

Claimant, an injured prison inmate, seeks review of an order of the Workers' Compensation Board holding that he is not entitled to payment of medical expenses from the Inmate Injury Fund (Fund) related to his compensable injury while he was on temporary leave from the Oregon State Penitentiary (OSP). We conclude that Fund's policy not to pay such claims conflicts with the controlling statute and reverse.

On May 26, 1987, claimant injured his back and neck in a motor vehicle accident while working as an inmate at OSP. He received immediate medical attention. On June 1, the Corrections Division (Division) released him on temporary leave:

> "You are granted a conditional release by the Oregon State Corrections Division. This release is granted with the understanding that you will conduct yourself at all times in a law-abiding manner. You will adhere to the conditions of your release."

On June 15, claimant checked into Holladay Park Medical Center, where a doctor examined and treated him. His temporary leave expired on July 1, and he returned to OSP.

In July, 1988, claimant requested payment from Fund for several medical bills related to claimant's May, 1987, injury. Fund accepted the injury claim, but it refused to pay the medical bills, because they were incurred while claimant was on temporary leave.

Under ORS 656.515, if an inmate sustains an injury in the course of authorized employment,

> "benefits shall be paid in the same manner as provided for injured workers under the workers' compensation laws of this state, except that:
>
> "(1) No benefits, except rehabilitation services, shall accrue to the inmate until the date of release from confinement and shall be based upon the condition of the inmate at that time."

An inmate's claim is filed with the Department of Justice (Department) pursuant to ORS 655.520, which provides that the claim is to be filed

> "in the manner provided for workers' claims in ORS 656.001 to 656.794, to the extent not inconsistent with ORS 655.505 to 655.550. Such claims shall be filed within the required periods after the injury *even though actual benefits may not accrue until release of the inmate from confinement*. * * *

"(2) When a claim is approved, [Department] shall make an initial award conditioned as provided in ORS 655.515(1). Upon release of the inmate from confinement, [Department] shall reaffirm or modify its initial award in a manner appropriate to the condition of the inmate upon release."

Benefits to inmates are paid out of Fund, administered by Department. ORS 655.540.

Department has no rules implementing the procedures for administering claims of injured inmates. It has a Policy Manual, however, that provides, in part:

"*Medical Benefits*

"Once a claim has been accepted, the Inmate Injury Fund may be responsible for a *released* inmate's necessary medical care directly related to the injury condition for the length of the inmate's life." (Emphasis supplied.)

It is clear from that and other portions of the Policy Manual that Fund believes that its obligation to pay benefits of any kind, including medical benefits, does not begin until the inmate is released from custody. Until that time, Fund contends, an inmate's medical expenses are paid by Division pursuant to its general obligation under ORS 423.020(1)(d) to provide for an inmate's medical care. Fund contends that when claimant was on temporary leave, he was not "released" as that term is used in ORS 655.515 and, accordingly, he was not entitled to reimbursement from Fund for his medical expenses. According to Fund, an inmate who is on temporary leave when he needs medical attention for a compensable injury must return to OSP to obtain it.

We need not decide whether claimant was "released from confinement" so as to be entitled to benefits for medical expenses under Fund's interpretation of ORS 656.515, because we conclude that release from confinement is not a condition for payment of medical expenses. ORS 656.515(1) states that "no benefits * * * shall accrue to the inmate until the date of release from confinement and shall be based upon the condition of the inmate" at the time of release. There are two reasons why we conclude that that subsection deals only with disability benefits, not with medical benefits. Medical expenses are not among the benefits that would ordinarily accrue and be paid *to the inmate*; they are paid directly to the provider. Furthermore, unlike benefits for disability, which are measured as of a particular time, medical expenses are paid for life for any services necessitated by the compensable injury. They are not, as Fund's interpretation would require, limited to services based on the condition of the inmate at the time of release. We conclude, therefore, that ORS 655.515(1) is intended to set apart and exclude from payment to injured inmates only disability benefits and not benefits for medical expenses.

As the Supreme Court said in *Johnson v. SAIF*, 267 Or 299, 516 P2d 1289 (1973):

"[L]ooking at the statutory scheme as a whole, it seems apparent that the legislature intended to incorporate into the statutes dealing with inmates * * * all of the procedural and remedial rights extended an injured workmen, with certain reservations *necessitated by the unique position of the inmate* * * *." (Emphasis supplied.)

That is the rationale for the distinctions in the payment of benefits to injured inmates, and it is one that is readily understood in its application. For example, a postponed accrual of disability benefits to an injured inmate is justified by the unique circumstances of confinement, because they relate to the possession of money. There is no comparable justification for the exclusion from Fund's coverage of medical services necessitated by a work-related injury, because payment for those services is made directly to the provider. The fact that Division provides for an inmate's general medical care while in custody pursuant to ORS 423.020(1)(d) is not determinative. Claimant's entitlement to benefits arises, not under that statute, but under the more specific provisions of ORS chapters 655 and 656, relating to inmates injured in the course of authorized employment. Those provisions control and require the payment of

claimant's medical expenses incurred while he was on temporary leave.[1]

Reversed and remanded with instructions to pay claim for medical expenses.

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[1] No party suggests that claimant might not be entitled to medical benefits because he violated the provision of OAR 291-116-030 that required him to return to OSP for medical treatment.

Cite as 112 Or App 441 (1992) April 22, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Trudy G. Langston, Claimant.

SAIF CORPORATION and BLUE CROSS OF OREGON, Petitioners,
v.
TRUDY G. **LANGSTON**, Respondent.
(89-22732; CA A68993)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 17, 1991.
David L. Runner, Assistant Attorney General, Salem, argued the cause for petitioners. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
W. Todd Westmoreland, Portland, argued the cause for respondent. With him on the brief was Westmoreland & Shebley, P.C., Portland.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
BUTTLER, P.J.
Reversed and remanded for reconsideration.

Employer seeks review of an order of the Workers' Compensation Board holding that claimant's dermatitis and respiratory conditions are compensable.

Claimant worked as a claims analyst for employer, beginning in September, 1985. In 1986, she was promoted to senior claims analyst, and her work area was moved to a place under an air vent. She found her new work stressful. Shortly after assuming that position, she noticed an acne-like rash developing on her face. It would worsen during the week within hours after her arrival at work and improve on weekends when she was home. She had experienced a similar, but less severe, rash a few years earlier during a stressful divorce, and the rash had resolved when the divorce became final.

In the spring of 1987, claimant also began to experience respiratory congestion and tightness that was worse than her annual seasonal allergy symptoms. All of her symptoms worsened in 1988, and she began to suspect that her employment was the cause. In November, 1988, she sought treatment from Dr. Green, a specialist in allergies and environmental medicine. Green noticed a correlation between claimant's symptoms and her work schedule and, in January, 1989, expressed the opinion that something in her work environment was causing the symptoms. He suggested a number of possible irritants, including mold, cigarette smoke, formaldehyde and fiberglass particles from insulation in the ventilation system.

An industrial hygienist from the Occupational Safety and Health Administration tested the air quality of claimant's work place, and the test results showed that none of the irritants suggested by Green was present in excessive quantities. There was no pattern of complaints by employees concerning air quality. Tests of claimant showed no sensitivity to formaldehyde or fiberglass. Nonetheless, Green continued to be of the view that some "unidentified factor" in claimant's work environment was the cause of her symptoms. On his recommendation, claimant left work on September 18, 1989. Drs. Morton and Baker concurred in Green's view that claimant's conditions are related to her employment. Dr. Bell, a dermatologist, suggested that stress might be the cause of the rash. Both he and Dr. Haberman were of the view that claimant suffers from acne rosacea and that that condition is not caused

by the environment, but is idiopathic. Green noted in February, 1990, that vehicle exhaust irritated claimant's respiratory tract.

SAIF denied claimant's occupational disease claim in October, 1989. The Board analyzed the claim under ORS 656.802(1)(a), which provides coverage for occupational diseases involving "ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gasses, radiation or other conditions or substances." It concluded that claimant had established that her exposure to unknown environmental conditions in the work place was the major contributing cause of her respiratory and dermatological conditions. Of greatest significance to the Board was the fact that the onset, waxing and waning and resolution of claimant's condition correlated directly with her work schedule.

The Board did not conclude that the claim failed because the specific cause of the condition had not been identified. It discounted medical opinions that the condition was not related to her work, partly because they failed to explain the correlation between her work schedule and her symptoms. Instead, the Board accepted the opinion of Green, who did not believe that claimant's skin condition was acne. He had considered and ruled out a number of other potential non-workplace causes and, because of the nature of her symptoms and the correlation between the work schedule and her symptoms, concluded that the conditions were work-related. Green was claimant's treating doctor and, considering that factor as well as what it considered to be the overall persuasiveness of his opinion, the Board concluded that the claim is compensable.

Employer contends that, in view of ORS 656.266, the Board erred as a matter of law. That section provides:

> "The burden of proving that an injury or occupational disease is compensable and of proving the nature and extent of any disability resulting therefrom is upon the worker. *The worker cannot carry the burden of proving that an injury or occupational disease is compensable merely by disproving other possible explanations of how the injury or disease occurred.*" (Emphasis supplied.)

The Board did not cite that statute, and it is not apparent that the Board considered it. We agree with SAIF that, under these facts, it is necessary for the Board to consider its application to this case.

Reversed and remanded for reconsideration.

Cite as 112 Or App 446 (1992) April 22, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Elena Meda, Claimant.

ELENA **MEDA**, Petitioner,
v.
SAIF CORPORATION and SLUSARENKO ORCHARDS, Respondents.
(89-22035; CA A69538)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 17, 1991.
Dennis O'Malley, Portland, argued the cause and filed the brief for petitioner.
Michael O. Whitty, Special 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 for reconsideration.

Claimant seeks review of an order of the Workers' Compensation Board affirming the referee's determination that she did not meet her burden to prove that the injuries that she sustained to her left heel and rib occurred on the job.

The Board adopted and affirmed the order of the referee. A section of the order captioned "Findings" contains a discussion of the evidence and findings. In support of her claim, claimant offered her own testimony and that of her son and daughter. Claimant testified that she went to work at about 7 a.m. on the morning of August 28, 1989, picked approximately one-half bag of apples and, at about 7:30 a.m, fell off a ladder while picking. She testified that she fell on her left side and injured her rib area and left heel.

The Board found that claimant's son, who also worked for employer, was the only other worker in the area of the tree from which claimant says that she fell. The Board also found that, as claimant and her son left the orchard at about 7:30 a.m., they passed the owner of employer, and the son advised him that claimant had sprained her ankle, that he was taking her home and that he would return to work. The Board found that, after that conversation, the owner went to the tree where claimant claimed to have been picking but found no apples on the ground or in a bin. It found that he was a credible witness.

The Board found that claimant went to the emergency room at approximately 11 a.m., where she was examined by Dr. Jacobs, who diagnosed a left heel fracture and a left cracked rib. He detected a strong odor of alcohol and took a blood test that showed claimant's blood alcohol level to be .217. He noticed marked bruising and swelling of claimant's left foot.

The Board purported to distinguish between legal and medical causation and found that claimant had not met her burden of proof with respect to either. It stated that there was nothing about the testimony of the owner or claimant's son or daughter that led it to question their credibility. It questioned the "reliability" of claimant's testimony, however, noting that her memory was not sharp and that she was sometimes vague. In particular, the Board was not convinced by her testimony that her foot had been injured as she described. Additionally, it found that claimant drinks heavily and commented that she had had a distinct odor of alcohol about her at the referee's hearing. The Board also commented:

> "While there is no evidence that she did injure herself away from work in an alcohol-related accident, it is certainly a viable possibility, particularly since her blood alcohol was measured at .217 approximately three and one-half hours after this accident."

The Board noted the discrepancy between claimant's and the owner's evidence concerning whether apples had been picked by claimant on the day of the injury. It also pointed out that Dr. Jacobs, who examined claimant in the emergency room, reported that the extent of the swelling of her ankle suggested that the injury had occurred before claimant went to work. However, Dr. Didelius, who became her treating doctor, had examined her the same day. He noted nothing unusual about the swelling and simply stated that the injury was sustained when she fell off a ladder that day.

The Board held that claimant had not shown, by a preponderance of the evidence, that her injury had occurred on the job as she described. It held that claimant had shown, at best, "a possibility that she fell from the ladder as described and that this fall caused the injuries later diagnosed."

We conclude that the Board must explain its conclusion further. For example, it must have accepted the son's testimony that he and claimant had gone to the orchard to pick apples, had left at 7:30 a.m. and had met employer's owner on the way home. It also believed that the son told the owner about the accident, because it found that the owner went to the area where he was told the accident had happened to investigate. It should explain why it rejected the son's testimony that claimant fell while picking apples, given its finding that there was no basis to question his credibility. The discrepancy concerning whether apples had been picked in the area of the alleged fall does not appear on its face to create doubt as to the cause of the injury, particularly in the light of the fact that employer accepted the claim initially. Additionally, other than the suggestion of the emergency room doctor that the injury might have occurred before claimant went to work, there is no evidence suggesting that the injury occurred off the job or other than as claimant and her son described. The Board should explain why it rejected the only direct evidence concerning the cause of the injury.

Reversed and remanded for reconsideration.

Cite as 112 Or App 480 (1992) April 22, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Martha A. Benefiel, Claimant.

MARTHA A. **BENEFIEL**, Petitioner,
v.
WAREMART, INC., and LIBERTY NORTHWEST INSURANCE CORPORATION, Respondents.
(90-06226; CA A70262)

Judicial review from the Workers' Compensation Board.
Argued and submitted December 17, 1991.
Robert J. Miller, Sr., Beaverton, argued the cause for petitioner. With him on the brief was Moomaw, Miller & Reel, Beaverton.
M. Kathryn Olney, Portland, argued the cause and filed the brief for respondents.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
ROSSMAN, J.
Reversed and remanded for reconsideration.
Buttler, P.J., dissenting.

Claimant seeks review of an order of the Workers' Compensation Board affirming the referee's determination that her knee injury is not compensable. The evidence is undisputed that claimant fainted and fell at work while checking groceries. The Board found that claimant had failed to meet her burden of showing that the fall was work-related and was not caused solely by a condition personal to claimant. We reverse and remand.

Claimant testified that she had stayed home from work for two days because she had the flu.[1] On the day of the injury, she requested permission to take another day off to recover, but her supervisor said that he would "really appreciate it if [she] could make it in," because the store was short on employees. She testified that she went to work in a weakened state because of the flu and that her condition intensified as the day went on. She also stated that the work was hectic and stressful and that

she was working two cash registers at the same time. She described how she became nauseated and light-headed and called her supervisor, asking to be relieved.[2] The supervisor arrived and helped the customer at claimant's second register. Claimant then collapsed to the floor on her knees. The supervisor testified that he continued to help the customer at claimant's register and, when he saw that claimant was too dizzy to get up by herself, he called another employee to help her to the employees' room. After that day, claimant's right knee continued to hurt, and it eventually required surgery.

A compensable injury is "an accidental injury * * * arising out of and in the course of employment." ORS 656.005(7)(a). A work-related injury is compensable, even if it is otherwise unexplained. *See Phil A. Livesley Co. v. Russ*, 296 Or 25, 30, 672 P2d 337 (1983). However, the fact that an employee is injured on the premises during working hours does not by itself establish a compensable injury. A claimant must show a causal link between the injury and the employment. 296 Or at 29.

Both the Board and the dissent contend that claimant did not establish that her injury was work-related, because the fall was unexplained. Nothing is unexplained. Claimant, who had asked to take the day off because of illness, was summoned to work by her employer, who knew that she was ill. She went to work in a weakened physical condition and was required to perform stressful work activities. The fact that she fell at work was not merely fortuitous. There is no evidence to support the Board's finding that claimant's work did not contribute to her injury.

Reversed and remanded for reconsideration.

BUTTLER, P.J., dissenting.

Because the Board's findings are supported by the evidence and those findings support the Board's conclusion, I would affirm.

Claimant had worked for employer for about 4 years as a checker. Some days were busier than others, and the day of her injury was a busy day. Checkers were entitled to a 10-minute break after 2 hours of work; on the day in question, claimant had worked for 2 hours, had had her 10-minute break and had returned to her check stand when she became nauseated and dizzy and then fainted.

The Board made these findings:

> "Claimant, a grocery checker, stayed home from work with her ill daughter on January 7, 1990. On January 8, 1990, claimant became ill with the flu. She was also ill on January 9, 1990. Claimant returned to work on January 10, 1990.
>
> "On January 10, 1990, while working her two check stands, claim-ant became light headed, nauseated and dizzy. She called her supervisor on the intercom and asked to be relieved. The supervisor entered her work area and helped the customer waiting at claimant's second register. Claimant was in the process of taking a check from her customer when she began to faint. Claimant slid down between the two cash registers and blacked out about one foot from the floor. She fell to the floor with her weight on her knees. The supervisor called another worker to help claimant. Claimant was taken

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[1] In oral argument, counsel for employer conceded that claimant's ailment was not a complex medical condition that required expert testimony to establish it in the record. Therefore, claimant was competent to testify at the hearing about how her condition impaired her ability to perform her job. *See Uris v. Compensation Department*, 247 Or 420, 427, 427 P2d 753 (1967).

[2] Specifically, claimant testified:

> "It was really, really busy that day. I -- like I said, I ran two checkstands, and with the -- we had them lining up, and I was going as fast as I could go, and I started feeling a little nauseated, kind of lightheaded, and so I called * * * my boss at the time, on the intercom, and I said, I'm feel [*sic*] kind of nauseated, a little dizzy; can you please come get me out of the checkstand?"

to the break room, then to the bathroom where she vomited. She was then driven home. The following day, claimant's right knee hurt. The more she moved, the more it hurt.

"* * * * *

"On January 10, 1990, claimant fainted at work. When she fell, she injured her right knee.

"Claimant's fainting was not due to her work."

The Board then correctly stated that claimant has the burden of proving by a preponderance of the evidence that her fall occurred during the course of her employment and was not caused by idiopathic factors. *Phil A. Livesley Co. v. Russ*, 296 Or 25, 672 P2d 337 (1983); *McAdams v. SAIF*, 66 Or App 415, 674 P2d 80, *rev den* 296 Or 638 (1984). It said that the mere fact that she fell when she fainted at work did not establish a compensable claim, because the cause of her fainting was not explained. Claimant *argued* that her injury is compensable because she was in a weakened condition because of the flu, that her work was stressful that day and that exertion caused her to fall, but the Board did not accept that argument, because the evidence did not support it.

The Board concluded that it could not infer that she fainted as a result of a work-related but unexplained cause; therefore, the injury is not compensable. Claimant simply fainted when she went to work in a weakened condition caused by the flu.

Because I cannot say that the Board erred as a matter of law, I would affirm.

Cite as 112 Or App 485 (1992) April 22, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Ronald W. Davis, Claimant.

RONALD W. **DAVIS**, Petitioner,
v.
R & R TRUCK BROKERS, OHIO CASUALTY, ROBERT BUKER, dba Bob Buker Trucking, ROBERTS AUTOMATIC FIRE SPRINKLERS, INC., and SAIF CORPORATION, Respondents.
(83-08268, 83-07641 & 83-07640; CA A65696)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 3, 1991.
Brad G. Garber, Salem, argued the cause and filed the brief for petitioner. With him on the brief was Law Office of Michael B. Dye, Salem.
Jerry K. Brown, McMinnville, argued the cause for respondents R & R Truck Brokers and Ohio Casualty. With him on the brief was Cummins, Brown, Goodman, Fish & Peterson, P.C., McMinnville.
Ann Kelley, Assistant Attorney General, Salem, argued the cause for respondents Roberts Automatic Fire Sprinklers, Inc., and SAIF Corporation. With her on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
No appearance for Robert Buker, dba Bob Buker Trucking.
Before Richardson, Presiding Judge, and Joseph, Chief Judge,* and Deits, Judge.
DEITS, J.
Affirmed.
*Joseph, C.J., vice Newman, J., deceased.

Claimant seeks review of an order of the Workers' Compensation Board, contending that the Board erred in upholding a denial of compensability by SAIF on behalf of Bob Buker Trucking (Buker Trucking) and in concluding that claimant was acting outside the course and scope of his employment at the time that he was injured. We affirm.

Claimant was injured in June, 1983, when the truck that he was driving for Buker Trucking left the road and flipped over. Buker Trucking had arranged for claimant to drive its truck on June 14, 1983, from a roofing company in Portland to Woodinville, Washington. Robert Buker (Buker), owner of the trucking company, instructed claimant to return the truck to Buker's home in Turner, Oregon, the same day. However, claimant telephoned him from Washington and told him that he could not return that day. Claimant delivered the load in Woodinville on June 15. Although Buker had not authorized him to do it, claimant then arranged through two truck brokers, R & R Truck Brokers (R & R) and Horizon Truck Brokers (Horizon), to pick up additional loads on the way back to Oregon. R & R asked him to pick up a load at Roberts Automatic Fire Sprinklers (Roberts) in Vancouver, Washington, on June 16, for transportation to Grants Pass. R & R called Buker for approval, and Buker agreed.

Claimant was to pick up the Horizon load in Tacoma on June 16, but Buker was not asked to approve that load. Claimant did not appear at the scheduled time on the morning of June 16 to pick up the Horizon load. Horizon had wired claimant expense money, which he had picked up. Horizon immediately called Buker to find out why claimant had not picked up his load. Buker contacted R & R and asked them to tell claimant, when he contacted them, not to finish the trip but to return the truck directly to Buker's yard in Turner. Claimant did pick up the load for Roberts in Vancouver. At that time, he called R & R and was told that Buker wanted him to return immediately to Turner.

Claimant was not authorized to go further south than Turner. However, he continued on his trip to Grants Pass. He picked up his friend, Evans, in Portland, and his son and ex-wife in Turner at a place within a mile of Buker's home. Claimant did not stop there or try to contact Buker, who had another driver waiting to complete the trip to Grants Pass. Claimant and his passengers continued south on I-5 to Canyonville, where they stopped for dinner. Claimant drank a small amount of alcohol. North of Grants Pass, the truck left the road and flipped over. Evans was killed. Claimant was taken to the hospital and treated for injuries to his chest, lower left leg, face and left shoulder. He was later cited by the police for a log book violation, defective brakes and consuming alcohol within a designated period before operating a truck.

On June 28, 1983, claimant filed a report of an occupational injury or disease with the Workers' Compensation Department (WCD). The claim was forwarded to SAIF as the processing agent for Buker Trucking, because it was a non-complying employer. SAIF was instructed to deny the claim on the ground that claimant was not a subject employee of Buker Trucking. WCD also forwarded the claim to SAIF for processing on behalf of its insured, Roberts.

SAIF sent two letters to claimant, one on behalf of Buker Trucking *and* one on behalf of Roberts. Both stated:

> "We are unable to accept responsibility under this employer as you were not a subject employee * * * on the date of your injury. *Therefore, without waiving other questions of compensability, this formal denial is made.*" (Emphasis supplied.)

On the same day, SAIF, *on behalf of Roberts only*, asked WCD to issue an order pursuant to ORS 656.307. SAIF also noted that R & R and its insurer, Ohio Casualty, might be responsible for claimant's injury. The letter to WCD stated, in part:

> "[W]e feel that our insured, Wes Roberts Automatic fire Sprinklers, may not be responsible for this injury. Ohio Casualty Insurance Company, in behalf of their insured, R and R Truck Brokers, Incorporated may be legally responsible. Therefore, while compensability is not an issue, responsibility is and we request that you designate a paying agent pursuant to ORS 656.307."

SAIF then forwarded the claim to Ohio Casualty, which denied responsibility for claimant's injury by letter stating that the claim was SAIF's responsibility.

One week later, a ".307 order" was issued. It stated that compensability was not an issue, referred the matter for hearing on the responsibility issue and designated SAIF as the paying agent. The order provides, in part:

"SAIF Corporation has requested designation of a paying agent. * * * Although there is no dispute his injury is industrially related, it is unclear who his true employer was at time of injury. There are three possible employers: Bob Buker Trucking, uninsured at the time of accident. * * * The second possible employer is R & R Truck Brokers insured by Ohio Casualty. The other is Roberts Automatic Fire Sprinklers insured by SAIF * * *. All three claims have been denied for responsibility not compensability."

At the hearing, Buker, on his company's behalf, SAIF, on behalf of Roberts, and Ohio Casualty, on behalf of R & R, all denied compensability of claimant's injury. The referee concluded that SAIF was barred from denying compensability and that Buker was "bound by SAIF's actions," because he was a noncomplying employer. The Board, however, reversed the referee and held that neither Buker nor SAIF, on behalf of Buker, had conceded compensability and that they could contest it at the hearing. The Board also held that claimant had suffered a non-compensable injury, because he had acted outside the course and scope of his employment in taking the truck past Turner.

Claimant first argues that the Board erred in concluding that SAIF is not barred from litigating compensability. He argues that, by requesting designation of a paying agent pursuant to ORS 656.307 and by not denying compensability after the issuance of the .307 order, SAIF conceded compensability and, under *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027 (1983), is precluded from arguing otherwise.

We conclude that the Board did not err in reversing the referee's order and in allowing Buker and SAIF to litigate compensability. The Board said: "We do not find that either Buker or his processing agent, SAIF, accepted the compensability of claimant's claim prior to issuance of an order pursuant to ORS 656.307." It reasoned that

"[t]he contention that claimant was not a subject employee of Buker at the time of injury arguably raises an issue of compensability, not only responsibility, because it challenges claimant's entitlement to compensation. See ORS 656.005(8). Furthermore, the denial letter expressly declines to waive further questions of compensability.

"* * * * *

"Here, SAIF had never expressly conceded compensability on Buker's behalf. Hence, the .307 order was invalid, and we decline to treat it as a formal acceptance of compensability by Buker or his agent SAIF. Absent specific acceptance of the compensability of claimant's claim, *Bauman v. SAIF* * * * does not apply to preclude Buker or his agent SAIF from denying compensability."

The Board's holding is supported by substantial evidence in the record and is legally correct. In the letter that SAIF sent claimant on behalf of Buker Trucking, it specifically reserved the question of compensability. The request for the .307 order was only on behalf of Roberts. There is no evidence that SAIF ever expressly conceded compensability on behalf of Buker Trucking. Consequently, as the Board correctly concluded, the .307 order was invalid because not all the parties had agreed that the claim was compensable, as required by ORS 656.307.

Claimant argues that, even if SAIF did not concede compensability on behalf of Buker Trucking, it failed to deny compensability within 60 days, as required by ORS 656.262(6), and may not now do so. Although an employer's failure to accept or deny a claim in a timely manner may result in penalties or attorney fees, it does not result in an acceptance of a claim. An acceptance must be specific, if it is to bar an employer from denying a claim. As we said in *Richmond v. SAIF*, 85 Or App 444, 448, 737 P2d 135, *on reconsideration* 87 Or App 401, 742 P2d 677, *rev den* 304 Or 547 (1987), "failure to deny a claim within the time limitation does not preclude a subsequent denial." *See Johnson v. Spectra Physics*, 303 Or 49, 55, 733 P2d 1367 (1987).

Claimant contends that the Board erred in concluding that he went outside the course and scope of his employment by taking the truck toward Grants Pass. He contends that that conclusion is wrong, because he was never told that he was supposed to return the truck to Turner. However, the Board found that he was told to return the truck, and that finding is supported by substantial evidence. Buker

testified that he told an employee of R & R to ask claimant to return to Turner and that that person later called him back and said that he had passed the message on to claimant.

Claimant also argues that, even if the message did get through to him, his action merely constituted a violation of the employer's rules, which does not take the activity outside the course and scope of his employment. The test for determining whether an employee's activities are outside the course and scope is stated by Larson:

> "When misconduct involves a prohibited overstepping of the boundaries defining the *ultimate work* to be done by the claimant, the prohibited act is outside the course of employment. But when misconduct involves a violation of regulations or prohibitions relating to *method* of accomplishing that ultimate work, the act remains within the course of employment." 1A Larson, *Workmen's Compensation Law* 6-10, 31.00 (1990). (Emphasis in original.)

Claimant's misconduct in this case was more than a violation of a regulation or prohibition relating to the method of accomplishing his work. He was specifically told to return the truck and to stop working. Instead, he refused to do either and continued on toward Grants Pass, contrary to his job responsibilities. Claimant overstepped the boundaries of the work that he was to do for employer. There was substantial evidence to support the Board's finding that claimant's injury occurred outside the course and scope of his employment.

Affirmed.

Cite as 112 Or App 563 (1992) April 22, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Audrey J. Cameron Higgins, Claimant.

AUDREY J. CAMERON **HIGGINS**, Petitioner,
v.
SCHRAMM PLASTICS, Employer, and SAFECO INSURANCE COMPANY, Respondents.
(90-02764, 89-18529; CA A70249)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 18, 1991.
Geoffrey Wren, Portland, argued the cause for petitioner. On the brief were Douglas Swanson, Daina Upite, and Royce Swanson & Thomas, 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 Warren, Presiding Judge, and Riggs and Edmonds, Judges.
EDMONDS, J.
Affirmed.

Claimant seeks review of a Workers' Compensation Board attorney fees award. We affirm.

Claimant filed a claim for work-related chronic toxic encephalopathy. Employer denied the claim, and claimant requested a hearing. Claimant prevailed before the referee on the issue of compensability, and the referee awarded her $14,450 in attorney fees. Employer requested Board review of the referee's order. The Board affirmed the referee's compensability determination but reduced the attorney fees award for services performed at the hearing level to $7,500. For prevailing on review, claimant requested attorney fees of $9,151. The Board awarded $2,000.

Regarding the award for services at the hearing, the Board said:

> "After considering the factors set forth in OAR 438-15-010(4)[1] and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services

at *hearing* concerning the compensability issue is $7,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to this case, as represented in part by depositions taken, the length of hearing and claimant's counsel's statement of services, the complexity of the issue (toxic exposure), and the value of the interest involved." (Emphasis in original.)

The Board explained its award for services on review:

"[A]fter considering the factors set forth in OAR 438-15-010(4) and considering the time devoted to the case as represented by claim-ant's briefs, we find that a reasonable fee for claimant's counsel's services *on review* concerning the compensability issue is $2,000, to be paid by the insurer." (Emphasis in original.)

Claimant argues that "[t]he Board erred in failing to make sufficient findings from which this court can determine whether there is a reasonable basis for the Board's attorney fee awards." In setting reasonable attorney fees, the Board must consider the factors in OAR 438-15-010(4) and give an explanation for its award that is "detailed enough to inform us that it considered all of the factors and had a reasonable basis for the award." *Weyerhaeuser Co. v. Fillmore*, 98 Or App 567, 571, 779 P2d 1102, *rev den* 308 Or 608 (1989); *see also Diamond Fruit Growers v. Davies*, 103 Or App 280, 796 P2d 1248 (1990). The Board's opinion explains how it made what it determined to be a "reasonable" award under the circumstances. That explanation suffices under the rule.

Affirmed.

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[1] OAR 438-15-010(4) provides:

"In any case where a referee or the Board is required to determine a reasonable attorney fee, the following factors shall be considered:

"(a) The time devoted to the case;

"(b) The complexity of the issue(s) involved;

"(c) The value of the interest involved;

"(d) The skill of the attorneys;

"(e) The nature of the proceedings;

"(f) The benefit secured for the represented party;

"(g) The risk in a particular case that an attorney's efforts may go uncompensated;

"(h) The assertion of frivolous issues or defenses."

Cite as 113 Or App 7 (1992) May 13, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Ralph L. Witt, Claimant.

EBI INSURANCE COMPANY and BEAR CREEK ELECTRIC, Petitioners,
v.
RALPH L. **WITT**, Respondent.
(88-07709; CA A67717)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 30, 1991.
Howard R. Nielsen, Lake Oswego, argued the cause for petitioners. With him on the brief was Beers, Zimmerman, Rice, Isaacs & Nielsen, Lake Oswego.
Robert L. Chapman, Medford, argued the cause for respondent. With him on the brief was Black, Chapman & Webber, Medford.
Before Richardson, Presiding Judge, and Joseph, Chief Judge, and Deits, Judge.
JOSEPH, C.J.
Reversed and remanded for reconsideration.

Employer seeks review of an order of the Workers' Compensation Board that granted claimant temporary partial disability (TPD) benefits for time loss that extended beyond 2 years. We reverse and remand.

Claimant, an electrician, contracted a compensable asbestos-related lung disease that became disabling in June, 1984. He was temporarily totally disabled from July 24 through September 12, 1984, while he recovered from surgery for that disease. He has been at least partially disabled ever since. His lung condition has gradually deteriorated, and his overall physical capacity has gradually decreased. His treating physician has never released him for full time regular work. He worked approximately 5 hours per day from September, 1984, until December, 1987, when he again had surgery. He was unable to work at all from December 16 through December 23, 1987; then he worked part time until May, 1988, when he stopped working altogether. In October, 1988, his doctor indicated that he could perform sedentary work for short periods of time but warned that environmental factors, such as dust, odors and volatile chemicals, might aggravate his condition. A revised assessment in February, 1989, disclosed that his condition had continued to deteriorate. The examining physician explained:

> "He could do some work but would have to pace himself in terms of activity level and time per day spent working. He could work with his hands for many hours but would ambulate slowly and need a chance to rest."

Claimant has never been declared medically stationary, and a determination order has never issued.

The Board awarded compensation for 2 years of time loss after the first surgery and for all of the time loss after the second surgery through May, 1988. Employer argues that claimant is not entitled to any compensation for time loss after the second surgery, because ORS 656.212 limits benefits for a temporary partial disability to 2 years.

ORS 656.212 provides:

> "When the disability is or becomes partial only and is temporary in character, the worker shall receive for a period not exceeding two years that proportion of the payments provided for temporary total disability which the loss of earning power at any kind of work bears to the earning power existing at the time of the occurrence of the injury."

The Board reasoned that the limitation applies only to a "period" during which disability is "partial only" and continues for 2 years with no intervening period of total disability. It held that claimant's week of total disability after the December, 1987, surgery ended the preceding "period" of partial

disability; the disability *became* partial again when he went back to work part time after that surgery, which triggered a new "period" of entitlement. It said that "if the statute had intended to combine separate intervals of temporary partial disability in reaching the two year 'period,' some reference would have been made to an aggregate formula."

Employer argues that the plain language of the statute does not support the Board's interpretation that a claimant can be entitled to more than one 2-year period for the same open claim. We need not address that issue, because we conclude that the statute does not apply to this case.

In ORS 656.212, "partial only" and "temporary in character" modify the noun "disability." They do not modify "benefits," "compensation" or "payments."[1] Whether claimant's disability is "partial" and whether it is "temporary in character" are questions of fact. "[T]he adjectives 'permanent' and 'temporary' describe duration, not extent, of disability. 'Partial' and 'total' describe extent." *Gwynn v. SAIF*, 304 Or 345, 351, 745 P2d 775 (1987). The parties agree that claimant is disabled and that he is not expected ever to recover fully from being disabled. His *disability* is not "temporary in character," according to the evidence.

However, neither the referee nor the Board decided whether claimant's disability is temporary in character. They merely remarked that he "had not been found" medically stationary and that the claim had not been closed. All of the evidence in the record demonstrates that, at least since the second surgery, no one has ever expected claimant's condition to improve, only to deteriorate. Even employer concedes that "[n]obody disagrees this guy has permanent impairment." There is no evidence in the record that would support a finding that, after the second surgery, claimant was ever expected to become less disabled or recover from his disease and regain his normal physical capacity. The record does not support a conclusion that claimant's disability is "temporary in character." ORS 656.212 does not apply.

Reversed and remanded for reconsideration.

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[1] Employer quotes OAR 436-60-030(4)(c), although it makes no particular argument about it:

"Temporary partial disability compensation paid under section (3) shall continue until:

"(a) The attending physician verifies that the worker cannot continue working and is again temporarily totally disabled; or

"(b) The compensation is terminated by order of the Department or by claim closure by the insurer pursuant to ORS 656.268; or

"(c) The compensation has been paid for two years."

Cite as 113 Or App 26 (1992) May 13, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Petition of CINDY LOU **PEASE**, dba EVANS FARMS, Petitioner,
v.
The Filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE**, Respondent below,
and SAIF CORPORATION, Respondent.
(91-01-014; CA A69128)

Judicial Review from Department of Insurance and Finance.
Argued and submitted January 24, 1992.
J. Michael Alexander, Salem, argued the cause for petitioner. With him on the brief was Burt, Swanson, Lathen, Alexander & McCann, Salem.
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 Buttler, Presiding Judge, and Deits and De Muniz, Judges.
BUTTLER, P.J.
Affirmed.

SAIF, the workers' compensation insurer for Cindy Lou Pease (petitioner), conducted premium audits of petitioner's account for 1988 and 1989. It sent final premium audit billings for both years, assessing additional premiums in excess of $30,000. The billings were received by petitioner on July 7, 1990. Petitioner filed an appeal with the Insurance Division of the Department of Insurance and Finance (Division) on September 10, 1990. Division dismissed the appeal as untimely, and petitioner seeks review.

ORS 737.505(4) provides:

> "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."

Petitioner concedes that that statutory provision controls in this case and that its appeal to Division was filed more than 60 days after the date it received the billing. Petitioner's only contention is that the 60-day limitation set out in the statute is not "jurisdictional" but is "akin to those applicable to pleading responses and is thus subject to appropriate accommodation."

Petitioner cites by analogy sections of the Uniform Model Rules of Procedure under the Administrative Procedures Act. OAR 137-03-075(1) provides that, when an agency has given a party an opportunity to request a hearing and the party fails to do so within a specified time, the agency may enter an order of default. The rule treats an untimely request for hearing much as ORCP treats a failure to answer in a civil case and provides for relief from default by a showing of mistake, inadvertence, surprise or excusable neglect. See OAR 137-03-075(7)(a). Petitioner contends that the same rule should apply here and that, "[a]bsent an intent to treat the mailing of a final premium audit billing as something other than an initial agency determination, and absent any indication of a jurisdictional prerequisite for timely appeal, it would seem clear that no such jurisdictional effect was intended."

The problem with petitioner's analogy is that the circumstances are not analogous. The 60-day period is not an *agency* imposed limitation; it is statutory. ORS 737.318 provides for an appeal from a final billing audit, and ORS 737.505(4) says that the appeal *must* be made within 60 days after receipt of the billing. Also, unlike in other contexts, the legislature has not chosen to provide a way around the limitation for those who were unable to meet it for some reason. *See, e.g.*, ORS 656.319(1)(b). We conclude that, whether or not the limitation is characterized as "jurisdictional," Division properly dismissed the appeal as untimely.

Affirmed.

Cite as 113 Or App 74 (1992) May 13, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Heriberto Valencia, Claimant.

HERIBERTO **VALENCIA**, Petitioner,
v.
BAILEY NURSERIES and ST. PAUL FIRE/MARINE, Respondents.
(WCB 90-08942; CA A70324)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 18, 1991.
Stanley Fields, Salem, argued the cause for petitioner. On the brief were Michael B. Dye and Brad G. Garber, Salem.
Robert R. Trethewy, Salem, argued the cause for respondents. With him on the brief was Garrett, Seideman, Hemann, Robertson, Paulus, Jennings & Comstock, Salem.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
RIGGS, J.
Reversed and remanded for determination of entitlement to attorney fees.

Claimant seeks review of an order of the Workers' Compensation Board denying his request for attorney fees. ORS 656.298. We reverse and remand.

The Board adopted the order of the referee, including these findings made on the basis of stipulated facts submitted by the parties:

> "On March 26, 1990, St. Paul issued a denial of chiropractic services for a previously accepted and closed 1988 knee injury.
>
> "Claimant requested a hearing to challenge that denial on April 24, 1990.
>
> "On May 7, 1990, the Oregon Legislative Assembly met in emergency session and significantly modified the Oregon workers' compensation law, including greater control and qualified closure over chiropractic services.
>
> "Before this scheduled hearing, St. Paul rescinded the denial of chiropractic services.
>
> "St. Paul concedes that had there not been a Request for Hearing, it would likely have allowed the denial to become final.
>
> "Claimant concedes, however, that had the legislature not changed the law relating to chiropractic care, St. Paul would not have rescinded its denial, and would have pursued its remedy for control and qualified closure of chiropractic services through the hearing process.
>
> "In a hearing, the claims examiner for St. Paul would testify that the denial was rescinded because the object of the denial (control of chiropractic services), was achieved by the coincident yet independent action of the legislature. Denial and litigation would have been a vacant and redundant exercise." (Citations omitted.)

Relying on *Jones v. OSCI*, 107 Or App 78, 810 P2d 1318 (1991), the referee concluded, and the Board agreed, that an award of attorney fees was not appropriate, because the denial had been rescinded before a hearing. After the Board's order was issued on June 10, 1991, the Governor signed into law Senate Bill 540, which amended ORS 656.386(1) to allow attorney fees if "an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held." Or Laws 1991, ch 312, 1. We allowed reconsideration in *Jones v. OSCI, supra*, withdrew our opinion and reversed and remanded to the Board for an award of attorney fees. 108 Or App 230, 814 P2d 558 (1991). In the

light of our opinion on reconsideration in *Jones* and the 1991 amendments to ORS 656.382(1), we reverse and remand this case to the Board for determination of entitlement to attorney fees.

Reversed and remanded for determination of entitlement to attorney fees.

Cite as 113 Or App 93 (1992) May 13, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Leo G. Campbell, Claimant.

SAIF CORPORATION and ST. VINCENT de PAUL, Petitioners,
v.
LEO G. **CAMPBELL**, Respondent.
(WCB 89-18636; CA A69988)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 13, 1992.
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.
Michael A. Gilbertson, Portland, argued the cause for respondent. With him on the brief was Hollis C. Ransom, Portland.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
EDMONDS, J.
Affirmed.

Employer seeks review of a Workers' Compensation Board order that held claimant's mental disorder claim compensable under ORS 656.801(1)(b).[1] The Board held that the stressful conditions that caused claimant's illness were the result of conditions other than those generally inherent in every working situation. ORS 656.802(2)(b).[2] We affirm.

The Board found:

> "Claimant suffered a bipolar manic depressive psychotic episode, the cause or worsening of which arose out of and in the course of his employment at St. Vincent de Paul. That diagnosed mental disorder is generally recognized in the medical community and it required medical treatment and resulted in disability.
>
> "Employment conditions which existed in a real and objective sense and which contributed to claimant's mental disorder included harassment and badgering by severely mentally handicapped workers because claimant did not bring in business

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[1] We cite the statute as amended in 1987. Or Laws 1987, ch 713, 4. It provided, in part:

"(1) As used in this chapter, 'occupational disease' means:

"* * * * *

"(b) Any mental disorder arising out of and in the course of employment and which requires medical services or results in physical or mental disability or death."

The statute was again amended in 1990. Or Laws 1990, ch 2, 43.

[2] 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 * * *."

That subsection was renumbered (3) by the 1990 revision. Or Laws 1990, ch 2, 43.

accounts which provided them paid work, the lack of a job description for a new job to which claimant was promoted, pressure to increase sales, inability to take time off work in May 1989, and responsibilities at the [Portland Rose Festival Indianapolis car] races in June 1989.

"The conditions which resulted in claimant's disabling mental disorder were not conditions generally inherent in every working situation. Conditions which were not disciplinary, corrective or job performance evaluation actions and which were not associated with the cessation of employment, materially contributed to claimant's mental disorder."

It then held that the legislature has delegated to it the responsibility for evaluating the evidence concerning the working conditions experienced by a particular worker in the light of its expertise, without the need for evidence regarding working conditions generally. Accordingly, it concluded:

"The record supplies detailed evidence about the conditions of claimant's work. We are persuaded that those conditions are not common to all jobs. All occupations do not usually involve working with demanding mentally retarded persons. All jobs do not usually require the worker to take responsibility for the total sales of an organization or require the worker to greatly increase productivity within a short period of time. All jobs do not usually preclude the taking of time off during stressful periods."

Employer argues that the Board erroneously supplied evidence by "going outside the record" to determine what work conditions are generally inherent in every working situation. It also argues that the Board erred when it concluded that the stressful conditions of claimant's work were not usually present in all jobs or occupations without evidence in the record to support that conclusion.

When the legislature enacted ORS 656.802(2)(b), it set out a legal standard against which the facts of each case must be measured. Although evidence can show whether particular conduct in fact fails the legal standard, the standard itself is not established by evidence. *Ross v. Springfield School Dist. No. 19*, 300 Or 507, 516, 716 P2d 724 (1986). Under the statute, the Board is authorized to develop the standard, that is, what "conditions [are] generally inherent in every working situation," either by formal rulemaking or on a case-by-case basis. *Trebesch v. Employment Division*, 300 Or 264, 710 P2d 136 (1985).

The Board has chosen to refine the legal standard announced in ORS 656.802(2)(b) on a case-by-case basis. *See Housing Authority of Portland v. Zimmerly*, 108 Or App 596, 816 P2d 1179 (1991). When it concluded that all working situations do not involve the conditions that caused claimant's mental disorder, it did not supply evidence, but simply further developed the standard set out in ORS 656.802(2)(b). That is all that it had to do.[3] Accordingly, we affirm.

Affirmed.

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[3] In the light of our conclusion that "conditions generally inherent in every working condition" are not a matter of evidence, we need not address the alternative argument relating to official notice. We also note that employer has not argued that the Board's interpretation of the statute is inconsistent with the legislature's intent, *see Springfield Education Assn. v. School Dist.*, 290 Or 217, 621 P2d 547 (1980), or that it inadequately explained why claimant's working conditions are not common to all employments. *See Housing Authority of Portland v. Zimmerly, supra*, 108 Or App at 598.

Cite as 113 Or App 152 (1992) May 13, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Dannie W. Crawley, Claimant.

SAIF CORPORATION, Petitioner,
v.
DANNIE W. **CRAWLEY**, Respondent.
(WCB 91-0127M; CA A69288)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 13, 1992.
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 by respondent.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
PER CURIAM
Judicial review dismissed.

State Accident Insurance Fund (SAIF) seeks review of a Workers' Compensation Board order denying its request to reopen claimant's claim. We dismiss the petition for review.

After claimant's aggravation rights expired, SAIF voluntarily paid claimant temporary total disability benefits from February, 1987, through May, 1990. It then asked the Board to reopen the claim to determine whether the compensation that it had voluntarily paid was payable under the Board's own motion jurisdiction. ORS 656.278.[1] The purpose of that request was to obtain an order issued pursuant to ORS 656.278 that would entitle SAIF to seek reimbursement from the Reopened Claims Reserve. ORS 656.625; OAR 436-45-010. The Board issued an order denying SAIF's request to reopen and for authorization for reimbursement.

ORS 656.278(3)[2] provides that an employer may seek review of an own motion order that increases the claimant's award of compensation. *International Paper Co. v. Wright*, 80 Or App 444, 447, 722 P2d 57 (1986). Because the Board's denial of SAIF's request neither increased nor decreased claimant's award, we cannot review SAIF's petition.

Judicial review dismissed.

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[1] SAIF characterizes the Board's order as an "Order on Reconsideration Denying Reimbursement." Because it is apparent that SAIF was seeking an order under ORS 656.278, we reject that characterization.

[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."

Cite as 113 Or App 173 (1992) May 20, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of James McCormac, Claimant.

JAMES **McCORMAC**, Petitioner,
v.
COTTAGE CRAFTS and SAIF CORPORATION, Respondents.
(89-17548; CA A68588)

Judicial Review from Workers' Compensation Board.
Submitted on record and briefs October 18, 1991.
Charles G. Duncan, Eugene, filed the brief for petitioner.
Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and David L. Runner, Assistant Attorney General, Salem, filed the brief for respondents.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
BUTTLER, P.J.
Affirmed.
Rossman, J., dissenting.

Claimant seeks review of an order of the Workers' Compensation Board dismissing his appeal of the referee's order for lack of jurisdiction. The appeal was correctly dismissed, and we affirm.

Claimant filed a claim for benefits for a heart attack. Employer denied the claim, and claimant requested a hearing. On the day set for the hearing, an hour before the scheduled time, claimant's attorney appeared before the referee and sought a postponement on the ground that claimant was in the hospital for treatment of his heart condition and would not be able to appear at the hearing. Employer's attorney objected to a postponement but offered to let claimant's attorney proceed without claimant or to let claimant present his testimony in writing and waive cross-examination. Claimant's attorney declined the offers.

The next day, the referee issued an order dismissing the claim with prejudice, because of claimant's failure to appear. The order also provided:

> "Claimant may submit, within thirty days of the date of entry of this order, an affidavit setting forth good cause for his failure to appear, including documentary medical evidence of his incapacity, and requesting that the dismissal be rescinded and the case rescheduled."

It also stated:

> "If you are dissatisfied with this order you may, within thirty (30) days after the mailing date * * * request a review by the Workers' Compensation Board."

Twenty-one days later, claimant filed a motion to set aside the order of dismissal, with attached documents. The motion did not come to the referee's attention until the 34th day after issuance of the order. On the 43rd day after issuance of the order of dismissal, the referee issued a second order, holding that she did not have jurisdiction over the motion to set aside the order of dismissal, because that order had become final under ORS 656.289(3) 30 days after it was mailed to the parties. On the 47th day after the mailing of the order of dismissal, claimant filed an appeal to the Board, which dismissed the appeal for lack of jurisdiction.

Claimant contends that the referee's order of dismissal was issued contingent on the passage of 30 days or the filing of a motion to set aside the dismissal, whichever came first, or, in the alternative, that the appeal time did not begin to run until 30 days after the mailing of the order. ORS 656.289(3) provides that the 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 a review by the board under ORS 656.295."

There having been no appeal to the Board within 30 days after the mailing of the referee's order of dismissal, the order became final. Although the order of dismissal invited claimant to submit, within 30 days, documents establishing "good cause" for his failure to appear, it was not and could not have been made contingent on the passage of 30 days. Additionally, the filing of claimant's motion did not and could not have effected a stay of the order. The time for appeal began to run when the order of dismissal was mailed, and the referee could not extend it. *Farmers Ins. Group v. SAIF*, 301 Or 612, 724 P2d 799 (1986). Accordingly, the Board did not err in holding that the referee's order of dismissal had not been abated, withdrawn, stayed, modified or republished before the expiration of the 30 days within which claimant could appeal. Therefore, the appeal was untimely, and the Board lacked jurisdiction to consider the merits of the motion to set aside the referee's order of dismissal.

Affirmed.

ROSSMAN, J., dissenting.

Because I cannot agree with the majority's conclusion thta the time for appeal began to run when the new order was mailed, I dissent.

ORS 656.289(1) provides:

"Upon the conclusion of any hearing, or prior thereto with concurrence of the parties, the referee shall *promptly and not later than 30 days after the hearing determine the matter and make an order* in accordance with the referee's determination." (Emphasis supplied)

Although the referee mailed a form of an order dismissing the claim on December 20, 1989--the day after the hearing--the *issuance* of the order was expressly contingent on either the passage of 30 days or the filing of a motion to set aside the dismissal, whichever came first. If claimant had failed to file the motion, the order of dismissal would have issued 30 days after the hearing, and claimant would have had 30 days from that date to appeal to the Board. Because claimant filed the required motion on January 10, 1990--21 days after the hearing--I would hold that the order issued on that day. Claimant requested Board review on February 5, 1990, within 30 days after the issuance of the order.

The majority would require claimant to file an affidavit explaining his reasons for not appearing at the hearing and, *at the same time*, file an appeal to the Board. That would lead to an unnecessary bifurcation of jurisdiction between the referee and the Board. Given the referee's specific directive to claimant to file an affidavit, and given claimant's timely compliance with that directive, it was reasonable for him to expect that the referee would not issue a final order until after the affidavit was considered. I would hold that the Board had jurisdiction to consider the appeal and to determine the merits of claimant's motion.

That is the only fair result in this case. The foremost objective of the workers' compensation system is to help workers who have been injured on the job. This claimant should not be prevented from seeking that relief simply because he did what the system told him to do. He timely responded to the referee's specific procedural directive by filing a motion to set aside the order of dismissal. To me, it would be unfair now to penalize claimant for the referee's failure timely to consider his motion.

Cite as 113 Or App 186 (1992) May 20, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Salvador Cervantes-Ochoa, Claimant.

NORTHWEST GREENTREE, INC., Petitioner
v.
SALVADOR **CERVANTES-OCHOA** and SAIF CORPORATION, Respondents.
(89-13027; CA A67870)

Judicial Review from Workers' Compensation Board.
Argued and submitted July 22, 1991.

Paul A. Dakopolos, Salem, argued the cause for petitioner. With him on the brief were Chess Trethewy and Garrett, Seideman, Hemann, Robertson, Paulus, Jennings & Comstock, P.C., Salem.

Roger H. Van Hoy, Vancouver, Washington, argued the cause for respondent Salvador Cervantes-Ochoa. With him on the brief were James L. Sellers and Sellers & Jacobs, Vancouver, Washington.

Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, Attorney General, Salem, waived appearance for respondent SAIF Corporation.

Before Richardson, Presiding Judge, and Deits and Edmonds, Judges.

DEITS, J.
Affirmed.

Employer seeks review of a Workers' Compensation Board order holding that it is a subject Oregon employer and that claimant was a subject Oregon employee at the time that he sustained a compensable injury. We affirm.

Employer is a reforestation company, licensed and bonded in both Oregon and Washington. It contracts to do work in both states. All of its employees live in the mid-Willamette Valley and report to work at employer's headquarters in Monmouth, Oregon. From Monmouth, they are transported in employer's vehicles to remote job sites for a few days at a time and then back to Monmouth. The vehicles are licensed in Oregon. At its headquarters, employer issues paychecks drawn on a local bank and withholds Oregon income tax. All of employer's insurance, except workers' compensation coverage, is purchased in Oregon. Employer has a small year-round staff and hires seasonal workers in January or February of each year to work approximately six months. The seasonal workers are given a document that explains that the work is temporary. Usually, employer's first and last work sites each year are in Washington. Approximately 80 percent of the seasonal work is done in Washington, and the rest is done in Oregon.

Claimant was hired in February, 1987, and worked most of February and March in Washington. In April, he began working near Detroit, Oregon. He was injured after working several days at that site. He received workers' compensation benefits under employer's Washington coverage. When he filed for benefits in Oregon, employer denied the claim on the ground that it was not a subject employer and claimant was not a subject worker under Oregon's Workers' Compensation Law. Claimant requested a hearing on the denial; the referee held that he was entitled to benefits under Oregon law, and the Board affirmed.

With certain exceptions, "subject workers" include all workers who work in Oregon. ORS 656.005(26); ORS 656.027. Persons who work temporarily outside Oregon generally continue to be covered for workers compensation in Oregon if it is the place of their permanent employment. *Power Master, Inc. v. National Council on Comp. Ins.*, 109 Or App 296, 299, 820 P2d 459 (1991) (*Power Master II*). ORS 656.126(1) and (2) govern entitlements and exemptions for workers temporarily working in or

outside of Oregon.[1] The question is whether claimant was a Washington worker temporarily working in Oregon or an Oregon worker who had worked temporarily in Washington.

Employer argues that the Board applied the wrong legal standard and that, if it had applied the proper test, it would have found that claimant was a Washington worker temporarily working in Oregon and, therefore, was not entitled to Oregon workers' compensation. Employer contends that it performs most of its work in Washington and that, because the first and last job sites for its seasonal employees are usually in Washington, their work in Oregon is temporary.

Employer argues that the Board applied what employer calls "the primary locus of employment relation test." It reaches that conclusion because, in its view, the Board based its determination that claimant was an Oregon worker solely on its findings that the employees, who all live in the Monmouth area, marshal at the headquarters there and are not hired with an understanding that they will work in any particular location.

We conclude that the Board did apply the correct standard, which is the permanent employment relation test. *Kolar v. B & C Contractors*, 36 Or App 65, 71, 583 P2d 562 (1978). The Board applied that test, under which the key inquiry is "the extent to which the claimant's work outside the state is temporary." *Hobson v. Ore Dressing, Inc.*, 87 Or App 397, 400, 742 P2d 675, *rev den* 304 Or 437 (1987). In making that decision, no one factor controls; rather, all of the circumstances are relevant, including the intent of the employer, the understanding of the employee, the location of the employer and its facilities, the circumstances surrounding the claimant's work assignment, the state laws and regulations that the employer otherwise is subject to and the residence of the employees. *Power Master, Inc. v. Blanchard*, 103 Or App 467, 471, 798 P2d 691 (1990) (*Power Master I*); *Phelan v. H.S.C. Logging, Inc.*, 84 Or App 632, 635, 735 P2d 22, *rev den* 303 Or 590 (1987). When employees are transient and work in various locations in more than one state, it is necessary to look at more than simply the sequence of assignments. *Power Master II, supra*, 109 Or App at 301.

The two *Power Master* cases provide examples of the application of the permanent employment relation test. They involved employees of one branch office who worked in several states. The cases arose after the employer relocated its only Oregon office to Washington. In *Power Master I, supra*, 103 Or App at 469, we examined whether the claimant was an Oregon subject worker. He was an Oregon resident who had been hired at the Portland office, was told that he might occasionally work outside Oregon and did most of his work in Oregon. The employer's accounting, administration and payroll functions were done in Oregon, and it withheld Oregon taxes from the claimant's pay. Approximately two months after the relocation, the claimant was injured. At the time of his injury, the only change in his employment resulting from the relocation had been that he stopped by the Washington office instead of the Oregon office each day for his job assignment and supplies. We concluded that his principal place of business continued to be Oregon and that the detour to the Washington office was incidental.

In *Power Master II, supra*, 109 Or App at 301, we affirmed a workers' compensation premium audit in which the Department of Insurance and Finance (DIF) found that the employer was not an Oregon subject employer during the six-month period after the relocation of its branch office. Because the branch employees were transient and worked in various locations throughout Oregon, Washington and Idaho, DIF decided that it was inappropriate "to simply look at the sequence of assignments." Instead, it appropriately "focused on other factors, such as the location of various supervisory and administrative activities as well as the intent of the parties." For the six-month period, the employer performed most of those activities in Washington. The Board concluded, and we affirmed, that the branch employees were Washington workers, and the employer was relieved of its premium obligation.

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[1] ORS 656.126 provides, in part:

"(1) If a worker employed in this state and subject to this chapter temporarily leaves the state incidental to that employment and receives an accidental injury arising out of and in the course of employment, the worker * * * is entitled to the benefits of this chapter as though the worker were injured within this state.

"(2) Any worker from another state and the employer of the worker in that other state are exempted from the provisions of this chapter while the employer has a temporary workplace within this state and the worker is within this state doing work for the employer [provided that certain requirements are met]."

The Board's findings show that it considered all of the circumstances pertinent to the permanent employment relation test. The Board found that claimant was hired in Oregon by a company that is located and operated in Oregon. The company's administrative functions, including banking, payroll, insurance, and vehicle licensing, are predominantly performed in Oregon. The Board also found that, although employer does a substantial amount of work in Washington, claimant was not hired with an understanding that he would work in any particular location. As the Board stated: "Its employees are all from [the Monmouth area], and employees marshall in that area for transport to particular work sites." The workers always returned to Oregon for their next work assignment. The Board concluded that all of the factors relevant to the permanent relation test with the exception of the percentage of work to be performed in Washington support the conclusion that claimant was an Oregon employee. The Board did not err in deciding that claimant was a subject Oregon employee entitled to Oregon workers' compensation.

Affirmed.

Cite as 113 Or App 234 (1992) May 27, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Emma G. Mosley, Claimant.

EMMA G. **MOSLEY**, Petitioner,
v.
SACRED HEART HOSPITAL; SAIF CORPORATION; OREGON MEDICAL LABS; CONNECTICUT INDEMNITY CO.; SACRED HEART HOSPITAL and LIBERTY NORTHWEST INSURANCE CORPORATION, Respondents.
(WCB 90-12032, 89-25360, 90-08108; CA A69125)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 18, 1991.
Karen M. Werner, Eugene, argued the cause for petitioner. With her on the brief was Allan H. Coons, Eugene.
Steven R. Cotton, Special Assistant Attorney General, Salem, argued the cause for respondents Sacred Heart Hospital and SAIF Corporation. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Lin Zimmerman, Portland, argued the cause for respondents Oregon Medical Labs and Connecticut Indemnity Co. With him on the brief was Beers, Zimmerman, Rice, Isaacs & Nielsen, Portland.
No appearance by respondent Liberty Northwest Insurance Corporation.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
WARREN, P.J.
Affirmed.

Claimant seeks review of the Board's dismissal of her request for review of the referee's order in a consolidated proceeding about three contested denials. The Board held that claimant had not complied with ORS 656.295(2), because she failed to send copies of the request for Board review to all parties to the proceeding before the referee. We affirm.

Claimant was employed by Sacred Heart Hospital (Sacred Heart), which was then insured by SAIF. On November 11, 1980, she stepped on a syringe and twisted her right leg. She filed a form 801 that indicated that the injury was a "turned ankle and knee." The claim was accepted on November 25, 1980. In January, 1981, she experienced hip pain; radiographic studies revealed that claimant had moderate osteoarthritis and degenerative sclerosis. The ankle and knee claim was closed by a determination order on January 4, 1982, which awarded 10 percent unscheduled permanent partial disability "related to claimant's lower back." Claimant continued to receive periodic diagnosis and treatment of her hip and right leg symptoms. She continued to work for Sacred Heart until 1986, when she began working for Oregon Medical Laboratory (OML). Her hip continued to degenerate until 1990, when she had hip replacement surgery.

Claimant filed a claim against Sacred Heart for her hip condition, asserting that her 1980 claim should be reopened because of an aggravation. SAIF denied the claim and moved to join Liberty Northwest Insurance Corporation (Liberty), Sacred Heart's subsequent insurer in 1990, based on *Runft v. SAIF*, 303 Or 493, 739 P2d 12 (1987). Liberty issued a denial. Claimant also filed a claim against OML, and OML issued a denial. Claimant requested a hearing on all 3 denials, and the cases were consolidated for hearing. The referee found that claimant's pre-existing degenerative arthritis was the major cause of her need for treatment of her right hip and that her work activities had minor, if any, impact on her need for hip replacement surgery. Moreover, the referee found that Sacred Heart had not previously accepted claimant's right hip condition and rejected claimant's contention that her hip condition was an occupational disease related to her work activities at Sacred Heart and OML.

Claimant sought Board review but served notice only on Sacred Heart. No timely notice was sent to OML or its insurer. Relying on *Zurich Ins. Co. v. Diversified Risk Management*, 300 Or 47, 706 P2d 178 (1985), the Board dismissed claimant's request for review, because not all of the parties to the proceeding before the referee had received timely notice. Claimant contends that she only needed to serve Sacred Heart, because she was appealing only her claim for payment of additional medical services by Sacred Heart. She was not contesting the issue of responsibility, so OML was not a party, because claimant did not assert on review that her work exposure after 1986 played a contributing role in her need for treatment.

ORS 656.295(2) provides:

> "The requests for review shall be mailed to the board and copies of the request shall be mailed *to all parties to the proceeding before the referee.*" (Emphasis supplied.)

ORS 656.005(20) provides:

> "'Party' means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer."

A party requesting Board review cannot limit the scope of that review by seeking review of only selected cases out of a group consolidated in the same proceeding before the referee, because an appeal is for Board review of a referee's order, not just particular claims. OML was a party to the referee's order, so it was a party on review. The plain language of the statute requires that OML be served.

Under ORS 656.295(5) and (6), the Board has de novo review authority to decide all matters arising from the record. Because claimant did not give notice to all parties, the Board did not err in dismissing her request for review.

Affirmed.

Cite as 113 Or App 242 (1992) May 27, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Paul Holmstrom, Claimant.

SAIF CORPORATION, Petitioner,
v.
PAUL **HOLMSTROM**, Respondent.
(WCB 87-0155M; CA A68422)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 18, 1992.
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 by respondent.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
WARREN, P.J.
Reversed and remanded with instructions that Board vacate portions of its Reopened Claims Reserve.

SAIF seeks review of a Workers' Compensation Board order denying authorization for reimbursement from the Reopened Claims Reserve (Reserve). ORS 656.625.[1] We reverse.

In March, 1987, after claimant's aggravation rights had expired, the Board entered an order pursuant to ORS 656.278, requiring SAIF to reopen his claim and to begin paying time loss benefits. SAIF complied with that order until August 13, 1990, when it closed the claim. Because claimant was not medically stationary at that time, he asked the Board to order SAIF to reopen the claim. The Board granted claimant's request, ordering SAIF to resume paying time loss benefits as of August 14, 1990. The order also provided:

> "Reimbursement from the Reopened Claims Reserve is not authorized as the claim was reopened prior to January 1, 1988."

SAIF asked the Board to reconsider that portion of its order. On reconsideration, the Board denied SAIF reimbursement from the Reserve for payments that it had made before August 14, 1990, but authorized reimbursement for the payments made after that date.

SAIF contends that the Board lacks the authority to grant or deny reimbursement from the Reserve. In its order, the Board asserts that ORS 656.625(2) gives it that authority. It is mistaken.

The Board's authority is limited by statute. It has authority to determine matters concerning a claim. ORS 656.704; *EBI Companies v. Kemper Group Insurance*, 92 Or App 319, 758 P2d 406, *rev den* 307 Or 145 (1988). A matter concerns a claim if it involves "the worker's right to receive compensation or the amount thereof." 92 Or App at 322. If a worker has been compensated and is not a participant in the dispute, the worker's right to receive compensation or the amount thereof is no longer at issue, and so the Board lacks jurisdiction. 92 Or App at 322.

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[1] ORS 656.625 provides:

"(1) The director shall establish a Reopened Claims Reserve * * * 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.

"(2) 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.

"(3) The director, by rule, shall prescribe the form and manner of requesting reimbursement under this section, the amount payable and such other matters as may be necessary for the administration of this section."

ORS 656.625(1) provides that a prerequisite to any recovery from the Reserve is compliance with a Board order issued pursuant to its own motion authority under ORS 656.278 directing an employer to compensate a claimant. ORS 436-45-010.[2] When an employer has complied with an own motion order, the worker has been compensated and is not thereafter a participant in the dispute. Consequently, after an employer has satisfied the prerequisites for reimbursement from the Reserve, there is no matter concerning a claim over which the Board can exercise
authority.

There is nothing in ORS 656.625(2) that indicates a legislative intent to expand the Board's jurisdiction. Reading ORS 656.625(1) and (2) together, the phrase "amounts prescribed by the board" referred to in subsection (2) logically relates to the amounts that the Board awards pursuant to its authority under ORS 656.278. So read, ORS 656.625(2) does not *grant* authority to the Board; it *limits* the authority of the director. The director can only reimburse insurers for amounts awarded by the Board pursuant to ORS 656.278 after January 1, 1988.

The Board denied reimbursement for some amounts that SAIF paid and authorized reimbursement for other amounts. Because the Board lacked jurisdiction to grant or deny reimbursement, we reverse and remand for the Board to vacate those portions of its order relating to reimbursement from the Reserve.

Reversed and remanded with instructions that the Board vacate the portions of its order relating to reimbursement from the Reopened Claims Reserve.

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[2] OAR 436-45-010 provides, in relevant part:

"(1) In order to qualify for reimbursement from the Reopened Claims Reserve there must be:

"(a) An order or award issued by the Board upon its own motion pursuant to ORS 656.278 and as provided by OAR Chapter 438, Division 12; and

"(b) Verifiable compensation paid in accordance with the order or award."

Cite as 113 Or App 249 (1992) May 27, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Rex J. Coon, Claimant.

DEPOE BAY FISH COMPANY and LIBERTY NORTHWEST INSURANCE CORPORATION, Petitioners,
v.
REX J. **COON**, Respondent.
(WCB 88-22459; CA A66759)

Judicial Review from Workers' Compensation Board.

On Respondent's petition for review of Order of Court of Appeals on attorney fees filed February 3, 1992.

Heather Reynolds, Astoria, for respondent.

Before Rossman, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.

Reconsideration allowed; claimant awarded $7,910 as attorney fees on judicial review; order otherwise adhered to.

Claimant has petitioned for review of this court's order allowing attorney fees. A petition for review constitutes a petition for reconsideration by this court. ORAP 9.15. We allow reconsideration and modify the order.

Employer's insurer, Liberty Northwest Insurance Corporation (Liberty), denied claimant's injury claim. The denial was set aside by the referee, and claimant prevailed on appeal of that denial to the Board. This court affirmed the Board's order without opinion. 108 Or App 366, 815 P2d 722 (1991). Claimant was awarded insurer paid attorney fees by the referee and the Board, although in an amount

considerably less than requested. This court allowed a portion of the attorney fees requested by claimant on judicial review but declined to change the fees awarded for services before the referee and the Board.

Claimant contends that this court should have increased the fees for services before the Board and the referee under ORS 656.388(1). He also asserts that this court was required under ORAP 13.10 to allow the fee petition filed in this court in its entirety, because Liberty failed to make a timely objection.

We still decline to change the fees awarded by the referee and the Board. Claimant did not seek judicial review of those awards, and this court lacks authority under ORS 656.388(1) or any other statute to change the amounts awarded.

The fees allowed for services in this court present a distinctly different issue. Claimant's attorney submitted a petition for attorney fees of $7,910 on August 30, 1991. Liberty filed objections on September 19, 1991. Under ORAP 13.10(4), "[o]bjections to a petition shall be served and filed within 14 days after the date when the petition is filed. A reply, if any, shall be served and filed within 14 days after the date of service of the objections." ORAP 13.10(6) provides:

> "In the absence of timely filed objections to a petition under this rule, the Supreme Court and the Court of Appeals, respectively, *will* allow attorney fees in the amount sought in the petition, except in cases in which:
>
> "(a) the entity from whom fees are sought was not a party to the proceedings; or
>
> "(b) when the Supreme Court or the Court of Appeals is without authority to award fees." (Emphasis supplied.)

Although Liberty's objections were not timely filed, this court allowed only a portion of the fees requested for services rendered on judicial review. Reconsideration is allowed, and the order allowing attorney fees is amended to allow claimant's attorney fees of $7,910 for services rendered in this court. Reconsideration is denied with respect to the remainder of the petition. ORAP 13.10(6)(b).

Reconsideration allowed; claimant is awarded $7,910 as attorney fees on judicial review; order otherwise adhered to.

Cite as 113 Or App 267 (1992) June 3, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Marvin C. Wright, Claimant.

SAIF CORPORATION, Petitioner,
v.
MARVIN C. **WRIGHT**, by and through GEORGIA WRIGHT, Personal Representative of the Estate of Marvin C. Wright, Deceased. Respondent.
(WCB TP-88016; CA A51030)

On remand from the Oregon Supreme Court, *SAIF v. Wright*, 312 Or 132, 817 P2d 1317 (1991).
Judicial Review from Workers' Compensation Board.
Submitted on remand October 30, 1991.
John A. Reuling, Jr., Assistant Attorney General, Salem, argued the cause for petitioner. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
David C. Force, Salem, argued the cause for respondent. On the brief were Randy M. Elmer and Vick & Gutzler, Salem.
Before Richardson, Presiding Judge, and Joseph, Chief Judge, and Deits, Judge.
RICHARDSON, P.J.
Affirmed.

This case is before us on remand from the Oregon Supreme Court. 312 Or 132, 817 P2d 1317 (1991).[1] We take the facts from the Supreme Court's opinion:

> "Claimant suffered injuries in a two-car accident in 1984. He filed claims with four employers, contending that he was injured in the course and scope of employment and that at least one of the four was his employer. SAIF received and processed three of the claims, because they involved noncomplying employers. ORS 656.054(1). In June 1985, SAIF denied all three claims, on the ground that claimant was not a subject worker of any of the employers. The fourth purported employer denied the claim on the same ground.
>
> "Also in 1985, claimant filed an action against the other driver who had been involved in the accident. His case against the other driver was settled on January 20, 1986, for $81,960.75. Claimant did not inform SAIF of the settlement, and SAIF was not otherwise aware of the litigation or of the settlement. Thus, SAIF did not consent to the settlement. See ORS 656.587 (settlement between worker and third party must have written approval of paying agency); ORS 656.593(3) (claimant may settle third party case with approval of paying agency). The settlement was distributed as follows: $29,869.72 to claimant; $27,243.18 to claimant's lawyers; $24,616.65 for medical expenses; and $231.20 for costs.
>
> "Meanwhile, claimant had appealed the denials of his four claims. After a hearing on January 30, 1986, the referee upheld the denials, on the ground that no employer-employee relationship existed with any of the four purported employers. Claimant appealed to the Board, which found that claimant was a subject worker of one of the three noncomplying employers whose claim had been referred to SAIF for processing. The Board set aside SAIF's denial as to that employer and remanded the claim to SAIF for processing. Thereafter, SAIF paid claims costs of $43,418.82, comprised of temporary total disability compensation ($39,693.35), a permanent disability award ($2,359.45), and medical expenses ($1,366.02).

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[1] After the Supreme Court's remand, claimant died and the personal representative of his estate was substituted as respondent.

> "SAIF first learned of claimant's settle the other driver in April 1988, when claimant sought reimbursement for the $24,616.65 in medical bills that had been paid directly to the providers from the settlement. On June 23, 1988, SAIF filed a 'Petition for Distribution' asking the Board for an order that would require claimant to distribute to SAIF $36,324.23 as its 'statutory share' of the third-party settlement, pursuant to ORS 656.593(3). The Board denied the petition on the ground that SAIF was not a 'paying agency' entitled to share in the settlement under ORS 656.593(3), because SAIF had denied the underlying claim. SAIF sought judicial review of the Board's order." 312 Or at 134-35. (Footnotes omitted.)

In our former opinion, we declined to reach the merits of the Board's decision that SAIF was not a "paying agency," because we concluded that, although the Board had jurisdiction over SAIF's petition, it had no authority to grant the relief sought by SAIF[2] and, hence, petitioner's motion to the Board should have been dismissed. Petitioner sought review of our decision.

The Supreme Court concluded that the Board had authority, under ORS 656.593(3), to determine whether SAIF was a "paying agency" under ORS 656.576. On remand, we are instructed to consider the merits of the Board's decision.

Under ORS 656.593(3), a claimant may settle a third-party action with approval of the paying agency, and the payingagency is entitled to share in the distribution of the settlement. ORS 656.576 provides:

> "As used in ORS 656.578 to 656.595, 'paying agency' means the self-insured employer or insurer *paying benefits* to the worker or beneficiaries." (Emphasis supplied.)

The Board, citing the present tense expression "paying benefits" in the statute, determined that SAIF is not a "paying agency" under ORS 656.576 because, at the time of the settlement, claimant's claim was in a denied status and no benefits were being paid. The Board interpreted the statute to require actual, present payment of benefits before an agency can qualify as a "paying agency" under ORS 656.576. That interpretation comports with the literal reading of the statute, but SAIF challenges it on the basis that it produces results contrary to the purpose of the third-party recovery statutes.

In *Schlecht v. SAIF*, 60 Or App 449, 456, 653 P2d 1284 (1982), we held that the purpose of the third-party recovery statutes is to allocate whatever a claimant recovers from a third party between the claimant and the paying agency. SAIF argues that that policy would be frustrated if a claimant is entitled to keep all of a third-party recovery in any case in which the recovery is received before the worker's entitlement to benefits is decided.

We disagree. The statutes allocate proceeds from a third-party settlement between the claimant and the entity responsible for the payment of workers' compensation benefits. In a case such as this, where at the time the settlement is reached the issue of compensability is still in dispute, there is no entity paying benefits and there is no certainty that there will be an entity paying benefits in the future. Under these circumstances, the question is not whether the "paying agency" is entitled to share in the settlement proceeds but whether the possibility that an entity may end up paying benefits in the future entitles it to some sort of present interest in a claimant's third-party settlement. The Board considered the question and answered it in the negative. It explained:

> "In [*Raymond Steiner*, 40 Van Natta 381 (1988)], we required the claimant's counsel to hold the remaining balance of a third party recovery in trust, pending a final determination concerning the compensability of the claim. However, there, in contrast

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[2] Contrary to what the Supreme Court concluded, we did not hold that the Board lacked authority to determine whether SAIF was a paying agent. We said, apparently incorrectly, that the Board had no authority to grant the specific relief that SAIF requested. We said that the "issues raised by SAIF's motion were, *inter alia*, whether the settlement of the case in the circuit court was void under ORS 656.587; whether SAIF could reach proceeds of the settlement after they had been distributed to medical providers, claimant's attorney and claimant; and whether either SAIF or claimant was estopped to assert the position that they did." 102 Or App at 601.

to the present situation, at the time of the recovery and proposed distribution, the claim was considered compensable and the paying agency was providing benefits. We consider it a very different proposition to conclude that whenever a possibility remains that a claim in denied status will ultimately be found compensable, a claimant must hold a third party recovery in trust pending a final resolution of the compensability issue. To do so would require a claimant, who is not receiving workers' compensation benefits, to not only support himself, but also provide for his medical services, without the financial assistance available from the third party recovery."

We agree. An insurer must be paying benefits at the time of the settlement or distribution in order to qualify as a "paying agency" under ORS 656.576.

Affirmed.

Cite as 113 Or App 314 (1992) June 3, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Dewey H. Gilkey, Sr., Claimant.

DEWEY H. **GILKEY**, SR., Petitioner,
v.
SAIF CORPORATION/COOS COUNTY HIGHWAY DEPARTMENT and LIBERTY NORTHWEST INSURANCE CORPORATION/COOS COUNTY HIGHWAY DEPARTMENT, Respondents.
(84-13492, 85-10096, 85-10535, 86-03407; CA A69991)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 20, 1992.
Brent Wells, Eugene, argued the cause for petitioner. On the brief were Donald M. Hooton and Malagon, Moore & Johnson, Eugene.
Jon Littlefield, Coos Bay, argued the cause for respondents Liberty Northwest Insurance Corporation and Coos County Highway Department. With him on the brief was Foss, Whitty, Littlefield & McDaniel, Coos Bay.
Thomas E. Ewing, Assistant Attorney General, Salem, argued the cause for respondents SAIF Corporation and Coos County Highway Department. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Assistant Attorney General, Salem.
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 affirming the referee's decision that his occupational disease claim relating to his left hip is not compensable.

Claimant had a compensable hip injury in 1975. The claim was closed in August, 1976. In 1978, claimant experienced severe hip pain, and his claim was reopened. Doctors determined that claimant's pain was caused by degenerative changes in the hip and discussed the possibility of surgery. SAIF denied responsibility for hip surgery in November, 1979. In May, 1980, claimant and SAIF entered into a disputed claim settlement (DCS), which provided:

> "It is agreed that SAIF shall pay to the claimant the sum of $4,000. This payment is not an acknowledgment of responsibility or compensability for the degenerate [sic] hip condition which is the subject of this disputed claim settlement. It is agreed that the denial shall remain in full force and effect. The claimant understands that there will be no future recourse for medical care and treatment, time loss benefits or permanent partial disability benefits arising out of the Workers' Compensation Act as a result of treatment or disability relating to the degenerative hip disorders involving the congenital dysplasia of both hips or degenerative osteoarthritis of the left hip."

Claimant returned to work. His hip pain increased over the next few years. In March, 1984, Dr. Bert diagnosed severe degenerative arthritis and requested authorization for left hip replacement surgery, which SAIF refused, relying on the DSC.

In June, 1985, claimant filed an occupational disease claim with SAIF and also with Liberty Northwest Insurance Corporation, which was employer's insurer after July 1, 1984, claiming that the physical strain and stress of work had "aggravated, accelerated or precipitated" the development of hip problems requiring surgery. Both insurers denied the claim.

The Board found that claimant's hip condition had worsened since the 1980 DCS and that the worsening was greater than might have been expected by virtue of the aging process alone. It also found that the DCS had the effect of establishing that claimant's degenerative hip condition as it existed on the date of the DCS was entirely the result of noncompensable causes. It reasoned that, as a result of the DCS, claimant was barred by *res judicata* and issue preclusion principles from establishing that the 1975 injury had contributed to his hip condition, and it found that he had not shown that work was the major contributing cause of the worsening.

Claimant contends that the Board erred in failing to consider the effects of the 1975 injury in determining whether the present claim is compensable. We agree with SAIF and claimant that neither claim preclusion nor issue preclusion bars consideration of the 1975 injury as a work-related factor contributing to claimant's present condition. However, by virtue of the DCS, the parties *have agreed* that there is no compensable relationship between the 1975 injury and claimant's degenerative hip condition. They are bound by that agreement, and the 1975 injury cannot be regarded as having contributed to claimant's present condition. Although the Board appears to have relied, in part at least, on *res judicata* or issue preclusion principles, it also made this conclusion:

> "Dr. Bert's opinion establishes that work activity was a more important factor than off-work activity in producing the worsening of claimant's condition after 1980. Nonetheless, because Dr. Bert attributed the major factor in claimant's post-1980 worsened condition to be the 1975 injury, which has been found by law to have no effect, we conclude that claimant has failed to prove that his work activities after 1980, in comparison with nonwork related conditions, were the major contributing cause of his current degenerative arthritis condition and resultant surgery. *See David K. Boyer*, 43 Van Natta 561 (1991). Accordingly, the denials of claimant's occupational disease claims are upheld."

That conclusion is correct.

Affirmed.

Cite as 113 Or App 364 (1992) June 3, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Linda M. Queener, Claimant.

LINDA M. **QUEENER**, Petitioner,
v.
UNITED EMPLOYERS INSURANCE and T.J.'s SUPERETTE, Respondents.
(90-02240; CA A70779)

Judicial Review from Worker's Compensation Board.
Argued and submitted January 17, 1992.
Richard M. Walsh, Salem, argued the cause for petitioner. With him on the brief was Olson, Rowell & Walsh, Salem.
David J. Lefkowitz, Portland, argued the cause for respondents. With him on the brief was Schwabe, Williamson & Wyatt, Portland.
Before Richardson, Presiding Judge, and Deits and Durham, Judges.
DURHAM, J.
Affirmed.

Claimant seeks review of a Workers' Compensation Board order that affirmed the denial of her aggravation and medical services claims. The Board held that her worsened back condition was not causally connected to her compensable injury. We affirm.

Claimant injured her back in May, 1985, while working as a convenience store clerk. By March, 1986, her condition had sufficiently resolved to permit her to return to modified work. A determination order closed her claim on June 5, 1987, and awarded her 15 percent unscheduled disability. A stipulated settlement in September, 1987, which was the last arrangement of compensation, increased her disability award to 25 percent. In the fall of 1989, while employed in a video shop, claimant began working longer hours and experienced increased symptoms in her back when she bent and twisted. The pain was in the same location and had the same general quality as the pain that had resulted from her 1985 injury. Before the 1985 injury, she had spondylolisthesis. She stands five feet tall, and her weight has fluctuated between 200 and 275 pounds since 1975.

The Board, adopting the referee's order, found that claimant had become more disabled as a result of the 1989 back pain in that she was less able to work than she was after the 1987 settlement. It also found, however, that it was not medically probable that her 1989 condition was materially related to the 1985 injury.

Claimant first asserts that the Board erred when it required her to bear the burden of proving the compensability of her 1989 claims. She contends that *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027 (1983), forbids an employer or insurer from issuing a "back-up" denial of a claim that has previously been accepted as compensable. *Bauman* is inapplicable here, because the denial was addressed solely to claimant's 1989 condition and did not seek to relitigate either the 1987 permanent disability award or potential future claims arising from the 1985 injury. The denial does not challenge the permanency of claimant's accepted back injury but only the causal relationship between that injury and her current condition. The Board correctly required claimant to prove, by a preponderance of the evidence, that her condition has worsened since the last arrangement of compensation in 1987 and that a causal relationship exists between that worsening and the compensable injury. ORS 656.273(1); *Hoke v. Libby, McNeil & Libby*, 73 Or App 44, 46, 697 P2d 993 (1985).

Claimant next argues that the Board ignored Oregon precedent and failed to apply "the law of the case." In *Kuhn v. SAIF*, 73 Or App 768, 772, 700 P2d 253 (1985), we held that, when the claimant had established that permanent disability arose out of an industrial accident, this court, on *de novo* review of her aggravation claim, should disregard a doctor's opinion that the injury resulted from congenital abnormalities. In that circumstance, the determination that the injury was compensable was the law of the case. Unlike in *Kuhn*, the doctors who examined claimant in this case were aware that she had suffered a compensable injury in 1985 but found that her present symptoms are no longer

causally related to it. The Board's acceptance of those findings does not disregard her permanent disability.

Claimant also asserts that the Board erred by refusing to defer to the treating physicians' opinion without persuasive reasons. When this court had *de novo* review in workers' compensation cases, we tended to give greater weight to the conclusions of a claimant's treating physician, unless there were persuasive reasons not to do so. *See Taylor v. SAIF*, 75 Or App 583, 585, 706 P2d 1023 (1985). In 1987, the legislature eliminated *de novo* review and confined this court to reviewing the record for substantial evidence to support the Board's findings. ORS 183.482(8)(c); ORS 656.298(6); *Garcia v. Boise Cascade Corp.*, 309 Or 292, 295, 787 P2d 884 (1990).

Claimant argues that substantial evidence does not support the Board's order. Employer's doctors stated that the 1989 problems are not related to the 1985 injury. The Board found persuasive reasons for rejecting the opinions of claimant's treating physicians. One treating physician examined her more removed in time from her 1989 symptoms than did some of the other doctors. The Board found that he had discounted the effects of her obesity, which went against the weight of the evidence. It found that the other treating physician incorrectly thought that her 1985 injury caused her spondylolisthesis and focused his testimony on his chiropractic treatments rather than the causation between the 1985 and 1989 injuries.

> In *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206, 752 P2d 312 (1988), we said:
> "[I]n a context which is likely frequently to occur in workers' compensation cases, if there are doctors on both sides of a medical issue, whichever way the Board finds the facts will probably have substantial evidentiary support. We would not need to choose sides."

This is such a case.

Finally, claimant asserts that the Board erred in failing to assess penalties and attorney fees. Because we affirm the Board on the merits, we do not address the question.

Affirmed.

Cite as 113 Or App 369 (1992) June 3, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON

MICHAEL **LACY**, Appellant,
v.
STATE ACCIDENT INSURANCE FUND, INC., an Oregon corporation, Respondent.
(8912-07148; CA A65549)

Appeal from Circuit Court, Multnomah County.
Ancer L. Haggerty, Judge.
Argued and submitted December 16, 1991.
Michael L. Williams, Portland, argued the cause for appellant. With him on the brief was Williams, Troutwine & Bowersox, P.C., Portland.
Jas. Adams, Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Richardson, Presiding Judge, and Deits and Durham, Judges.
DURHAM, J.
Affirmed.

Plaintiff was seriously injured at work in 1978 while cleaning a rock crushing machine. SAIF, employer's carrier, paid his medical costs. In 1989, he commenced this action against SAIF for negligence, breach of fiduciary duty and breach of an insurance contract between it and his employer. The gravamen of the claims was that SAIF failed to advise him to retain counsel to pursue, or itself to

pursue, a third-party product liability action against the machine manufacturer. The court granted SAIF's motion to dismiss.[1] ORCP 21A. We review for errors of law and affirm.

In *Eschliman v. GAB Business Service*, 80 Or App 459, 722 P2d 60, *rev den* 302 Or 158 (1986), the plaintiff was injured while at work and the defendant agency paid him benefits. After the Statute of Limitations had run, barring the plaintiff's right to maintain an action against a third party for his injuries, he sued the defendant, alleging breach of fiduciary duty and negligence for its failure to inform him of the existence of a third-party claim. We affirmed the dismissal of the complaint, holding that the rights and remedies provided by the Workers' Compensation Law are exclusive, ORS 656.018,[2] and impose no duty on insurers to inform an injured worker of potential third-party claims. 80 Or App at 460.

Plaintiff seeks to avoid ORS 656.018 and *Eschliman* by characterizing his claim as one for injury to property (i.e., the cause of action) rather than for personal injury. We reject that argument. Plaintiff seeks recovery for personal injury. *Eschliman* governs that claim.

Plaintiff asserts that *Eschliman* is wrong and that we should overrule it. He submits several policy arguments against its holding. We decline to overrule *Eschliman*.

Plaintiff also asserts that Eschliman does not apply to the breach of contract claim. See *Montgomery Elevator Co. v. Tuality Community Hosp.*, 101 Or App 299, 303, 790 P2d 1148, *rev den* 310 Or 243 (1990). Even assuming that plaintiff may be a third-party beneficiary of the contract between SAIF and his employer, he fails to specify any express or implied provision of the contract to support the claim. *See Aetna Casualty & Surety Co. v. OHSU*, 310 Or 61, 65, 793 P2d 320 (1990).

Affirmed.

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[1] The court did not specify on what basis it granted the motion. SAIF had asserted three grounds for dismissal: (1) the court lacked subject matter jurisdiction; (2) the claims were time-barred; and (3) the complaint failed to state ultimate facts constituting a claim.

[2] ORS 656.018 provides:

"(1)(a) The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability arising out of compensable injuries to the subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such injuries or claims resulting therefrom, specifically including claims for contribution or indemnity asserted by third persons from whom damages are sought on account of such injuries, except as specifically provided otherwise in this chapter."

"* * * * *

"(3) The exemption from liability given an employer under this section is also extended to the employer's insurer * * *."

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